

# **Negotiating the Margins: Aging, Women and Homelessness in Ottawa**

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## **Abstract**

As the population ages and income disparities increase, issues affecting older adults and marginalized individuals are examined more frequently. Despite this, little attention is paid to the community experiences of women over the age of fifty who face marginalization, criminalization and homelessness. This study is an institutional ethnography of older marginalized women in Ottawa, focusing on their identities, lives and their experiences of community life. Its findings are based on ethnographic fieldwork as well as interviews with 27 older marginalized women and 16 professionals working with this group. The women described their identities, social networks, daily activities and navigations of their communities as well as the policy and discursive framework in which their lives are situated.

Regardless of whether the women had housing or were staying in shelters, upheaval, uncertainty and change characterized their experiences in the community, reflecting their current circumstances, but also their life courses. Their accounts also revealed how, through social support, community services, and personal resilience, older marginalized women negotiate daily life and find places and spaces for themselves in their communities.

As an institutional ethnography, this research foregrounds participants' responses, framing these with theoretical lenses examining mobilities, identity, social capital, governmentality, and stigma. Specifically, it uses the lenses of mobilities and identities to understand the nature of their community experiences, before moving outward to examine their social networks and the world around them. Governmentality theory is also used to describe the neoliberal context framing their community experiences. The study concludes with a reflection on the research and a set of policy recommendations arising from the study.

## Acknowledgements

While my name appears on the title page of this dissertation, completing this degree was far from a solitary pursuit. Although the arguments advanced herein are my own, none of this would have been written without the support and assistance of those around me.

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## **List of Acronyms**

AA	Alcoholics Anonymous
ACTT	Assertive Community Treatment Team
APPLE	A Post-Psychiatric Leisure Experience
CMHA	Canadian Mental Health Association
CPP	Canada Pension Plan
CSC	Correctional Service Canada
GIS	Guaranteed Income Supplement
LHIN	Local Health Integration Network
NA	Narcotics Anonymous
OAS	Old Age Security
ODSP	Ontario Disability Support Program
OHIP	Ontario Health Insurance Program
OICH	Ottawa Inner City Health
OIM	Ottawa Innercity Ministries
OPH	Ottawa Public Health
OW	Ontario Works
PG&T	Public Guardian and Trustee
PNA	Personal Needs Allowance
NIMBY	Not In My Back Yard

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# Chapter I – Introduction

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# 1 Introduction

More and more of those people have fallen through the cracks and are looking at a life of, you know, from fifty to seventy – I'm going to be poor. Great; I'm going to be in and out of shelters for the rest of my life. In a town like Ottawa, I think a lot of people who do have decent jobs don't see that. They don't see the reality of what's out there. I've seen it only because I've spent some time in jail and I've spent some time in shelters. *I've seen the other side.* – Kristin<sup>1</sup>, age 50

I think a lot of it has to do with attitudes. *You don't expect a senior to be in a shelter.* Honestly, that's what it boils down to. We all like to believe in that magical thinking, that you're an addict and you drink and you do all these things and you're whatever when you're younger. We like to think that as you age, you mature and that's not your life. That's not true. – Staff, Hope Outreach

As the population ages, and particularly as the baby boom generation reaches their senior years, governments, as well as the mass media, the health care industry, researchers, and those who themselves are aging have all shown an increased interest in aging-related topics, issues and concerns (Abu-Laban and McDaniel 2004; Canada 2002; Foot 1998; Health Canada 1999; Holstein and Minkler 2003). This demographic change highlights older adults' needs, in general, are more frequently considered in terms of the impacts on government policy and programs, especially regarding health care and pension issues; however, little attention is paid to those older adults who are less fortunate. Indeed, when one considers homeless, criminalized, or otherwise marginalized individuals, the first images that come to mind are often of *men* lined up at soup kitchens; *young adults* in conflict with the law; or *single mothers* looking after young children and struggling to make ends meet on welfare. While these images undoubtedly reflect some of the faces of homelessness, criminalization, and marginalization, one group that is notably absent from this picture is *older women*, particularly women aged fifty and older. This research aims to further our overall understandings of older marginalized women, particularly those living in Ottawa, examining how they form identities and navigate daily life.

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<sup>1</sup> This is a pseudonym, as are the names given to all of the older marginalized women whose voices are included in this research.

Recently, the health and pension costs of older adults have been front and centre in funding and policy debates (Commission on the Reform of Ontario's Public Services 2012; M. Kennedy 2012a, 2012b). In addition, older criminalized adults have received increasing attention over the past several years due to their growing numbers and health needs (Aday 2003; Aday and Krabill 2011; Uzoaba 1998; Wahidin 2004; Wahidin and Cain 2006). For example, Wahidin (2004) indicates that in the United Kingdom, prisoners aged fifty and older account for one-half of prison health expenditures. While the *costs* of aging bring older adults into the spotlight, collectively we still ignore the *experiences* of aging, marginalization, and homelessness. Although some data on older women and marginalized people exist, there is a gap in knowledge surrounding older marginalized women, particularly their identities and social networks. My project helps to fill this gap; I examine how older marginalized women construct identities and navigate the social world. Specifically, I study older women – those who face social ostracism, isolation, and blocked opportunities – both social and economic – resulting from addictions, criminalization, the aftereffects of imprisonment, homelessness, poverty, discrimination (e.g., ageism, classism, racism, sexism), mental and/or physical health issues, or social disinvestment in them and their communities. They often lack ties to employment, relying on state assistance to survive. These physical, social and economic conditions leave them vulnerable to further deprivation, isolation, and hardship that block opportunities for their social integration (cf. Comack 1996; Maidment 2006; Shantz and Frigon 2009; Shantz, Kilty, and Frigon 2009; Strimelle and Frigon 2007, 2011; Uggen, Manza, and Behrens 2004). In my study, I explore these women's identities; the policies, structures, discourses and conditions affecting them; the composition and construction of their social networks; and how they access resources and meet their needs in the community. In the process, I interrogate how policies, discourses and contemporary society affect marginalized women's experiences of growing older. I also turn my

attention to the theoretical domains of governmentality and social capital, examining how social discourses, power relations and governance tactics influence women's lives, identities and social networks.

Older marginalized women are a very small, but rapidly growing segment of the population due in part to increasing social inequalities and demographic aging (Connidis 2002; Sen 2000; Uzoaba 1998). They have limited ties and supports in the social world and are largely overlooked in contemporary social discourses and dialogues (e.g., discussions on "healthy aging"; defined benefit or defined contribution pension plans; seniors' travel and recreation, etc.) as well as in everyday life. Older marginalized women find themselves on the boundaries of society and not easily fitting within pre-existing stereotyped categories, such as grandparent or retiree. This marginalized position leaves them with limited and tenuous social networks (Keating, Swindle, and Foster 2005; Novak and Campbell 2006). Older marginalized women are often forgotten in existing criminological and sociological research, yet their realities deserve exploration. Indeed, these women must form identities whilst navigating and negotiating stereotypes and social discourses portraying them as objects of pity, humour or revulsion (Calasanti, Slevin, and King 2006; Codd 1998; McDaniel 2004; Shilling 1993). While they are often marginalized, the women are not without agency or social ties; they still have identities, relationships, and social networks (cf. Wahidin 2006; Washington 2005). This research explores women's identities and social networks, examining how they see themselves and their place within contemporary society, and increasing our understandings of their lives and how they actively negotiate their place in society. As the Canadian population ages, and the numbers of older marginalized adults grows, research examining aging and social inclusion in this group has become increasingly important and urgent.

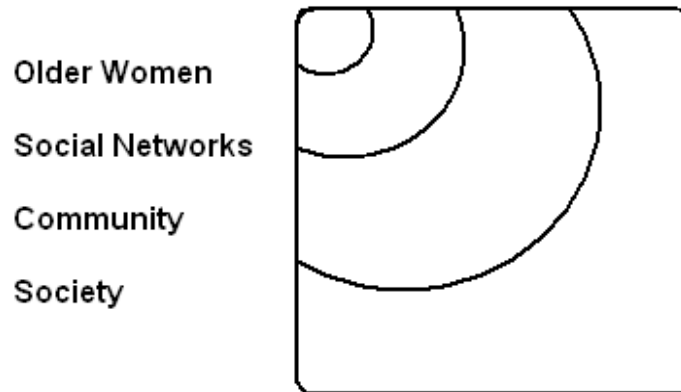
## 1.1 *Research Approach*

This research arose out of a series of slow afternoons and long nights spent working at a women's homeless shelter. Working in a shelter can be hectic and stressful even on a good day, but there are invariably moments of calm and quiet, even of boredom. In these slow moments, I would often look to the bed list – a computer-generated list of shelter residents that includes the individual's name, date of birth, room assignment, and date of arrival – to better learn the women's names and also entertain myself by noting the length of the women's stays (some up to four years); finding the woman whose birthday was closest to mine in the year (one woman had a birthday one day before mine); and counting the number of women younger than me (usually about 10 of the 55 women). My little game took a serendipitous turn one day when instead of counting the number of women *younger than me*, I instead counted those who were *older than my mother*, and then *older than my grandmothers*. The fact that there *were* women of my mother's age in the shelter did not surprise me, but the fact that there were regularly 10, 15 or 20 of them certainly did. And, women *older than my grandmothers in the shelter?!?* Who were these women? What brought them here? Where would they go next? This research project represents my attempt to answer these questions.

In my attempts to understand how older marginalized women construct identities and navigate the social world, I recognized that traditional data sources offered little information on this group. I also wanted to ensure that my research accurately reflected the lived realities of the women that I had met through my work. Therefore, I sought out knowledge from experts in this area: older marginalized women. I approached this inquiry as an institutional ethnography (cf. Smith 1987, 2005), examining the women's accounts of their experiences, and also the accounts of those who work with and for them in the community and the structural (policy and discourse) framework in which they are situated. This method of inquiry examines older marginalized

women, and then, like tracing the ripples after a stone is dropped into the water, examining an ever-widening view of their worlds and experiences. The following diagram highlights how these analyses fit together.

**Figure 1.1: Logic Model**



I used several lines of questioning to learn about the women and their worlds. First, I explored the women's lives, focusing on *who they are* but also on the journeys (temporal, physical, and emotional) that brought them to the places and spaces where they met me. Following this, to understand their interactions in the social world, the women were asked about the world around them – essentially – what they did, where they went, and who they talked to along the way. Next, I asked the women to describe their social networks, including the composition of the networks and what the networks mean to them. Next, the women discussed the programs, services, and organizations available to them in the community. The final questions explored how the women interpreted discourses on aging and marginalization and their places within these discourses and social understandings.

In the interviews with the experts, my questions focused on the environment in which services are delivered and received. This included a discussion of the participants' roles; the work they and their organizations do; and an overview of the people that they serve. The interviews also explored older marginalized women's needs in these settings. The final line of questioning

addressed the public policy and social discourses on aging and marginalization. Together, I use these perspectives, my experiences as a shelter worker, and policy and regulatory documents affecting older marginalized women in the community to form a picture of their worlds.

