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A picture of the older homeless female veteran: A qualitative, case study analysis

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ABSTRACT

Background: Homelessness among female veterans is increasing and expected to rise further as more women enter the military. Very few studies qualitatively describe female homeless veterans' needs from their own perspective.

Purpose: Homeless female veterans' perceptions of their homelessness and what they believe is needed for independence and self-sustenance was examined.

Methods: OA qualitative interpretive interview design was used and findings are reported as a case study.

Results: A definitive picture emerged of a homeless female veteran, bounded by several factors they all had in common including age, family upheaval, mental health diagnoses, substance abuse, trauma, and need for information and networking.

Introduction

Over the past 30 years, women have entered the military in ever-increasing numbers, leading to rising numbers of female veterans. With the military services now allowing women to enter service in direct combat roles, although they have actually seen combat in the recent wars, these numbers are predicted to climb sharply (Goldstein, Dinh, Donalson, Hebenstreit, & Maguen, 2017). In addition to the increasing numbers of female veterans, there also has been a concomitant increase in female veterans who are homeless.

An accurate count of the numbers of homeless in general has been problematic, primarily due to the inconsistent and sometimes restricted definitions of *homelessness* (Busch-Geertsema, Culhane, & Fitzpatrick, 2016). Most definitions of homelessness include an individual or family not having permanent housing, those staying in a shelter, on the street, or other unstable housing situation, such as *couch-surfing* (National Health Care for the Homeless Council, 2018). However, some definitions are limited only to those who are on the street (Busch-Geertsema et al., 2016). Although homelessness in the United States has declined slightly from 2016 to 2017, homelessness among both male and female veterans has slightly increased during that same timeframe with the most substantial increase being among unsheltered veterans in major urban areas (US Department of Housing and Urban Development, 2016; US Department of Housing and Urban Development, 2017). Despite the emphasis on homelessness among veterans and a decline in overall veteran homelessness since 2009, approximately 40,000 veterans are estimated to remain homeless on any given night. Although veterans usually have lower poverty rates than the general US population, numbers for those veterans at risk for homelessness range from 341,000 to 1.4 million. Reasons vary and include disability, support and relationship issues, age, and geographic location (Department of Veterans Affairs, 2017a; National Center for Veterans Analysis and Statistics, 2016).

It is difficult to find current statistics about the number of homeless women veterans, however the Department of Veterans Affairs (2017b) stated that women veterans are two to four times more likely than their male counterparts to encounter homelessness sometime in their lives after leaving the military and that 10.3% currently live in poverty, with 22.2% earning less than $20 K per year. Boothe (2017) indicated that 8.6% of all homeless veterans without shelter are female. Reports of numbers of female homeless veterans differ according to source and range from 3300 (US Department of Housing and Urban Development, 2016) to 14,000 (Montgomery & Byrne, 2014) to 55,000 (Boothe, 2017). Boothe (2017) contends there is a substantial number of women who cannot afford housing, meaning they are without homes, but are couch-surfing or relying on families for shelter. These women are not counted in the Housing and Urban Development (HUD) and Veterans Administration (VA) numbers.

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Study purpose and aims

In our original qualitative study, we proposed to investigate homeless female veterans' perceived reasons for homelessness, how they got there, and what they understood they needed to attain and sustain independence. We were able to achieve this, however during our interviews, it became evident that very similar characteristics bounded the sample we had, so we report our results as a case study.

Literature review

Reports about the over-all numbers of female veterans in the United States vary from 1.9 million, projected as of 09/30/2018 (Department of Veterans Affairs, 2016) to over 2 million (Department of Veterans Affairs, 2017a). Of these women, approximately 45.8% are 25–49 years old, and 33% are 50–64 years old. Within these two age groups, the largest sub-group of women veterans are 50–54 years old, comprising about 12% of the total female veteran population (Department of Veterans Affairs, 2016). These women likely served during the Desert Storm and Iraq/Afghanistan conflicts, two wars that were very different from previous wars because circumstances of combat were unpredictable and more pervasive (asymmetric warfare). The 2016 Annual Homeless Assessment Report (AHAR) (US Department of Housing and Urban Development, 2016) indicated that the largest increase of homeless veterans in the last year had occurred in Colorado, with a 24.3% upsurge, although the 2018 AHAR (US Department of Housing and Urban Development, 2018) reported a large increase in California at 29% of all veterans and half of all veterans who are unsheltered. This report also stated that women veterans had a higher rate of being unsheltered when compared with those who are sheltered.