## **1.2 Organization**

The following chapters detail the components of my study, demonstrating what I did and how I did it. Chapter II provides background information on older marginalized women, by way of a literature review highlighting existing research. It describes older marginalized women and issues of aging and marginalization. The chapter also includes an exploration of how these women form identities and navigate community life.

The theory chapter further investigates older women's identities and social networks, using the notions of mobility (cf. Urry 2000, 2003), as well as performance and performativity (cf. Butler 1988, 1990, 1993a; Goffman 1959, 1963), to examine identity performances, sedimentation, and the women's navigations of the social world. I also examine the environments in which these performances occur, highlighting the context of the risk society and the stigma women face in the community (Goffman 1963; Hannem 2012b). The chapter concludes by examining resistance and resilience in older marginalized women's navigations of the social world.

Chapter IV documents the research approach used in this study, explaining in detail how the study was conducted. I explain the study's epistemology, my methodological choices, as well as sample selection, recruitment, data collection, and analysis. I also include an overview of my sample, providing readers with a better understanding of who the women are and how they compare to marginalized women in general. In addition, I discuss two issues that proved challenging from both ethical and practical standpoints: first, an exploration of how I managed

my identity and my roles as a researcher and shelter worker; secondly, I examine the muddiness of 'truth' and 'fiction' in the research process.

After these foundational pieces are outlined, I move on to present the analysis of the research results. In these chapters, the focus is primarily on the women's accounts of their experiences, linking their observations and those of the professionals to the theories and concepts outlined in the earlier chapters. These chapters follow the flow set out in the logic diagram above. The focus begins with the older marginalized women and broadens to examine their social networks and interactions; community experiences; and finally, the larger social world in which these interactions take place.

The first analytic chapter asks: *who are these women?* It examines older marginalized women's identities, using the women's voices to interrogate questions of identity. The focus is on the nature of their identity performances and the fluidity (or lack thereof) of these performances. The section includes discussions of static and dynamic identities as well as how aging impacts identity. The women's strategies for coping (or not) with these identity changes are also explored, focusing on resiliency and also on negative coping mechanisms and outcomes, including addictions and depression.

The following section moves outward to examine the women's social worlds and ask: *to whom are the women connected? What is the value of these connections?* The chapter begins with a discussion of the value of social networks. Next, it examines the women's networks, including their ties to family and community. The chapter also examines the role of community organizations in the women's social networks and workers' roles as significant social contacts.

Chapter seven moves outward again, this time asking *how do these women navigate the social world?* This chapter offers a phenomenological look at the women's experiences in the community and the service environment, particularly their discussions of the drop-in centres and shelters and their overall treatment by community organizations. The chapter examines *what* the women look for in community services, as well as *how* they perceive the services available to them. I also include some of my field notes in order to provide the reader with description of the environments that the women describe.

Chapter eight reverses the direction of inquiry, asking *how does the everyday world respond to older marginalized women?* After a discussion of the women's physical access to programs and services by way of mobilities within the community, I provide an in-depth examination of a subset of older marginalized women who are labelled 'difficult to serve.' Next, I explore the policies and procedures that affect older marginalized women and how the women respond to these policies and rules. Finally, I discuss the discourses surrounding older marginalized women and how discourses affect them.

In the final chapter, I offer my concluding thoughts on older marginalized women, summarize what I have learned from this study, advance policy recommendations to address older marginalized women's needs, and outline avenues for further research.

## Chapter II – Literature Review

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## 2 Literature Review

We're all human. We all get hurt. We all cry. We all bleed. We all die. It's just that some people grew up with families, some grew up with none. Some grew up being beat all their lives and cowered and had no one to talk to or were too scared to talk to someone. – Deborah

Largely, women outlive men, and again, they often outlive their friends. We also find a lot of people, as they age – a lot of the shit comes out. – Good Companions Manager

Older women on the margins of society are not frequently studied in criminology, sociology, or women's studies. Information on this group, while sparse, can be found at the nexus of literature on aging and gerontology; criminology and social control; health studies; and women's studies, among other literature domains. The literature on these women is limited not just because of their small numbers, discursive invisibility, lack of political clout or the dominant androcentric biases in the social sciences, but also due to the challenges in determining *who* they are. These women are difficult to classify as they do not fit easily into any one category; as they are aged fifty and older, they do not necessarily fit within the commonly-held definition of "seniors" which demarcates age at 65 and above (Uzoaba 1998; Wahidin 2004). They can claim space as women, elders, parents or grandparents, or as ex-prisoners, addicts, homeless, or marginalized people, but the conflicts and tensions within and between these descriptors and their identities place them on the boundaries of a number of these discursive spaces. None of the categories fully describes older marginalized women; the group is too diverse to fit into narrow categories, and the categories themselves may shift in importance for a woman at any given time. As such, they are not only marginalized in the physical world, but are also discursively liminal<sup>2</sup> to the social world and to the purview of the various disciplines that seek to classify them. That is, the women find themselves at the margins, between, or on the

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<sup>2</sup> "Liminal," meaning between spaces, is a term first used in anthropology to describe individuals in tribal societies who are transitioning to a new stage in the life course. As they undergo the various rites of passage, they do not fit easily into "child" or "adult" categories, instead finding themselves "betwixt and between" these two spaces (cf. Turner 1967, 1981, 1995).

boundaries of, more easily defined categories. Indeed, older marginalized women find themselves at the margins of social life, and on the threshold of many different categories with which they may or may not self-identify.

These women, while diverse, share several overarching realities that may affect them to various degrees: they are aging, often at an accelerated rate; they face (or are vulnerable to) poverty, social exclusion and limited choices; they may alter their identities to reflect their changing positions in society and changes in abilities; and they interact with their social networks and broader society in various ways. Of note, these concepts and categories, despite their breadth and general applicability, do not allow these women to be easily defined or compartmentalized. The categories, and the concepts used to define and understand them, interrelate, overlap, and blur together, highlighting the many ways of understanding the women and their lives, while also forming a discursive tapestry that bundles these diverse women together. I note the commonalities as well as the tensions within and between the categories.

I begin this chapter by describing older marginalized women and highlighting some key characteristics of this group. The following section discusses the physical aspects of aging, and the social and environmental negotiations that accompany it. I then discuss poverty and social exclusion, and how these factors limit older women's participation in the social world. Next, I examine identity, including how women's identities change and shift as they age; their ability to express agency through identity; and how women negotiate identity in the social world. This section concludes with a discussion of older women's social networks, relations in the social world and experiences of loneliness.

## **2.1 *A Portrait of Older Marginalized Women***

Older marginalized women are women aged fifty and older who face social ostracism, isolation, and blocked opportunities – both social and economic – resulting from a variety of issues: addictions, criminalization, the aftereffects of imprisonment, homelessness, poverty, discrimination (e.g., ageism, classism, racism, sexism), mental and/or physical health issues, and/or social disinvestment in them and their communities. They often lack ties to employment, relying on state assistance to survive. This constellation of conditions leaves them vulnerable to further deprivation, isolation, and hardship and blocks opportunities for their social integration (cf. Castel 1994, 1995b, 2003; Paugam 1991; Schnapper 1996; Smyth, Goodman, and Glenn 2006; Strimelle and Frigon 2007). Fifty is considered by many to be a relatively “young” age – especially as the baby boomers age (cf. Foot 1998); however, it is often used as a demarcation point to separate “old” and “young” adults in literature on vulnerable and marginalized populations, including the criminalized and homeless as those who face chronic poverty, homelessness, isolation and addictions often experience accelerated aging, including physiological changes normally associated with much older adults (Aday 2003; Cohen 1999; Wahidin 2004; Wahidin and Tate 2005; Washington 2005). For example, they have elevated rates of illness and health conditions, from arthritis and diabetes to colds and infections (Hecht and Coyle 2001; Kisor and Kendal-Wilson 2002; Wahidin 2004, 2004; Washington 2005). By comparing data from a health survey of Ottawa’s homeless to data for Ottawa from the Canadian Community Health Survey, we see that arthritis rates are 2.2 times higher among the homeless; asthma rates are 2.5 times higher; and chronic obstructive pulmonary disease rates are 6 times higher (Alliance to End Homelessness 2011; Statistics Canada 2011). A fifty year-old homeless woman who struggles with addictions, for example, may appear to be many years older than her chronological age, and will likely be in similar, or poorer, health compared to a relatively privileged woman fifteen or more years her senior.

Older marginalized women represent a small proportion of the Canadian population. Gathering precise statistics on this group is impossible – it would require connecting data on the confluences of many attributes that are normally not considered in social surveys or the census and would also require tapping into a population often not reached by these instruments. An approximate picture of this group, however, can be constructed by examining a variety of existing data. In 2006, Canada’s population was approximately 31.6 million, including 4.3 million women aged 55 and older<sup>3</sup> – about 13.6% of the population (Statistics Canada 2006). Most of these women will not experience marginalization and criminalization, though we know that women are more likely than men to experience poverty, physical health problems and mental health disorders, especially in older age; all of these challenges leave women vulnerable to poverty and marginalization as they grow older (Chunn and Gavigan 2006; Health Canada 1999; Raphael 2004, 2006; Schellenberg and C. Silver 2004; Washington 2005). While there are few statistics on this group, older marginalized women are an important and growing subpopulation with real needs that must be addressed.

As the population ages and income disparities grow, more older women find themselves on the margins of society. Indeed, Voyer et al. (2005) indicate that women aged 65 and older are the fastest growing population segment in North America. Several researchers have documented the increasing numbers of marginalized and criminalized older people. Estimates of the elderly share of the homeless population in Canada and the United States range from 2% to 30%, depending on the region, methodology, and criteria used to designate someone as “older” (Stergiopoulos and Hermann 2003). These estimates are particularly troubling as homeless elders are often undercounted in homelessness studies due to their high mortality rates, which

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<sup>3</sup> These data are calculated based on the larger age categories published in Statistics Canada’s publicly available census data files, and combine data for women aged 55-64 and 65 and older.

can be 2 to 31 times greater than for seniors who have housing, depending on the study (Cheung and Hwang 2004; Ploeg et al. 2008). Researchers also note that there is a strong demand for homeless services for older people in Canada (Ploeg et al. 2008). A study by Correctional Service Canada of the Canadian federal prison population<sup>4</sup> revealed that those aged 50 and older represent the fastest growing age group in Canadian federal prisons (Uzoaba 1998). While this group is dominated by men, women represent a growing minority (Sinclair and Boe 2002; Uzoaba 1998). Because prisoners with life sentences who earn parole remain under supervision for the rest of their natural lives, we see a corresponding increase in the number of older parolees (Sinclair and Boe 2002; Taylor and Flight 2004). As there is more data on criminalized adults than other groups of marginalized older adults, the following section highlights research on this subgroup.

## **Criminalization**

Criminalized women are literally and figuratively a “captive” population for research; while they are under state control – in prison or in the community – correctional authorities follow and collect data on them. Therefore, research on this group, at least statistical research,<sup>5</sup> is somewhat easier to collect than that which examines other marginalized groups that are less diligently tracked.

Older marginalized women are more likely than their more affluent counterparts to have come into conflict with the law at some point in their lives. Often times, behaviours associated with marginal and precarious living, such as substance use/abuse, work in the sex trade, trespassing, as well as shoplifting and fraud (e.g., bounced cheques), place these women under

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<sup>4</sup> The federal prison population includes individuals who are serving sentences of two years or more; sentences of two years or less are administered in the provincial jail system.

<sup>5</sup> While more statistics exist on prisoners than on other marginalized populations, conducting research on this group remains extremely difficult due to the challenges in gaining access to prisoners via correctional authorities.

the purview of the police, courts, and correctional systems (Comack 1996; Maidment 2006). For some, conflicts with the law are a life-long reality; these women are sentenced to long prison terms while they are relatively young and they grow old inside prison (Uzoaba 1998). Of note, this group also contains many women with mental health issues, ranging from depression and anxiety to schizophrenia; these disorders and the women's resulting behaviour inside the prison often preclude their releases and result in extended sentences due to institutional charges (Hannah-Moffat 2000, 2001; Kendall 2000). Other women in conflict with the law may have cycled in and out of imprisonment throughout their lives, often for relatively minor crimes or non-payment of fines; their criminalization is often linked to underlying issues, such as the aftereffects of physical or sexual abuse, addictions, or mental health issues (Comack 1996). While they predominantly live *in* the community, they are not considered to be part *of* it; that is, they remain on the margins of society and are often involved in long term cycles of homelessness, imprisonment, mental health issues, and substance abuse (Comack 1996; Maidment 2006). The final group of older criminalized women is significantly different from the first two, and includes those who are involved with the justice system for the first time as older adults (Uzoaba 1998). This is the largest of these three groups, and often includes women who commit relatively minor crimes.

Azrini Wahidin (2004) studied older criminalized women, noting many similarities between all three categories – those cycling through the justice system, those who are serving long sentences, and new older prisoners – identified in the literature to date. Her study indicated that older women were the least likely of any group of prisoners to reoffend. Despite this, older women experience prison environments that create extra hardships for them. While this is sometimes also the case for men, the relatively larger numbers of older men in prison have resulted in more accommodations for this group (Aday 2003). Wahidin argues that prison is a

more painful experience for older women compared to younger prisoners due to their declining abilities, health problems, and isolation from family and society. Older women's needs have been documented, including environments that are easy to navigate, quiet spaces, fewer stairs, no bunk beds, and a less hurried routine. Little is done, however, to address these needs at a policy level (Eastman 2006; Strimelle 2007; Wahidin 2004). In addition to this lack of accommodation, older prisoners are socially marginalized. While they may use self-isolation as a coping mechanism, this long-term withdrawal creates real concerns about their abilities to cope on either side of the prison walls (Aday 2003; Kratcoski and Babb 1990; Wahidin 2004). In short, prison is a double punishment for older adults.

Older women – whether or not they are criminalized – represent a growing group of individuals who require attention from policy makers and researchers. While their needs vary, their concerns become increasingly salient as the population continues to age. The aging population, and the growing number of seniors and near-seniors, brings elders' issues to the fore. The following section provides an overview of the physiological aging process as well as social discourses relating to aging in Canada.

## **2.2 Aging**

Aging is a physical and a social process, affecting both one's body and one's identity. Here, I focus on aging and the body. I also explore how aging is perceived in Western society and the implications of this for older women. Aging's implications on identity are addressed later in the section on identities.

As women age, their bodies change, affecting both their abilities and their needs. Depending on their culture, these changes may be celebrated or hidden from others (Donaldson 1996). Older adults face sensory decline: they are less able to touch, hear, smell, taste, and see (Kratcoski

and Babb 1990). Their motor skills degrade, increasing their susceptibility to slips and falls and creating further activity limitations and challenges. Mental health problems like dementia and depression also become more frequent (Aday 2003). In addition, elders' immune systems weaken, making them vulnerable to infections and disease. Older women also experience menopause; while it can be liberating, menopause can also bring a host of symptoms, including fatigue, sweats, mood swings and insomnia (Burrell 2009; Dillaway 2006). In short, the changes women experience as they age significantly alter their bodies, and thus their physical capabilities, but also their potential psychological health and well-being.

Given that aging is both a physical and social process, it often incites individuals to reassess and modify or change their identities in response to their physical bodies and social circumstances. Finding oneself in new roles, such as retiree or grandparent, can affect one's body. Retirement or changes in one's work (e.g., transitioning to part-time work) can mean the end to work-related physical challenges, stress and strain. If a woman leaves a stressful job, the negative effects of stress may abate, bringing her more energy, less physical pain and greater happiness (Mein et al. 2003). However, for low income earners, exits from the job market are frequently linked to illness and disability (Schellenberg and Silver 2004). New demands may also arise if one is required to care for one's aging parents, spouse or grandchildren; in addition to the emotional strain, the duties associated with physically caring for others (e.g., bending, lifting and carrying) can bring their own challenges (Schulz and Beach 1999). These physical challenges, depending on the individual's attitude and willingness to take on new roles, can be exciting or upsetting. Regardless of whether the end result is an improvement or worsening in one's physical and emotional state, the unknown nature of change challenges women's identities, often causing fear, frustration and depression – at least

temporarily – as their bodies and abilities change (Barrett and Robbins 2008; Clarke 2001; Dillaway 2006).

Age-related limitations and declines in health increase older women's requirements for health care services, proper diets and nutrition, and personal products and services. For example, older adults' caloric needs and appetites are less than those of younger adults; however, their requirements for protein intake remain the same or increase (Campbell and Leidy 2007).

Malnutrition becomes a key concern at this life stage; without the required protein, older adults are susceptible to decreased energy and stamina, accelerated muscle loss and functional decline, and an increased risk of death (Campbell and Leidy 2007; Health Canada 2002a).

They must eat a high-quality diet to maintain their health, which is not always possible given their limited incomes. As their needs increase at the same time as their incomes generally decrease<sup>6</sup>, low-income older adults face increasing challenges to maintain their health and well-being (Health Canada 1999).

The deteriorating health and increasing health needs associated with older age are exacerbated by many factors, including living in long-term poverty (Pederson and Raphael 2006; Turcotte and Schellenberg 2007). In fact, income and social status are the primary social determinants of health in older age (P. H. A. of C. Government of Canada 2010; Raphael 2004, 2006). The increased stress associated with marginal living, as well as the quality of the diets and health care to which they have access, all limit older marginalized women's chances of being in and maintaining good health. Researchers have found that as they age, women's health is more strongly determined by income than men's health, and that women are more susceptible to

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<sup>6</sup> Of note, social assistance recipients will experience an *increase* in income after turning 65 as the Old Age Security and Guaranteed Income Supplement programs provide more income than social assistance programs. This increased income, however, is traded off for a decrease in health benefits (Service Canada 2011).

poverty than men (Plouffe 2003; Raphael 2006). Poor people are more likely than those with adequate incomes to have diabetes, hypertension, and mental health issues (Heslop, Miller, and Hill 2009; Laurie 2008; Rabi et al. 2006). In addition, the poor are often unable to access preventive health care services, including basic vision care, dental care, and prescription medications that are not covered by state-funded drug plans (Laurie 2008). Social and income deprivations can result in chronic conditions going undiagnosed and untreated, as well as poorer long-term health and earlier death for people with low incomes (Lynch et al. 2004). Health problems are further exacerbated for those who experience marginalization, criminalization, and poverty (Aday 2003; Reviere and Young 2004; Robert, Frigon, and Belzile 2007). More specifically, marginalized women have more serious health challenges, often making them heavily reliant on medications and creating challenges for those who lack extended health coverage or who cannot manage their medications on their own (Voyer et al. 2005). As they may have lacked preventive health care, and their chronic health problems have often gone unaddressed, marginalized women may experience health concerns that are normally confronted by much older women (Bruckner 2001; Wahidin 2006; Wahidin and Tate 2005).

Aging is often considered to be an unpleasant reality in western society, where the focus on individualism makes the process particularly painful; this process is amplified for those who experience accelerated and early aging. As one invests time, money and effort in one's body, its withering and weakening become signs of personal failure (Shilling 1993). Indeed, these bodily transformations are difficult to grasp and accept, especially for individuals who do not feel as old as their chronological age (Clarke 2001). In addition to these bodily transformations, older adults must make many significant life transitions to accommodate their aging bodies. When one's abilities are limited, older people, along with their families and other caretakers,

must reassess care relationships and where the elder lives. Frequently, older women must make the difficult transition from primarily being caregivers to receiving care, or possibly simultaneously filling both roles. Receiving care can include accepting help from family and friend networks, accessing community supports, and possibly entering nursing homes or other care institutions – either at their own discretion or as a necessity – if one can no longer cope with the routines and activities of daily living without assistance (Keating et al. 2005; Lakdawalla et al. 2003; Miller 2000; Tulle and Mooney 2002). While these transitions are common to many older people and are certainly not unexpected by most, they can be extremely painful, and can assault one's identity and one's personal conceptions of autonomy, self-determination and independence.

Declining abilities can lead to reconfigurations of physical and social space that often isolate older adults from younger people and society in general (Shilling 1993; Tulle and Mooney 2002). This isolation becomes increasingly problematic as people continue to age. Late modernity provides an extremely difficult context for aging and death (Giddens 1991). Death has largely been sanitized and removed from everyday experience (Lee 2008; Shilling 1993; Walter 1991). Now, more than ever, people die in hospitals or nursing homes instead of in their own homes. Funerals are no longer conducted in the home; the process has been sanitized and professionalized so that individuals no longer confront death as a natural part of the life course (Mellor and Shilling 1993; Shilling 1993). Instead of a family looking after the details of a funeral, funeral directors, morticians, and crematoria take over as those responsible for managing the processes and rituals associated with death. This can leave individuals isolated from the process. To compound this, the individualization and a lack of communal ties through religion and kinship networks that are associated with late modernity make people more concerned about dying and leaving some sort of legacy (Giddens 1991; Mellor and Shilling

1993; Shilling 1993). In earlier times, a person could find comfort from death in religion, or at the very least, had the comfort of knowing that one's community would remember him or her. Now, however, individuals are left to contemplate their mortality, often without the luxury of these external aids and comforts.

Although everyone grows older, "aging" and aging-related discourses have disproportionate effects on women: women live longer than men on average; spend more years of their lives with disabilities and chronic illnesses; are more likely to be poor in old age; signs of aging lead them to be judged harshly; and they are also more likely to be caregivers for their elders throughout their life spans (Abu-Laban and McDaniel 2004; Dressel 1991; Flynn 2002; Health Canada 1999; O. M. A. S. Ontario 2008). The physical and social aspects of aging are intimately linked: bodies change with age, as do social responses to individuals and their aging bodies (Shilling 1993). Indeed, the physical process of aging manifests itself on individual appearances. As such, examining the discursive and physical changes associated with aging bodies is important should we wish to gain a better understanding of the aging process.