As of 2018 (VA Programs for Homeless Veterans Fact Sheet, 2018), the HUD-Veterans Administration Supported Housing (VASH) voucher program stated it had provided housing vouchers in an attempt to house and care for more than 85,000 veterans who were homeless or at risk for homelessness, although this report does not differentiate or provide numbers of female homeless veterans. Female veteran homelessness is speculated to rise as more women serve and then return to civilian life after their service or deployment.

While there may be an overall decline in veteran homelessness, some literature also suggested a small increase in urban and a larger increase in suburban/rural female homelessness across the country (Mondello, Bradley, McLaughlin, & Shore, 2009). The lack of programs designed specifically for the seemingly growing numbers of female homeless veterans is troubling (CNBC, 2015). Additionally, many of the women may not access VA services, to include healthcare (Fitzgerald, 2010; Tsai, Mota, & Pietrzak, 2015; Washington, Farmer, Mor, Canning, & Yano, 2015). However, Gabreillian, Yuan, Andersen, and Gelberg (2016) found that more women used the VASH program than those who remained unsheltered. Montgomery and Byrne (2014) provided a secondary analysis of data from one large urban area about housing (female N = 47) and found roughly three-quarters of these women veterans used VA homeless services. The number of homeless women veterans who have not accessed the VA system specifically for housing assistance could not be found after an extensive search of the world-wide-web and the literature.

Most studies about homelessness in veterans that were published prior to the past 10 years investigated only the male population (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006; O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003; Tessler, Rosenheck, & Gamache, 2002). Of those studies that also examined female veterans, the females were described as part of the larger population of homeless veterans and no distinctions were made concerning their specific needs (Chen, Rosenheck, Kasprow, & Greenberg, 2007; Gabreillian et al., 2016; O'Connell, Kasprow, & Rosenheck, 2016; O'Toole, Roberts, & Johnson, 2017). In contrast to the literature about homeless male veterans, a smaller amount of published information deals with homeless female veterans, their risk of homelessness compared to that of nonveteran women, or their sociodemographic and clinical characteristics compared to those of other homeless women.

Gamache, Rosenheck, and Tessler (2003) studied 2658 homeless women from 1994 to 1998 and found that the highest risk of homelessness was in the 45–54 year age cohort, coincidentally the age of the highest numbers of female veterans. These women were more than four times as likely to be homeless than their male counterparts. Washington et al. (2010) conducted a quantitative case-controlled survey study of 33 homeless women veterans to examine specific risk factors for homelessness. They found that many of the greatest predictors of homelessness in women in general, such as being unemployed, disabled, or single also were the strongest predictors in women veterans, yet their rates of homeless were much higher than the non-veteran population. Unique to this study was the inclusion of women from three war eras, to include Vietnam, Desert Storm, and the wars in Iraq and Afghanistan. The average age of the homeless women was 54.6 years and none of that age group had served in the recent wars in Iraq and Afghanistan. Washington et al. (2010) also indicated that Vietnam era female veterans were most at risk for homelessness. Of interest is that 57% of the homeless women reported poor health as compared to only 29% of the housed veterans. There was more Post-Traumatic Stress Disorder (PTSD) and anxiety among the homeless. The researchers did not differentiate the needs of women from different war eras. Therefore, it is reasonable to expect that veterans of varying age groups and from different war eras have varying needs, some more acute than others. It is also speculated, based on the ages of the participants, that those younger veterans had not yet reached the shelters, as borne out in a study conducted by Tsai, Rosenheck, Kasprow, and Kane (2015).