### **Aging and Discourse**

Older women born in the first half of the twentieth century were often raised with very specific gendered expectations about how they would live their lives from childhood through to old age (Mandell 2004a). These views are still strongly entrenched in society, but are not immune to contemporary cultural influences. New generations of older women will have experienced the social changes brought by the second-wave feminist movement such as women's increased workforce participation, changing family norms (e.g., increased divorce rates) and the advent of birth control pills, among other changing norms and roles for women (Donaldson 1996; Mandell 2004a). As the "baby boom" generation grows older, and as social norms and expectations for older adults broaden, some of the traditional notions of aging have begun to change shape (cf.

Foot 1998). For example, the influences of Asian and First Nations cultures – in which older adults are held in high esteem – can challenge Western discourses that place a high value on youth (Abu-Laban and McDaniel 2004). Indeed, now both old and new discourses about aging hold sway and shape how we view, understand and react to aging – both as the process manifests in others and in our own bodies.

Traditionally, women's identities have been closely linked to their gendered (assumed heterosexual) bodies. Indeed, mythic representations of the triple goddess, including maiden, mother, and crone are all generally seen as powerful and often as positive figures due to their connections to the earth, fertility in the case of the mother, and wisdom in the case of the crone.<sup>7</sup> These three depictions highlight changes in the female body throughout the life course (Conway 1994). In contemporary Western society, however, many negative discourses are associated with women and their bodies; they portray women as different and deficient in comparison to men, and their bodies, even when perfectly healthy, are seen as different and therefore abnormal (Koch and Mansfield 2004; Ussher 2006). Throughout the life course, female identities and bodies are intertwined. Menarche is often used to mark a girl's transition into womanhood. Subsequently, menstruation, childbearing, childrearing and caregiving form key components of traditional female roles and identities in adulthood (Abu-Laban and McDaniel 2004; Mandell 2004a). After women enter menopause, they can no longer bear children, at which point their bodies are considered deficient not just in relation to male bodies, but also in relation to younger, fertile female bodies (Koch and Mansfield 2004). These processes are normal and natural parts of the life course; though they are considered worthy of celebration in other cultures, traditional western discursive constructions of women do not always celebrate these changes.

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<sup>7</sup> It should be noted that the crone is also often considered to be withered and undesirable due to her age and infertility as well as the power and mystery linked to aged women in folklore (Estés 1992).

As women age, they face constant reminders that they are no longer young. Older women's talents, needs, desires and concerns are not well reflected in contemporary discourses or popular knowledge. While some cultures place particular value on older people for their wisdom, experience and cultural knowledge, western culture tends to devalue elders (Abu-Laban and McDaniel 2004; Ussher 2006). Indeed, while Buddhist and Aboriginal cultures depict older women as wise and valuable, images of the "crone," "spinster," and "witch" are often used to describe older women in western culture (Donaldson 1996; Ussher 1992, 2006). Despite their increasing numbers and physical visibility, western society 'makes up' older women as either liminal or completely invisible, both discursively and in everyday social life. As women age, they are often perceived as less attractive, and will frequently be overlooked or ignored by both men and younger adults who previously considered them attractive (Abu-Laban and McDaniel 2004; Donaldson 1996; Shilling 1993). Middle-aged women sometimes describe feeling invisible compared to their younger peers as they receive less attention based on their appearances; this feeling is amplified and exacerbated for older women (Clarke 2001). In addition, older women's physical needs are overlooked; contemporary discourses consider aging and sexuality to be incompatible for women: older women are often depicted as asexual (Abu-Laban and McDaniel 2004). Despite women's continuing sexual desires and needs, their sexuality is rarely described beyond menopause. Sexual activity between seniors, while a social reality, is often considered taboo to discuss; many people are revolted by the notion of older women having sexual desires, especially toward younger men (Shilling 1993). While older men's sexuality is constructed in relation to younger women and their continued (medically-

assisted) virility<sup>8</sup>, older women are constructed as asexual, divorced from bodily needs and desires.

Women's discursive disappearances are mirrored in social interactions. Not only are women generally deemed to be less attractive as they age, they are also avoided by younger adults, especially as they become seniors. Societal obsessions with youth and sexuality make older adults appear shrivelled and useless to those who are 'young', although these descriptors do not describe the realities of aging (Clarke 2001; Flynn 2002; Shilling 1993; Ussher 2006). Indeed, social responses to aging often consist of those who are 'not-yet-old' avoiding those who are stigmatized with the label 'old.' For example, seniors are often socially and geographically separated from other adults, secluded in retirement homes or shut in to their apartments or homes, despite their desires to remain connected to society and the activities, places and spaces that marked their younger years and remain emotionally significant to them (Manzo 2003; Tulle and Mooney 2002). In addition, it is expected that the elderly will avoid or minimize social interactions with the young, except when they are trotted out to fill stereotypical roles at family celebrations, during church services and whenever home baking is required. These norms are produced and maintained by societal fears about aging; people do not like to think about their own mortality and often attempt to avoid any reminders of it, fearing that aging and mortality in others will rub off (Shilling 1993). Those who are not (yet) old themselves may attempt to avoid even passing reminders of aging and death (Abu-Laban and McDaniel 2004; Ussher 2006). Obsessions about youth encourage older women to form identities outside of youthful culture; instead, they are isolated from society and expected to stay quiet, prim and proper, and on the margins.

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<sup>8</sup> A lifelong sexual role for males, but not females, is culturally normative in western society. This is seen through such iconic figures as Hugh Hefner and hosts of aging male actors, as well as through drugs and medical interventions, such as Viagra, Cialis, and changing treatments for erectile dysfunction and prostate cancer.

In contrast to this marginality and liminality, the “successful aging” discourse reframes aging as a potentially positive experience full of activity and engagement and free of many of the negative experiences often linked with growing older. In addition, the discourse hands responsibility for and control of the aging process over to individuals, whether or not they are willing or able to “manage” it. Rowe and Kahn (1997:37) state, “[S]uccessful aging is dependent upon individual choices and behaviors. It can be attained through individual choice and effort.” Interestingly, while Rowe and Kahn base their definition and discussion of successful aging on research conducted on the health and social outcomes of the highest functioning seniors, this discourse is advanced as what should be the normal course of aging for the *entire* greying “baby boom” generation (Holstein and Minkler 2003; O. M. A. S. Ontario 2008; Rowe and Kahn 1987, 1997). Although Katz (1996) argues that most seniors are not affected by gerontology or gerontological discourses, the discourse surrounding successful aging has had a marked effect on understandings and expectations of elders, particularly regarding one’s own ability to influence and control the course of aging.

As successful aging moves from a reality for a select few outliers to a goal for all, it has become a “technology of the self,” meaning one must work on oneself to age and achieve a positive and ‘successful’ old age (Foucault 1988a). Monitoring and disciplining one’s mind and body become necessary to ensure that aging is successful. One must remain physically active, be engaged in social life, read, exercise (both the body and mind), have regular bowel movements, apply the correct firming moisturizers and sunscreens, eat and drink the right foods, take the right vitamins, and get the correct amount of sleep, among other practices (Abu-Laban and McDaniel 2004; Rimke 2000). Creating the correct aging body becomes a “body project,” in which individuals must use self discipline and regulation to make their bodies conform to the ideal type

presented (Shilling 1993). This body project, like all others, is doomed to failure, given that no matter what a woman does to her body, it will eventually show its age; body projects can only delay the inevitable. Regardless, the successful aging discourse seeks to prolong youth and ward off death and decline wherever possible.

The successful aging discourse encourages many actions which are thought to improve health and reduce aging, while shunning the idea of “letting oneself go.” Indeed, the terms “healthy” and “unhealthy” have gained moral meaning: the healthy (i.e., those who proactively care for themselves and self-govern) are constructed as being better and more responsible than those who do not, who are seen as undeserving, incompetent and lacking self-control (Reeve 2002). Older age is no longer primarily a time for relaxation, passivity or reduced activity; efforts to keep going and to “age well” require one’s body projects and work on the self to continue or accelerate (Gimlin 2007). New challenges must be pursued and conquered. Notions of diversity between individuals, including differences based on class, ethnicity, genetics and life history, are removed, making the discourse appear as if *everyone* could age healthfully and successfully if they really wanted to and exercised the requisite discipline, regardless of background factors (Holstein and Minkler 2003). As discourses on aging absorb and rebroadcast messages touting the potential of aging *successfully*, anything less than this ideal is reconceptualized as *failing*.

In short, both old and new aging discourses create proscribed positions for older women, into which older marginalized women are pressured to fit. These discourses do set aside spaces for women to be included in society, but in a limited way. They rely on broad stereotypes that do not capture the realities for many aging women, including marginalized, liminal women. These women’s experiences may be more effectively – although no more charitably or sensitively –

characterized by their marginal statuses and the discourses that accompany the poor, ill and criminalized.

Older adults are not the only groups upon whom stereotyped ideals are imposed; our understandings of marginalized people are also shaped by stereotypes and discourses. Social perceptions of marginalized or liminal women are affected by state, media, and popular discourses that provide scripts for how one *should* act. These scripts shape how we understand aging and offer an idealized path to a “successful” old age, therefore allowing individuals to self-govern instead of relying on state regulation to control behaviour. These scripts allow the state to govern at a distance,<sup>9</sup> working on the assumption that all individuals have the same choices and opportunities, and that responsible, self-governing subjects will take prudent actions to maintain their health, vitality and social status (Foucault 1991; Garland 2001; Rose 1994, 1998). Poor individuals, especially those who receive welfare or state assistance, are usually considered to be undeserving, lazy and selfish (Chunn and Gavigan 2006; Kingfisher 1996). Likewise, individuals with disabilities are portrayed in a variety of negative ways: as social curiosities; as frightening freaks of nature; as incapable, incompetent, and lacking agency; or as vulnerable and in need of care (Reeve 2002). In contrast, older women in conflict with the law are often constructed in the media as “mad, sad or bad” (Codd 1998:187; also see Ussher 1992). That is, they are either portrayed as having mental health disorders; as pathetic, feeble, and incompetent; or as women who are ‘evil’ or demonic for transgressing gender and age norms. Their offences, which are often minor (e.g., shoplifting) are most often interpreted as trivial cries for help and attention, leading them to be constructed and seen as the objects of humour (Codd 1998; Wahidin 2006). If the offence is more serious, however, the woman involved is often constructed as monstrous, dangerous or evil (Barnett 2006; Comack and

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<sup>9</sup> ‘Governing at a distance’ refers to the interlinkages and alliances between various authorities that seek to collectively govern individual, social and economic activities (Rose and Miller 1992).

Brickey 2007; Kilty and Frigon 2006; Morrissey 2002). For example, Barnett cites newspaper accounts of women who committed infanticide, noting that they are constructed as flawed or “bad” and described as “remorseless” (2006:421), an “urban savage” (2006:423), and “an evil daughter-in-law” (2006:423). In short, the various discourses surrounding marginalization and criminalization remove individual agency and identity, using broad, derogatory and unrealistic categories to explain women’s lives and experiences.

When discourses on aging and marginalization or criminalization intersect, few spaces are left for older marginalized women. In fact, the two sets of discourses are largely incompatible; marginalization discourses take away agency and dignity, leaving little room for discourses that are normally invoked vis-à-vis older women, including the vital, energetic, successfully aging senior and the prim, proper, and moral grandmother. Thus, some older women find themselves in liminal positions, caught between competing, often essentializing discourses that do not describe their realities, but yet have real implications for how they are viewed (and treated) by others. New discourses that promote social engagement and downplay notions of aging raise expectations for seniors, who are now expected to maintain youthful appearances and activities. For women who worry about where they will get their next meal, how to access medical services, or about how they will pay the rent, concerns about wrinkles and what to wear for a trip to the doctor seem trivial at best, and even offensive in comparison to the other pains they experience. Despite the inapplicability of these discourses, failing to live up to their corresponding standards or ideals may leave older women not just marginalized, isolated or liminal, but completely *excluded*. This possibility is explored next.

### **2.3 Poverty and Social Exclusion**

This section explores two intertwined concepts that affect older marginalized women: poverty and social exclusion. Generally, poverty is used to refer to a lack of financial resources

(Paugam 1996; Sen 1995); I examine this aspect of older women's poverty in the first subsection. While a lack of money certainly represents one facet of marginalization, it provides only a partial view of disadvantage and deprivation; these states of being rely on many overlapping and intersecting factors that are not as easily quantified as examining one's income. Although one's financial means have a profound impact on one's life, other factors – including social engagement and capabilities – are also worth considering; indeed the presence of these factors in spite of poverty can provide significant advantages (Keating et al. 2005; Reisig, Holtfreter, and Morash 2002; Sen 1995). I adopt the term 'social exclusion' to explore broader, qualitative states of deprivation. Social exclusion includes more than one's financial resources; it considers income, but it also more generally refers to one's social situation and capabilities in the social realm. While the term is not without its criticisms, tensions and contradictions (cf. Castel 1995a; Paugam 1996), it can provide a broader lens through which to examine older marginalized women. Therefore, I discuss this term in the second and third subsections, first focusing on its use as an analytic concept, then as it relates to older marginalized women.

### **Older Women and Poverty**

Discussions of poverty often focus on younger women with children – the group most likely to be poor (Canadian Council on Social Development 1984; Chunn and Gavigan 2004; National Council of Welfare 2010). Older adults, however, are not immune from poverty; indeed, 17% of single adults aged 65 and older live below the after-tax low income measure (LIM), which is half of the after tax median income (Green et al. 2010). This rate is much lower than poverty rates for younger adults due to the social security programs in place. While they are somewhat better off financially than younger poor people, poverty is feminized to an even greater degree among older adults: five out of six, or 86%, of poor seniors are female (Gavigan 1999; Green et al. 2010; Kérisit 2000; Plouffe 2003). The gender disparity in older adults' incomes is mostly explained by women lacking pension income, or having less pensionable earnings than their

male counterparts; they may also have less knowledge of the income support systems available to them and may therefore miss out on benefits to which they are entitled (cf. Informetrica Limited 2009). Poor, marginalized older women face added challenges: they often have health conditions that increase their needs for assistance (e.g., needing to purchase vitamins, diabetic stockings, incontinence products, taxi or bus rides for doctor's appointments, etc.), and also face additional barriers – both physical and social – to working and earning income. As such, these women often rely on state aid and are vulnerable to extreme poverty.

Welfare benefits are terminated at age 65 when most older adults qualify for financial assistance from the federal government. Women over the age of sixty-five are eligible for a variety of federal pension programs. If they have lived in Canada for 10 years or more, they can access the universal old age security (OAS) pension.<sup>10</sup> In addition, the Guaranteed Income Supplement (GIS), a means-tested benefit program, provides supplementary funds if one's income is sufficiently low. Although many older marginalized women raised children and have limited work histories, if they have worked, they may also receive a pension from the Canada Pension Plan (CPP). While these programs do provide more money than is available to an individual under Ontario welfare programs – Ontario Works (OW) and the Ontario Disability Support Program (ODSP) – the benefits are modest; more money is provided,<sup>11</sup> but there is no coverage for health items that are subsidized by provincial social assistance (Service Canada 2011; Green et al. 2010). Seniors receiving OAS and GIS can also own assets, including homes, savings accounts, and vehicles, luxuries not afforded to those on welfare. Also, just as under the OW/ODSP framework, a person's GIS benefits are reduced if they have other income (Service Canada Government of Canada 2011). In addition, CPP and OAS benefits are

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<sup>10</sup> New immigrants to Canada can receive assistance from Citizenship and Immigration Canada (CIC). CIC provides benefits at approximately the same rate as provincial welfare programs.

<sup>11</sup> The benefits received by low-income individuals guarantee an income that approximates the After-Tax Low Income Measure (LIM-AT) (Service Canada 2011).

taxable, further limiting the income provided (Green et al. 2010). Thus, while seemingly better off than their younger peers, older poor women also face significant financial challenges.

Federal benefits do not flow to all marginalized older women. As these women are considered “older” at age 50, federal benefits may be a faint light of hope at the end of a long tunnel of deprivation. For women aged 50-65 with limited incomes, provincial social assistance programs, including basic welfare and disability allowances, are the most common forms of assistance. Of note, despite the fact that living costs for older adults are often higher than for their younger counterparts, the amount of financial assistance provided does not take the recipient’s age into account. While the systems vary by province, they generally offer fewer financial benefits than federal assistance programs and, by design and philosophy, provide barely enough money to allow a person to eke out a living. Indeed, the income provided to recipients, while never overly generous, was cut heavily in the mid-1990s and continues shrink in terms of real dollars (National Council of Welfare (Canada) 2007). These cuts and low incomes, however, are justified as a way to ensure that welfare recipients exhaust all other income options before requesting state assistance and view welfare as financial assistance of last resort.

Since the nineteenth century, social assistance policies have been designed based on the principle of ‘less eligibility.’ That is, those receiving social assistance are given a subsistence allowance which provides less than the lowest earning workers receive (Gavigan and Chunn 2007; Thane 1978). Indeed, in the past, people receiving assistance also had to be considered “deserving” – that is, their circumstances (e.g., physically infirm, caring for a large family, mentally ill) prevented them from supporting themselves (Castel 1994, 2003). In current practice, Canadian social assistance rates usually remain far lower than minimum wage

employment earnings (National Council of Welfare (Canada) 2007). The less eligibility principle reflects the common view that social assistance is a disincentive to work (Mitchell and Shillington 2002). Less eligibility is justified as a way of forcibly encouraging people to work, thus minimizing their dependence on the state. In contrast, historical social assistance rates for the *deserving poor* – including war widows and workman’s compensation beneficiaries – were much higher (Gavigan and Chunn 2007). While less eligibility has long been tied to state benefits, there are many flaws in the logic of the principle. For example, many people who rely on social assistance are unable to work for a number of reasons. Assistance programs are often accessed by those who have significant obligations as caregivers; the disabled; when one’s work opportunities are blocked due to sexism, racism or discrimination; and by those who cannot work due to age, health or personal difficulties (e.g., addictions). These individuals’ handicaps – be they physical, social or structural – make the idea of less eligibility seem cruel and nonsensical.

In addition, many assistance programs are structured to emphasize individual responsibility and action. As part of a multi-year overhaul of the welfare system that included a dramatic decrease in the benefits provided, new work requirements for recipients and the institution of a “snitch line” to report suspected welfare fraud among other changes, Ontario’s welfare program was renamed in 1998. At this time, the province’s *General Welfare Act* was replaced by the *Ontario Works Act*. While both laws outline social assistance policies for the province, the former title appears to speak to universal assistance, whereas the latter adopts the language of self-sufficiency and individual agency, linking “work” to welfare (Canada 2004). In Québec, welfare is not discursively tied to work, but it is further stigmatized by the name “last-resort financial assistance,” implying that individuals should exhaust any other possible means of assistance before considering applying for welfare (Collin 2007).

Welfare may be a measure of last resort, but it serves a vital purpose within society, ensuring that everyone, regardless of ability or social participation, can survive. Although the receipt of social assistance is stigmatized and the benefits are often considered inadequate, these benefits can provide recipients with basic autonomy, stability, as well as a much-needed, if meagre, income (Canadian Council on Social Development 1984; Comack 1996; Paugam 1991, 1996). For someone who has been homeless, for example, entering a shelter and receiving welfare can be the difference between bare survival and an adequate, if lower than average, standard of living.

## **Homelessness**

At the far end of the continuum of relative wealth and poverty are those who cannot afford the basic necessities of life, including clothing, food, and shelter. While some people who find themselves without a home of their own have the means – through financial stability or assistance from others – to ensure that their needs are met without state or community assistance, this is not the case for many. Homelessness does not have a single cause and is not solely related to poverty: it may, for example, be the result of an emergency, such as a fire; a breakdown in one's relationship with family, friends, or other cohabitants; or the result of arriving in a new area with few resources. For people living in precarious circumstances amid entrenched poverty, however, homelessness is an ongoing concern (Castel 1994, 1995a).

Castel describes the transformation of the “social question” – or, how to manage the underclass or impoverished, tracing the history of the poor and itinerant from pre-modern societies to the present (Castel 1995a). Historically, disadvantaged individuals (e.g., the disabled, orphans, etc.) were the concerns of the seigniorial communities from which they originated; the community, through the church or individual generosity, would provide for the individual and

ensure their survival (Castel 1995a). Able-bodied itinerants, such as migrant workers, however, were not treated charitably; they were seen as a threat to this system.<sup>12</sup> As society began to transform through the Industrial Revolution and the concurrent trends of urbanization and globalization, people were no longer tied to communities or relationships with employers or seigniorial landowners. As such, the disadvantaged moved to cities in search of employment as wage labourers (Marx 1847). This system required people to work for support and once again, provided meagre supports only to those who could not otherwise care for themselves. While this labour fuelled the Industrial Revolution, the capitalist system did not provide for the poor or itinerant; they led lives of bare subsistence. In modern society, this underclass is managed via state-based interventions: we have seen the rise of a broad set of social supports for those who are poor or disadvantaged (e.g., welfare, employment insurance, old age pensions). These systems, however, are currently under attack, placing the marginalized and disadvantaged again, to increasing degrees, at the mercy of the capitalist labour system and charity.