Hamilton, Poza, and Washington (2011) also conducted a qualitative study using focus groups comprised of 29 homeless women veterans and concluded that many of the participants ascribed trauma occurring during military service to their difficulties after leaving service. Tsai, Rosenheck, Decker, Desai, and Harpaz-Rotem (2012) supported the fact that various types of trauma seemed to be prevalent among the female homeless veteran population but concluded that the trauma could have been experienced at any point in their lives, not exclusively during military service. Only these two studies directly examined the characteristics of homeless female veterans. Other studies examined housing (Tsai, Rosenheck, & McGuire, 2012), effectiveness of a cognitive behavioral therapy intervention (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008), and secondary data about mental health disorders (Leda, Rosenheck, & Gallup, 1992). Although most studies reported this population suffering with PTSD and other unspecified mental health disorders (Desai et al., 2008; Hamilton et al., 2011; Leda et al., 1992; O'Connell et al., 2016; Tsai, Rosenheck, Decker, et al., 2012; Tsai, Rosenheck, & McGuire, 2012), only Washington et al. (2010) reported anxiety as a risk factor, although they did not disclose which anxiety measurement scale was used in their study.

Methods

Case study

Initially, the chosen methodology for this study was qualitative interpretive phenomenology to describe the Homeless Female Veteran population. This methodology was deemed to be appropriate for use in this study because the women to be interviewed seemingly had devolved into a situation where they could no longer maintain their independence. A thorough understanding of the processes leading to their situation was needed to begin to appreciate their needs and design potential interventions to assist them in regaining their independence. However, as recruitment progressed, it became clear that the women interviewed were bounded by age and several other similar characteristics, painting a distinct picture of an older female homeless veteran. No younger veterans from the current conflicts in Southwest Asia were

able to be recruited, despite numerous and varied attempts. Thus, we subsequently decided to report our results as a case study given their attributes. Meyer (2001) discussed "case study" methodologically from the standpoint of its strengths and weaknesses, but emphasized the need to be explicit in making decisions regarding the design and processes one follows. She defined a case study as contextual and process-oriented, yet open to the understanding of human behavior that is not well understood. A case study is actually in keeping with the Heideggerian notion of "being as evident" as entwined with the voice of the females being interviewed. Schramm (1971) described a case study as particularly amenable to the process of making decisions regarding interventions based on a set of circumstances. Yin (2014) further defines that a case study "investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not clearly be evident." (loc. 951–952)

Recruitment

Participants for this study were recruited at a homeless shelter for women in a large southwestern metropolitan area in the United States. Directors of women's homeless shelters across several urban areas were contacted to determine if women meeting our inclusion criteria were available for recruitment. The following inclusion criteria were used to guide the purposive selection of potential study participants: had served in one of the military services, were female, and were homeless and residing in a shelter, were 18 years or older, were able to speak and read English, and were able to provide informed consent. All women meeting the study inclusion criteria were enrolled as participants. The final sample size for this case study was five women.

Procedures

Protection of human subjects

Institutional Review Board (IRB) approval was obtained prior to data collection from both universities at which the authors are affiliated and are available upon request. A waiver of documentation of consent was requested to preserve confidentiality of the participants and this was granted by both IRBs. Participants were given a consent form to read and the investigators explained the study, giving participants adequate time for questions. Each participant elected to sign the written informed consent document although they were told this was not a requirement. Because the women were vulnerable, they were asked if they desired the homeless shelter director to be present during the interview. All the participants had established a professional relationship with the director and asked that she be allowed to remain present for support. To mitigate any potential acute distress in the participants, the director of the shelter had immediate access to mental health counselors should they be needed. Participants were told they could stop the interview at any time or if they became emotionally distressed. All the women cried at some point during their interviews but none of them wanted to stop relating their stories, as painful as some of them were. Data collection took place in a private room in the homeless shelter and interviews were audiotaped. To protect participants' confidentiality, all participants interviewed were identified using a pseudonym. All audiotapes and transcriptions were stored as digital files in a password-protected computer with no identifiers other than a participant number.