Homelessness among older adults, especially older women, is rarely discussed. While homelessness receives much attention, many research studies and funding dollars are explicitly focused on ending homelessness for particular subgroups, including youth, families, and the mentally ill; however, homelessness is also a problem for older adults. Relatively few studies of this subpopulation exist, most of which are based on American data. In an early study of older homeless women, Cohen et al. (1997) described some basic characteristics of this group. The authors noted an overrepresentation of African-American women, similar to other research showing that Black and other visible minority groups are overrepresented among the homeless and marginalized (Cohen 1999; Washington 2005; Williams and Williams-Morris 2000). The study also found that older homeless women frequently lived with addictions and mental illness;

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<sup>12</sup> Foucault also remarks on the plight of the poor and itinerant, noting that these people are transformed into docile bodies via institutions such as workhouses, the military and prisons (Foucault 1977).

40% of the sample had psychotic symptoms and 27% had been hospitalized for psychiatric reasons. More recently, Olivia Washington (2005) studied older homeless African-American women in the United States. Her findings mirror the trends seen in the earlier research; she notes that discrimination, health disparities, mental illness, a lack of education and limited family support all contributed to older women's homelessness (Washington 2005).

As with prison populations, older homeless men significantly outnumber their female counterparts (Cohen 1999; Cohen et al. 1997). Researchers posit, however, that this reflects the fact that homelessness among women is more often "hidden," not simply that there are fewer older homeless women (Cohen 1999). A study of older homeless adults in Toronto (Stergiopoulos and Hermann 2003) found that this group is undercounted in studies as they avoid shelters and have a higher mortality rate than their younger peers. The study also noted common reasons for homelessness among older women, including elder abuse, family breakdown, eviction, and hospital referrals. In practice, hospital referrals may cause homelessness when a person is unable to maintain her housing due to a health condition (e.g., living in a third floor apartment with no elevator access and breaking a hip); in other cases a person may be admitted to a hospital from a nursing home or other care facility and then become homeless when the facility refuses to re-admit her upon her release. The authors also note that this population is growing as the baby boom generation ages.

Physical and financial resources are extremely important – for basic survival, one must have food in one's stomach, clothes to wear, and a roof over one's head. However, deprivation is not always monetary (Gaulejac and Léonetti 1994; Sen 2000). Indeed, a low income does not necessarily make a person "poor"; those with low incomes may be privileged in terms of non-

financial resources (Paugam 1991). To examine other aspects of poverty and vulnerability, I draw on the concept of social exclusion.

## **Social Exclusion**

*Social exclusion*, while often linked to poverty, is a broader concept, emphasizing the consequences of constrained or limited freedoms and choices. This concept connects the impacts of multiple, intersecting deprivations to better understand contemporary social realities (Mitchell and Shillington 2002). In relation to poverty, social exclusion represents both a cause and consequence; it can limit one's ability to earn income, or result from having a low income. Social exclusion also represents a limit to one's freedom, reducing one's options for identity and social participation (Rose 1999; Sen 1995). In connecting deprivation, capabilities and freedom, social exclusion offers a nuanced view of the linkages between poverty and marginalization.

While social exclusion discourses have emerged in North American academic and policy debates relatively recently, holistically examining inequality can be traced to Aristotle, who saw deprivation as an inability to participate in society (Sen 2000). Aristotle noted that humans are naturally social and experience deprivation when their participation in community life is blocked, including by way of poverty. Aristotle's philosophy reflects the fact that deprivation is not merely a lack of financial resources; rather, it affects many aspects of a person's life (Sen 2000). Adam Smith, considered to be the father of modern economics, also examined poverty and deprivation in his work, *The Theory of Moral Sentiments* (1759). This work is less well known than *The Wealth of Nations* (1776), and is more concerned with caring for others than self-interest. Smith described poverty and noted that deprivation was present when one was not capable of "being able to appear in public without shame" (Smith, as quoted in Sen 2000:4).

More recently, René Lenoir, an official in the French government, explored exclusion as deprivation. Lenoir is credited with having coined the term “social exclusion” in 1974, although it appeared in France during the 1960s (Lenoir 1974; Paugam 1996). Lenoir indicated that the “socially excluded” included various groups, such as the “...mentally and physically handicapped, suicidal people, aged invalids, abused children, substance abusers, delinquents, single parents, multi-problem households, marginal, asocial persons, and other social ‘misfits” (Silver 1995:63). Most discussions of social exclusion explore the basic citizenship rights of all individuals and indicate that everyone within a state has the right to civil, political and social participation (Larner 2000b; Marshall 1992; Purvis and Hunt 1999). Indeed, welfare state programs and ideologies supported this view, noting that greater citizenship benefits could engender greater loyalty to the state and simultaneously foster national solidarity and social inclusion (Marshall 1992; Purvis and Hunt 1999). This view, however, is often considered overly optimistic: despite their universality, laws and social programs do not provide equal rights or equal benefits to all citizens (Chunn and Gavigan 2006; Smart 1989). Some theorists note that citizenship is employed in the neoliberal era to responsabilize citizens and create “active”, deserving citizens who are governed through their freedoms, receiving state benefits in exchange for social and economic participation (Rose 1999). This group is juxtaposed against “targeted populations” – individuals who require special interventions to make them capable of self-governing – over which the state asserts its sovereign power (Dean 1997; Larner 2000b). Despite these differences, Sen and others argue that civil societies must ensure that all citizens have the ability to participate (Sen 1995).

“Exclusion” can include blocked access to basic needs such as adequate food, shelter, and clothing, as well as a lack of education, employment, or health services (European Commission

2011; Newfoundland and Labrador 2005; Sen 1995, 2000). Silver notes that some of the things that people may be excluded from can include:

...a livelihood; secure, permanent employment; earnings; property, credit, or land; housing; minimal or prevailing consumption levels; education, skills, and cultural capital; the welfare state; citizenship and legal equality; democratic participation; public goods; the nation or the dominant race; family and sociability; humanity, respect, fulfillment and understanding (Silver 1995:60).

Gaulejac and Léonetti (1994) indicate that one may face economic, social or symbolic exclusion, or some combination of these. Economists have also noted that social exclusion and “poverty” can include social deprivations (Griffin and Knight 1990; Hossain 1990; Sen 2000; Silver 1995; UNDP 1990). More specifically, Sen (2000) notes that a deprivation of capabilities – what you are physically, emotionally, and intellectually able to do – is a defining characteristic of poverty. Under the auspices of neoliberal rhetoric, autonomous individuals choose between a variety of options surrounding work, income, and lifestyle. These “choices” are seen as being free from constraints, and equally open to everyone, despite social inequalities (Rose 1999). A tautology develops between individual capabilities and options: when people lack options, their capabilities are reduced as they are not able to exercise choices or benefit from their abilities; simultaneously, having fewer capabilities results in reduced (or no) avenues for choosing courses of action. Both avenues result in and reinforce inequalities and limited choices.

While the concept of social exclusion is widely used, not all theorists see the utility of the term. A key weakness of social inclusion/exclusion discourses is the malleability and transferability of the language. Due to its broad figuring, “exclusion” can, and has, been used to describe almost any deprivation, regardless of its cause or consequences (Castel 1995b; Sen 2000; Silver 1995). It may be used to describe situations where deprivation does exist, but not as a result of active or passive exclusion. Indeed, Robert Castel sees “social exclusion” as a trap; he argues that it is too broad to be useful as an analytic concept (Castel 1995b:13). He also warns that

the discourse overlooks the *process* of exclusion, and only focus on the end results (Castel 1995b). As exclusion can result from intentional action (e.g., discrimination) or be completely unintentional, this absence is problematic (Schnapper 1997; Sen 2000). This oversight leads to an incomplete analysis of exclusion, ignoring its causes and consequences.

Furthermore, Castel (1995b) notes that social integration is seen as a cure for exclusion. He affirms the potential value of social integration programs and related governmental strategies, but warns that they are not panaceas for individual problems. That is, they offer some benefits, but do not address the *root causes* of exclusion (Castel 1995b). Castel indicates that government attempts to reduce social exclusion often limit the field of intervention, narrowly defining which “exclusions” (e.g., physical disabilities) are worthy of intervention and which are not (e.g., the able-bodied unemployed). By limiting intervention strategies, government programs further exclude some individuals, deeming them not worthy or important enough for assistance. Therefore, inclusion programs can further exclude some marginalized groups. While the term has acknowledged flaws, it has been widely adopted and popularized outside of the academic sphere; for example, many government agencies now use the term to discuss poverty and inequality. While the term has weaknesses, its utility for this project lies in the spectrum of states and conditions that it covers. When used as a descriptive term instead of an analytic one, social exclusion is useful for highlighting a constellation of conditions that serve to marginalize older women.

### **Social Exclusion and Older Marginalized Women**

Older women experience exclusion to varying degrees; their marginalized statuses place them on the boundary of the social world, and their limited financial capabilities preclude their full participation in it. While they are usually not integrated into the work world, this does not preclude their social integration (Castel 1995b, 2003). Indeed, social integration and work

integration are independent – one may easily be integrated in society and not in work, or vice versa. For example, a person may have a large circle of friends and an active social life, but not be economically integrated. Conversely, someone may be employed, but be very isolated both in their workplace and in the other places and spaces that they frequent. In addition, one may be excluded for other reasons, such as possessing a stigmatizing trait (e.g., severe disability, mental health issues, criminalization, etc.) or through self-isolation. Integration and disaffiliation are not binaries; instead, they represent a continuum which also includes states of vulnerability and assistance. Older women may fit in various places along this continuum.

Older women are often not fully excluded; indeed, they often have significant ties to the social world, but they find themselves *vulnerable* to exclusion or becoming reliant on assistance (Castel 1994, 2003). These transitions toward precariousness, exclusion, and, at the extremes of exclusion – disaffiliation<sup>13</sup>, have become increasingly frequent as state supports, in the form of basic income and assistance programs, are reduced under various neoliberal governments in Canada and other western countries (Castel 1995a; Cohen 1985; Garland 2001). While the decline of the ‘welfare state’ is not new, its effects are cumulative; past service reductions are rarely restored, instead, there is a political impetus to further reduce spending. This trend has eroded the social infrastructure that complemented financial social assistance – including housing subsidies, food banks, counselling and continuing education services – while simultaneously increasing demand for these programs and services. This process limits individuals’ abilities to access low cost services and assistance formerly funded by the state, leaving them vulnerable to a quick progression from vulnerability to disaffiliation (Castel 2003; Maidment 2006). As such, a personal emergency or unforeseen event may move someone rapidly from a state of vulnerability to assistance or disaffiliation. For example, Kisor and

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<sup>13</sup> Castel (1994, 1995a) uses the term “disaffiliation” to signify a lack of integration from both the worlds of work and society generally.

Kendal-Wilson (2002) found that older homeless women often faced multiple barriers to maintaining housing, including mental health issues, low incomes, abuse, and family problems. This poses particular challenges as it is much easier to find one's way *into* exclusion and disaffiliation than *away from* these states.