Qualitative approach

Data collection

Participants were interviewed individually and provided consent to have their interviews audiotaped. A digital recorder and a computer using the Soniclear™ audiotaping program were used to collect the data. After informed consent was obtained, sociodemographic data, including age, marital status, time served in the military, deployments, and branch of service were collected via a demographic data collection tool created by the investigators. Audiotaping began after sociodemographic data were obtained. Each interview lasted 60–90 min and all participants received a $25 gift card after completing the interview.

We conducted five separate interviews of women who were sheltered in a large metropolitan city in the Mountain West. Our line of questioning was consistent with the study purpose, asking such questions as, "How did you come to be homeless?", and "What do you think would help you achieve and maintain independence?" Between each interview, discussion of the content by the investigators allowed for probing of specific topics for more in-depth exploration of themes heard in the interviews. Theoretic saturation was reached with the five participants. Into the fourth interview, the investigators began hearing many of the same themes, but a fifth interview was conducted to ensure saturation of the subject matter and because the five women interviewed were scheduled and willing to give their time to us. We attempted to find a comparative sample of younger homeless female veterans from two other cities within the state but were unsuccessful. We were told by shelter directors that younger women had not yet been seeking care at the shelters and surmised they were relying on friends and families, not wanting to be found out for fear of having children taken from them. Furthermore, the directors stated these young women were expected in the future because of the number of men from the Iraq and Afghanistan wars who were coming to them for assistance. The search was even expanded to include women who were using services, but who were still housed (considered near homeless) without success.

For analytic consistency, transcripts were coded separately by the investigators, both of whom are experienced in qualitative analysis. Data were managed using the Atlas.ti version 7 qualitative software program. Both investigators met in person twice to discuss findings and held several phone conferences to determine themes found in the data. Themes were clustered and categorized to achieve theoretical congruence and ensure the meanings were manifested in the data to ensure trustworthiness.

Results

Demographic characteristics

Early into the process, the investigators realized the boundaries that ended up forming the case reported here. All of the women in the study were aged 50 or older. Five female homeless veterans representing three branches of the U.S. Armed Forces: Army (n = 2), Navy (n = 2), and Air Force (n = 1) participated in this study. Only the Air Force participant had ever been deployed to a war zone, but she deployed to Saudi Arabia, Bahrain, and Europe during Desert Storm. All the participants served as enlisted personnel; the sample did not include any officers. This is an important distinction and may have contributed to some of their military experiences. The women's average age was 55 (SD = 7), and their length of military service ranged from one to ten years (mean = 4 years); they served during the years spanning from 1964 to 1992. All of the participants were living alone; three were divorced; one was married but separated and one was single and had never been married. None of the participants had dependent children at the time of the interviews. One participant had placed her children up for adoption when she entered the military. Of the three participants who had been married, one was estranged from her children and was not allowed to see her grandchildren; another was estranged from her son and was asked to leave his home after staying with him for a brief period of time; and a third divorced participant lost custody of her children to her ex-husband and did not have visitation rights. Three of the women possessed an Associate degree, one had completed some college, and one had completed only high school.

Qualitative results

Several themes emerged from the data. These included family history of abuse, substance abuse, family upheaval, military sexual abuse, being able to live minimally without having to work, mental health diagnoses, need for information, and networking.

Family history of abuse

All the women consistently reported differing types of abuse as children. This ranged from verbal abuse to physical violence, to explicit and prolonged sexual molestation. One woman described a long history of incestual relationships with multiple family members, including immediate and distant relatives. To protect this individual's confidentiality, we included no quotes in this paper from her interview regarding sexual abuse as a child. Several of the women reported denial within the family surrounding the abuse, but all of them reported its pervasive presence.

> "…the boys were physically abused. They were a challenge and my dad physically would punch them. And, we heard it. My mom wouldn't do anything. I didn't want to live like that. The girls, he just threatened with violence. He had a rifle in his closet. When he thought things were really bad with this[sic] girls, he would bring it out and say, I brought you in this world and I will take you out. We didn't know any different. At that time if you complained you would get taken away."