Older marginalized women's pathways *into* exclusion are often fraught with personal hardships, including histories of abuse, discrimination or oppression, criminalization, mental health problems, addictions, systemic poverty, blocked access to education and well-paying jobs, lifelong involvement with social services (e.g., social assistance and child welfare), and troubled family relationships (Comack 1996; Daly 1992, 1996; Maidment 2006; Richie 2001). Many of these women have faced these hardships throughout their lives, making integration and 'normal' (read middle class) life a faint possibility (cf. Crenshaw 1991). Marginalized women have often spent large spans of their lives as recipients of welfare or other forms of social assistance. In contrast to most recipients, who use welfare for short periods of time, those with long-term constant welfare dependency – less than 10% of welfare cases – rarely transition to self-sufficiency (Canadian Council on Social Development 1984; National Council of Welfare (Canada) 2007, 2008; Rank and Hirschl 2001).<sup>14</sup> Many marginalized women have also had lifelong contact with social control regimes, including children's aid societies (both when they were young and if they became mothers), parole supervision and mental health services, all of which subject women to supervision and control that further limit their chances of independence (Maidment 2006). This group may also have had frequent conflicts with the law. Comack (1996) describes how these elements intersect to create a population of women with few social ties and few chances of breaking free of poverty or leading the idealized lives espoused by popular culture and neoliberal discourses. In short, exclusion, as Castel (1995b, 2003)

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<sup>14</sup> While little Canadian data exists, American studies reveal that poverty is usually transitory and short-lived; only 3% of the population live in poverty for five or more years at a time (Rank and Hirschl 2001).

describes, is the bottom of a slippery slope – a place where it is easier to end up than it is to leave.

The pathways *out of* exclusion are more difficult to uncover. While idealized stories of breaking free of poverty and becoming successful are touted as possible for everyone, these cases, while possible, are infrequent and often the result of social circumstances beyond the individual's control (cf. Becker 1994; Gladwell 2008). Existing research indicates that those most likely to be vulnerable or marginalized but still included are those people who were never fully excluded in the first place; that is, those who retain several strong ties to the social world through family, friends, or community networks (Comack 1996; Farrall 2004; Maidment 2006; Richie 2001). While individual resilience and social networks are considered key to successfully integrating into society, the odds of remaining integrated strongly favour those who already reap the advantages of good education, a comfortable income, and strong social connections (Farrall 2004; Richie 2001; Shantz and Frigon 2009; Shantz, Kilty, and Frigon 2009).

Older marginalized women navigate between vulnerability, assistance, and disaffiliation or exclusion based on their own attributes, resources and connections to others. Therefore, they must navigate the social world and create spaces for themselves within it. To do so, they develop identities that encapsulate aspects of themselves, while also bearing the influences of societal discourses on the poor, elderly, criminalized and marginalized persons. They use a variety of means and strategies to negotiate identities within these constraints. The following section explores how liminal older women construct identities.

## **2.4 Identity**

Identities are primarily social constructs. While physical attributes *are* important – bodies enable and constrain actions, negating the possibility of a blind person being a pilot or a paraplegic

being a high steel worker – the social world is the site of identity construction, performance, and negotiation. Through discourse, it limits the roles and identities into which a person can fit and provides frameworks for social interaction (cf. Cooley 1902; Goffman 1959, 1963). For example, young, successful individuals in the Aboriginal community cannot be elders even though they may have a great deal of wisdom; they must attain a certain age before they can hold this role. While people still have a range of identity options, the social world structures these possibilities, providing limits and boundaries. In this section, I explore how identities are constructed and negotiated.

Erving Goffman (1963) used “identity pegs” to explain identity construction. Identity pegs are facts about a person around which a story, image or identity is constructed. These markers are social and physical; they may be empowering, stigmatizing, or commonplace (Goffman 1963). Shilling (1993) highlights the physical aspects of identity construction, arguing that identities are intertwined with bodies; the way one looks, dresses, and acts all affect identity. According to Shilling, the body is a space where individuals can express themselves and assert identities. Foucault (1990) focuses on how social structures shape our bodies, how we see them, and how we can (and cannot) talk about and make them up. Thus, physical appearance and self-presentation are intertwined with social elements in constructing and negotiating identities.

The physical and social forces shaping a person’s identity are dynamic, changing over time and between situations. A person may have multiple identities, each of which takes prominence in different situations and connotes different levels of power and privilege (Comack 1999; Harding 1986). Theorists use the term “positionality” to refer to these variations in power, indicating that power is relative and contextual, as are positions of subordination (cf. Mohanty 1997, 2003). For example, one person may be a woman, a mother, an Aboriginal, a scientist, a gardener, or

a combination of these roles, depending on the social setting. She may be relatively powerful compared to women in non-western countries, or may be relatively powerless when compared to white males in her own country. Identities are constantly being negotiated to reflect contextualized social realities. Positionality is useful for highlighting how social structures and discourses can have differential impacts on one's various social identities.

Older women's physical appearances shape others' perceptions of them, reflecting social norms (i.e., societal standards of beauty), but also individual choices (e.g., how the woman dresses and presents herself). In western culture, bodies are integral to identities, enabling us to make statements of identification (Shilling 1993). As discussed above, western beauty standards value youth and sexuality, abhorring signs of aging, such as grey hair, wrinkles, flaccid muscles, sagging breasts, and other markers of 'imperfect' bodies (Calasanti et al. 2006; Shilling 1993; Ussher 2006). As women age, beauty standards become less and less attainable; despite this, women maintain a high level of concern about their appearances (Abu-Laban and McDaniel 2004; Barrett and Robbins 2008; Clarke 2001; Gimlin 2007). Clarke (2001) notes that older women often express frustration that the way they *look* completely contrasts how they *feel*; this experiential disconnect often leads to frustration and sadness. In addition to changing appearances, aging affects women's abilities and personalities. As noted, older women experience physical and sensory decline (Clarke 2001; Health Canada 1999; Shilling 1993). Moreover, some women may self-isolate or face social isolation as they withdraw from the workforce, their families grow older, and friends their own age die.

Aging is a process of change: women's identities must adapt to match the physiological and life course transitions that they undergo. This may involve navigating new settings, such as a seniors' activity centre or a nursing home; developing new social relationships – perhaps with a

care provider, a friendly visitor or a nursing home administrator; ending social relationships as friends die or lose abilities; and modifying continuing ties as families age and parent-child care relationships become inverted.

## **Negotiating Identity**

Negotiating identity is a social process. Symbolic interactionists argue that identities are social constructions and are shaped by what people think about themselves, the image or persona that they present to others, by what they believe others think of them, and by how others react to them (Cooley 1902; Goffman 1963). Erving Goffman argues that Identities are performed and negotiated in individual interactions; like an actor on stage, each performance or negotiation represents a chance for the identity to be accepted or challenged (Goffman 1959). Thus, social interactions are key grounds for women to assert agency through creating, managing and negotiating identities (Goffman 1959, 1963). Goffman's insights are intuitively understood by many, especially those with a "criminal" identity. Indeed, many researchers have found that people who are attempting to renegotiate their places in the world are deeply attuned to others' cues and acceptance or rejection of their new or re-shaped identities (Kilty 2011; Maidment 2006; Richie 2001; Shantz et al. 2009; Uggen, Manza, and Behrens 2004).

Judith Butler uses similar terminology, but takes a different perspective. Butler (1990) asserts that identities are performed, and that our identities are formed through processes of repetition, where identity is an effect of emulating the idealized discursive performance of the norms governing one's existence. Through this repetition, one assumes roles, based on social norms and constraints, that allow one to adopt different identities (Butler 1990, 1993b). Repetitions, however, can be unstable and can reify or challenge existing structures and norms. As each repetition represents a chance to resist the status quo, identities are neither tied to fixed categories nor are they static constructions; instead they are positional, changing over time as

the repetitions, or performances, change. While the perspectives of Goffman and Butler appear incompatible – one taking a poststructuralist stance, arguing that performances are the expression of discourse while the other takes a concrete worldview, holding that identity performances are dramatic acts performed for others – both agree that identities are negotiated through interactions instead of being determined by structures, note the importance of norms and social factors in identity negotiation, indicate that identities are fluid, and show that identities, through negotiations and renegotiations, hold the potential for resistance. Here, my use of the phrase “identity performances” more closely matches that of Judith Butler.

### **Identities as sites of Contestation and Resistance**

Identities are contested, managed, and negotiated in social interactions. Indeed, others may accept one’s self-presentation and identity performance, or they may reject it, discrediting the performance and the performer (Goffman 1959). These negotiations of identity take place as individuals try to fit themselves and others into various identity categories and stereotypes. The proscribed social identities offered to older women may not match their realities and self-perceptions; thus older women may negotiate, subvert, or co-opt existing categories in order to accommodate their personal identity performatives.

In one sense, identity categories are created by the social forces that control and shape how older women understand themselves. Power relations within social negotiations are highly important, shaping available identity choices and modulating the likelihood that various identities will be accepted by others. As identities are constructed, negotiated, and maintained within social relationships, they are affected by the various forces present in these relationships, including power and resistance (Foucault 1990); indeed, power shapes social relations (Foucault 1982). Power’s dynamics change between situations; a person’s relative power is fluid, as is their ability to resist others’ power. Older marginalized women’s social and economic

positions offer them relatively little socio-economic power. While they still negotiate space and identity, they often fight losing battles; they may attempt to resist the categories imposed on them, but their success in these endeavours may be limited. Judith Butler (1990) also argues that resistance can be embodied in identity. As identity is produced through the repetition of social norms and roles, individuals who do not perform and repeat these normative acts in the usual manner open spaces of resistance, in which they can create resistant and unique identities (Butler 1990). Resistant identities may also be created through *counter discourses*, in which messages and ideas from the dominant discourse are subverted, repurposed, and used by the marginalized as a platform for resistance (Kingfisher 1996). For example, welfare mothers' counter discourses portray their needs for increased income as an investment in their children's futures that will benefit society as a whole, thus subverting notions that they only think of themselves and that they require instant gratification (Kingfisher 1996). Counter discourses repurpose existing discourses and provide opportunities for women to challenge and contradict the dominant messages that shape and influence them.

Both older women in general, and marginalized and criminalized women in particular, face a range of narrow discursive categories into which they are classified and by which they are labelled, based on their age, gender, and other personal characteristics (Abu-Laban and McDaniel 2004; Ussher 2006). These roles are often stigmatizing and inappropriate, providing few realistic choices based on readily available roles. From this standpoint, older women may attempt to fit into dominant social roles and identities; discursively disappear by accepting their marginalized position; or, they may actively or passively resist these categories through their thoughts, actions, or self-presentations. As the dominant identities do not fit, women may look to aspects of their personalities, interests, friends or acquaintances, or to the circumstances of their lives as anchors on which to construct and reconstruct resistant identities (Castells 2011).