Much of the verbal and physical abuse was a result of a family member with substance abuse. This included alcohol and other illicit substances, but alcohol seemed to be the prevalent substance abused.

> "I remember when we were getting a little older, my dad.... there wasn't alcohol in the house that I ever seen, but my dad started going out on Friday nights to bowl. He would come home drunk and start hitting my mom. And, they will both deny it, but we saw it. Yeah, he came home drunk and….."

Personal substance abuse

Most of the women discussed their personal struggles with substance abuse, but also described substance abuse within their families as a contributory factor for their use; with parents, siblings, and children. It varied from person to person but was mainly alcohol and marijuana. None of the women described harder drug addictions. One woman denied either drugs or alcohol, but related that her "drug of choice" was food and it had caused her obesity and numerous related health problems.

Most of the women were interested in discontinuing substance abuse, but they all seemed to return to their substance of choice, either because they had extra money, or found themselves in stressful situations. The women seemed to use substances as an escape from their situations, but they all realized it was not productive, or substance abuse created more troublesome situations.

> "When I had substance abuse. It got so bad that I wasn't functional anymore, which got cornered. Went into treatment through the VA. Um, a total of eight, eight and a half months through treated facilities. Um, ground down in (site deleted) for 30 days. (site deleted) for six and a half months and (site deleted) for 30 days. And after that I returned to (site deleted). And I didn't last too long as far as for using again. Alcohols the main problem but I'll do anything. So it's been substance abuse that's put me here."

Anecdotal sources cite a significant rise in shelter use as a result of the recent legalization of marijuana in the state in which the study was conducted (Larson, 2014; McGhee, 2014). Recent research across the United States demonstrates marijuana as one of the most used substances of individuals who wind up in homeless shelters (Carmona, Slesnick, Guo, Murnan, & Brakenhoff, 2017; Patanwala et al., 2018; Stringfellow et al., 2016).

Family upheaval

All the women described coming from very dysfunctional families. However, interestingly, they did not label it as other than their "normal." They matter-of-factly discussed the different dysfunctions experienced within their families. They described the death of a parent or sibling, moving in and out of foster care or being shuffled from relative to relative, then having dysfunctional relationships with spouses and children as if these events were nothing out of the ordinary. In fact, for all these women, it was quite routine for them and they had no different expectations for their future.

> "I went through some foster care. My father was abusive and in all ways abusive and he died when I was 12 and my mom abandoned us - there were three children and two of us went to live with my father's relatives in Alabama…… We felt we were going to stay for a couple of weeks but we ended up staying with them and becoming wards of the state and once I knew I could get out of my aunt's home - which was also abusive - I ran away and was put in foster care. So I was in foster care for about a year and a half, in seven different foster homes and then I got in trouble in the last one with the other foster kids that were there…… I was 13, close to 14. But I was pretty much making my own decisions."

A number of the women felt compelled to care for family members who were also in trouble, despite being unable to care for themselves. Rather than try to get their own lives on a better path, they somehow believed that helping their grown children, parents, and friends, would improve their own situation.

> "For instance, the last time I guess, I went intending to help my mom because she's really old and I brought her up here for a little while to stay here but she didn't like the north so she wanted to go back to the south, so… I did that and then I brought my daughter and her kids up here and she stayed about three days in this place and she doesn't like rules so she has since left and went back to her abusive boyfriend…."

However, they all reasoned it could have been some of this enabling dysfunction that led to their ultimate homelessness. It was almost as if they could solve their own issues if they could solve those of others.

Sexual abuse while in the military

Almost all of the women experienced some manner of sexual trauma while in the military. The abuse ranged from harassment to blatant sexual exploitation. Many of the women admitted that alcohol and drug use was a contributory factor to some of this abuse.

> "….Yeah. There was continuous harassment just because it was the environment, that's just how it was and of course the alcohol along with it, it made it a lot easier for everyone to think it's okay. There were several instances where, after having been drinking myself, I would get involved with people sexually and then realize after that it was all wrong, that all of this shouldn't have happened……."

One woman who found herself one of only a few women in a drug abuse treatment program described a particularly difficult experience. She related that because of her anxiety regarding potential sexual abuse during the rehab, it was not useful for her.

> "I will say that the treatment I'm going to in (name removed) is all female. When I went before it wasn't. Now (name removed), I was the only female in 18 patients. That wasn't an issue. I went to (named removed), which was a nightmare because there was, like,

200 veterans. It's not really a treatment program. It's more uh, get some sober time under your belt type. It's a domiciliary. Okay. There was about 200 vets and, at best, 10 females. And it was a nightmare. And I managed to stay on there for six and a half months. But you were a banana in a monkey cage as far as being a female. And they did not, they tried. They really tried. There is only so much you can do when you're outnumbered like that….It was pretty much a playground for male vets that didn't want to do anything."

There was a prevalent feeling among the women that the rank structure prevented them from reporting and that they could get special treatment and career progression if they went along with some of the abuse. However, the women also believed they somehow contributed to it. Furthermore, it is noted the times of service for the women in our study was 1964–1992 and we recognize that efforts have been made, however successful, in preventing Military Sexual Trauma (MST).

Living minimally

Many of the women interviewed, though they had marketable job skills, admitted they were comfortable living minimally, or with just the benefits they had. However, many of them also had numerous jobs or admitted the inability to keep jobs they had because of substance abuse issues.

"And I got real odd jobs, I worked for a cable company as a secretary for a while and since then I've been doing mostly admin work. First, it was for a temp agency, and just secretarial typing and stuff and then a cable company, installing cable for about five months and then as a bartender …And then, went to school and got a degree in medical assisting….."

Another woman stated,

"I just started drinking again. I don't know if drinking has to do with self-sabotage, I do that. But, I wasn't doing well at my job… paralegal."

Yet another stated she did not want to work because having money was just a trigger to start using drugs and alcohol, so she would rather live very frugally on the streets than be using again.

Need for information and networking

We found it very interesting that not one of the women we interviewed were aware they had benefits from the Veteran's Administration (VA) before they entered the homeless shelter. It was only then that they were encouraged to seek benefits to which they were entitled. One of the women had been out of the military for over 30 years, been in several dysfunctional marriages and relationships, and claims she was told upon leaving the military that she had no VA benefits. All the others were under the same impression. Even though most of them had suffered some sort of sexual assault prior to and since being in the military, many of them had also suffered MST, an occurrence that automatically allows treatment at the VA. However, their separation from the military occurred at a time when servicemembers were not generally made aware of their benefits, as they are currently. Subsequent to entering the homeless system, the participants all now receive at least mental health care from the VA, and some of them receive other disability benefits.

The women spoke of forming networks with other friends and homeless people to get many of the services of which they availed themselves. For example, one woman, who was residing in another state, spoke of calling on friends to find out if there were homeless shelters in the area where she wanted to move and was informed of the services of that particular shelter. Another spoke of visiting the local VA hospital where she could get information and support from other veterans. She also told us how she was very interested in helping other veterans through their experiences, because of what she thought she had missed.

Some of the women spoke of social networks among the homeless, where they could get meals, where they could find shelter, and learn about the places to avoid. Because of the length of time most of these women had been separated from the service, they did not have recent military friends to whom they could turn, but they were able to find and develop new networks of former military service members, many of them homeless themselves, who could advise them.

"And, the guy told me, I remember he told me… the first guy I met said, You know, the first two days are the hardest… or no, the first three days are the hardest. He said, after that, you will be okay. He said, but the first three days are fine. And then, later I had met some women. They gave me a couple of names of different places that were helping homeless".

Discussion

Based on the prevalence of issues heard from the five women interviewed, it became clear that, at least for these older women, there were many of the same factors contributing to an emerging picture of a homeless older female veteran. Thus the "Case" for this particular research was bounded by the following factors. First, there were multiple factors rather than a single event that led the veterans to end up ultimately in a shelter, or housed unstably. Second, the older female veteran seems to have had many resources upon which she relied for prolonged periods of time before becoming homeless. These resources were through any combination of spouses, children, or friends. Even when homeless, they relied upon other homeless veterans for information about where they could shelter or find other benefits to remain off the streets. Third, the older homeless female veterans experienced childhood abuse or family upheaval, but they perceived it to be their "normal." Even adverse experiences in the military and afterward were not perceived as peculiar for their circumstances. This would seem to support the idea it is unknown whether a female veteran becomes homeless as a product of military service or whether their situation is a reflection the self-selection of women with predisposing factors for homelessness after serving in the armed forces (Gamache et al., 2003). Fourth, the older homeless female veterans all had mental health disorder diagnoses. All of our participants had one or more diagnoses, to include depression, anxiety, and anger. Fifth, all of the women related personal drug or alcohol abuse. The only woman who did not use illicit substances identified food as her "drug of choice," and blamed this for her obesity. Sixth, although the educational level of these women could potentially support an independent lifestyle, they all stated they could live minimally on the benefits they received either from the VA or Social Security. One, in particular, chose not to work, believing having money only fueled her drug addiction. Last, none of the interviewees realized or were told they had veteran benefits when they left the military. In fact, most of them related being told they had no benefits, having left the military voluntarily after only a few years and prior to benefits being widely known. Only after they found themselves in a desperate situation and in the homeless shelter did they learn of the possibility of benefits for care.

Limitations of the study

The picture that emerged of a homeless female veteran was limited to the age of our sample and of not being able to find younger women, despite contacting numerous shelters across the regional urban areas known to house veterans, and in communities with large populations of veterans. Therefore generalization of our results also is limited, however, potentially could be applied to those in this population or to those who will eventually be of the age of the women in our study. Despite having a sample size of only five women, we were able to achieve

theoretic saturation within the interviews.

Conclusion

As we were speaking with these homeless women and analyzing their words, it became clear that a single face of the older female homeless veteran was emerging from the data. This picture was one of an older woman who had experienced difficulties/abuse in childhood and had developed specific dysfunctional coping strategies. These coping strategies persisted during active military service and she was not able to remain in the military until eligible for retirement. The dysfunctional coping strategies continued after leaving the military, preventing her from engaging in a purposeful, productive life. The picture also included mental health disability and continued substance abuse. Although she may have expressed hopefulness about the future, she also seemed resigned to her circumstances as normal, a sort of "giving up" and acceptance of continued poverty and living minimally. However, the resourcefulness of the homeless female veteran was very apparent in her ability to remain out of a shelter or the streets until she had exhausted the kindness of friends and family (couch-surfing). Once the female veteran had discovered and entered the Veterans Healthcare System, she found more resources and re-entered a certain camaraderie with other female veterans. However, there was some trepidation in the full use of the system because of past male abuses.

As we ascertained this picture of an older homeless female veteran, we began to discover some ways in which these women could be supported during their transition from military to veteran status to mitigate their chances of eventually becoming homeless. First, none of our participants were aware they might be eligible for veteran's benefits and, as it turned out, all of them were. Today's veterans are given more information of benefits and of those specifically designed for women as part of their transition back into civilian life, however, it does not seem to be enough to keep female veterans from becoming destitute and then, homeless. Second, although mental health services while a woman is still in the military are available, more needs to be done to remove the current military cultural stigma surrounding help-seeking. Third, the women described separating from the military and finding themselves lost because they did not have the structure found in the military lifestyle. Vulnerable service members should be identified and we recommend that as a woman transitions out of the military, an individualized assistance program be developed to assist in providing some structure to a post-military life.

Finally, we would like to express our sincere appreciation to these women for the gift of their stories. Some of them were difficult for them to express and difficult for us to hear, but they were willing to openly discuss how they came to be homeless and all took some personal responsibility for winding up in a shelter or on the streets. Although they definitively had difficulties with their mental health, they also had a mental toughness to persist.

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