Older women's identities are typically defined in relation to a small range of pre-set roles that exist on the margins of society. These roles, which evoke images of withering beauty and liminality, present older women as harmless, frail, and largely useless (Breytspraak 1984; Flynn 2002; Ussher 2006). Although still conforming to some social scripts, the stereotypical *mad* and *bad* identities given to older marginalized women bear some markers of resistance, forcing society to pay attention to older women, and also challenging ideas about older women being harmless and powerless. For older women, these identities neither present dramatic challenges to the main discursive images affecting them, nor offer socially desirable roles; rather, these alternative and stigmatized roles highlight the potential to challenge and subvert traditional stereotypes about aging. Thus, marginal positions and identities contain the potential for resistance (Bosworth 1999; Faith 1994). As alternative and resistant identities are seen in some social scripts, marginalized and criminalized women may be able to construct resistant identities and identity performatives that better reflect their views and social positions.

Although a woman may be marginalized or criminalized, these attributes do not necessarily define her or her interactions with others. Indeed, these labels are fluid and do not always reflect social or material realities. Homeless people, for example, may not be the most marginal of the marginalized. While they lack homes, they do not all lack social networks and may be far more socially engaged than they appear (Washington 2005). Women on welfare, while seen as lazy and undeserving, often have significant responsibilities as caregivers for children or other family members (Canadian Council on Social Development 1984; Kingfisher 1996; Schellenberg and Silver 2004). Disabled individuals, who are often infantilized or treated as freaks or curiosities, may "come out" as being disabled and proud, or may present themselves as just as able, if not more so, than their able-bodied peers (Goffman 1963; Reeve 2002). Women with

experiences of addiction, imprisonment, or homelessness may identify themselves simply as “survivors.” These cases show how negative identities and stereotypes can be challenged in and through the negotiation of individual identities. Similarly, the generalizations applied to marginalized women also amount to stereotypes, which fit no better in reference to this group than to any other; as with all generalizations, they miss the nuance and uniqueness of women’s lives and situations. While these identities and the resistance they embody cannot always shield women from the judgments of others, they do represent a way for the woman to re-frame her reality and more comfortably navigate the social world.

Identities are physical, personal, and social, and they are affected by and affect the social world. Therefore, to gain a better understanding of older marginalized women’s social worlds, we must examine their social connections and networks, including family, friends, acquaintances, and others with whom they regularly interact.

## **Resilience**

Resilience refers to an individual’s ability to adapt and persevere despite adversity and negative circumstances (cf. Bluglass 2007; Cyrulnik 2005; Eisold 2005; Fonagy et al. 1994; Gergen 2009; Masten et al. 1999; Smith 2009). Like resistance, resignation, and negative coping, it marks another pathway through adversity. The process of resilience is distinct from *recovering* from a traumatic event; resilient individuals do not experience psychological or physical damage or deterioration (or experience these to a lesser degree) as a result of trauma and adversity (Bonanno 2004; Cyrulnik 2005, 2007). Resilience is one of many adaptive responses that women may show in the aftermath of a traumatic event. Bonanno (2004:20) elaborates:

Some people experience acute distress from which they are unable to recover. Others suffer less intensely and for a much shorter period of time. Some people seem to recover quickly but then begin to experience unexpected health problems or difficulties concentrating or enjoying life the way they used to. However, large numbers of people manage to endure the temporary upheaval of

loss or potentially traumatic events remarkably well, with no apparent disruption in their ability to function at work or in close relationships, and seem to move on to new challenges with apparent ease.

Bonanno (2004) further notes that resilience is exceedingly normal; it can be seen in everyday actions and responses to trauma, such as laughter, self-enhancement (i.e., maintaining a positive and optimistic outlook) and overall hardiness. Here, “hardiness” includes three elements: “...being committed to finding meaningful purpose in life, the belief that one can influence one’s surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences” (Bonanno 2004:25). Boris Cyrulnik (cf. 2005, 2007) builds on these themes, noting that resilience is a matter of how one understands events and frames them after they occur. He examines resilience through discourse, talk, and the signification and attribution of meaning to events. He argues,

Freud thought that the seeds of adult suffering were sown during childhood. We now have to add that the way families and the cultural environment talk about wounds can either attenuate or exacerbate that suffering, depending upon what stories they tell (Cyrulnik 2007:10).

As humans, we use ‘stories’ as discursive frames to make sense of our experiences and the world around us. Spaces for resilience can be created when the definitions and understandings applied to events and situations through these stories allow for a potential positive definition of the outcome and the possibility of success – or at least normalcy – afterwards. Cyrulnik continues:

Our tendency to tell ourselves stories about what has happened to us is a resilience factor, provided that we can give a meaning to what has happened and rework it in emotional terms. ... Human beings could not live in a world without memories or dreams. If they were prisoners of the present, their world would be meaningless (Cyrulnik 2007:19).

Our pasts – including traumatic events that have occurred – give meaning to our lives.

Understanding and accepting these traumatic events is important to developing resilience. As a person comes to understand and frame these events as difficult or trying, but not as definitional to or limiting of one’s life, moving onward becomes a possibility. For those who cannot do this,

however, the same event may be understood as personally damaging and life-altering. The stories we tell ourselves can turn us into victims and sufferers, but also leave space for us to be “overcomers”<sup>15</sup> or to develop self-definitions and understandings outside of traumatic events. While definitions of resilience vary, all link it to a person’s attitude and her attempts at perseverance (cf. Notter, MacTavish, and Shamah 2008; Smith 2009).

Resilience is traditionally associated with child development and cases of trauma, where it does not imply exceptional achievement or results; rather, it is “*normal* development under difficult conditions” (Fonagy et al. 1994:233). Although resilience has often been used in the relatively narrow domain of childhood development, its applications have broadened, reflecting that its relevance and applicability extend outside of childhood; adverse situations and traumatic events are not isolated to one’s early life, and as the processes of identity formation, negotiation, and performance are life-long, the concept of resilience resonates throughout the lifespan. Now, it is considered to be an important consideration for examining older adults’ lives (cf. Gergen 2009; Street 2007). Although uncommon, resilience does emerge in criminology. Dance in prison, for example, offers an avenue for prisoners to develop resilience through connecting with their bodies (Frigon 2008; Frigon and Jenny 2009). In testament to this, Point Virgule, a French dance company that works with prisoners has performed a work entitled *Resilience* (Frigon and Jenny 2009). In addition, resilience is used in health care, developmental psychology, and aging literature to reflect individuals’ differing abilities to cope with daily challenges as well as traumatic events and long-term stresses, such as health problems or poverty (Bluglass 2007; Bonanno 2004).

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<sup>15</sup> “Overcomer” is a term used by Dina, one of the older marginalized women who participated in this study, to describe and reflect on her own resilience to negative and traumatic circumstances.

Fonagy et al. (1994) summarize factors associated with childhood resilience. Resilience is linked to a wide range of attributes, including higher socio-economic status; high IQ; close relationships and support; sex (females have an early advantage, while males tend to be more resilient at older ages); good overall health and ability; good temperaments; being young at the time of the traumatic event/circumstance; having a good relationship with at least one parent; having a strong social network; being involved in one's community; empathy and awareness of others; being able and willing to plan; and a sense of humour. Of note, most of these factors – including socio-economic status, community involvement, relationships, and age – are external to an individual's control, especially during childhood. As a woman grows and ages, however, she gains increasing control over her relationships, interactions and world. As noted previously, this "control" is relative; control is constrained by the environment, including its human, cultural, social, and regulatory aspects.

A growing body of literature reflects the value of resilience in older age (cf. Bonanno 2004; Fry and Keyes 2010; Gergen 2009; Lamond et al. 2008; Smith 2009; Wells 2009). Research studies have positively correlated resilience with lowered levels of depression and positive health outcomes for older adults, as well as social and personal background factors, such as higher education levels and strong social engagement (Gergen 2009; Smith 2009; Wells 2009). Additionally, though resilience is not necessarily linked to improved incomes or social status, it may be a protective factor against other types of adversity, such as isolation and substance abuse (Notter et al. 2008), and is thought to positively affect longevity and overall health status. As noted by Fonagy et al., resilience and social capital are linked; social networks can provide both emotional and material support and assistance, both of which can bolster resilience.

Resilience can take many forms – from talk, to interpersonal support, to dance – thus negating a “one-size-fits-all” definition and making it interesting and significant from theoretical and analytic perspectives. Bonanno concludes,

The evidence reviewed above presents an important challenge to the view that adults who do not show distress following a loss or violent or life-threatening event are either pathological or rare and exceptionally healthy. Rather, this evidence suggests that resilience is common, is distinct from the process of recovery, and can potentially be reached by a variety of different pathways (Bonanno 2004:26).

From this perspective, the pathways through life events can be understood not merely in terms of the “who”, “what”, “where”, “when” and “why” questions; these pathways also tell “how” the women adapt and adjust to adverse events. The women’s journeys along these paths also illustrate the myriad ways that they can negotiate their circumstances and how the interplay of identity, social world, and negotiations shape who they are.

## **2.5 Social Networks**

Ties with family, friends, and communities are important identity markers for older women. While there are studies of older women’s social ties, this work almost exclusively focuses on older women who have led relatively privileged lives and who do not face isolation, marginalization or criminalization (cf. Breytspraak 1984; Henwood 1993; Keating et al. 2005; Koch and Mansfield 2004; Matthews 1979). These studies show the importance of family, friend, and community ties for elders, linking these with improved health outcomes, better social engagement and prolonged longevity and vitality. For example, friendships can provide social connections and access to resources (Keating et al. 2005). Friendships and leisure time are sometimes seen as luxuries for women who negotiate multiple, competing roles (Green 1998). This is especially true for older women, who often took on familial responsibilities from a young age, limiting their chances to develop personal interests and leisure activities outside of these roles. Friendships, however, provide women with spaces in which to seek support and develop their identities, processes which become more important as women age.

Friendships provide real and tangible benefits, although these ties are often taken for granted to some extent as not everyone has friends. Depending on a woman's personal situation, she may lack ties to friends, family, or her community (Comack 1996; Maidment 2006; Richie 2001). As discussed, this is often the case for marginalized women, many of whom have strained relationships with families and friends. Isolation exacerbates the liminality felt by many older adults – they find themselves ignored by younger adults and separated from the places and spaces they once freely occupied (Shilling 1993). Although new gerontological discourses try to forcibly insert elders into the social realm, this is often accomplished by creating *new* social spaces for seniors, including activity programs, holiday trips, and media targeted specifically at older populations (Abu-Laban and McDaniel 2004; Tulle and Mooney 2002). However, these social spaces and media are often reserved for older people with privileged backgrounds; few less affluent seniors can afford the memberships for magazines such as *Zoomer* and *Fifty Plus*, let alone the items and lifestyles advertised in their pages. In addition, seniors' recreation and social clubs often have membership fees and play games commonly associated with affluence and higher education levels – such as golf and bridge – instead of games more common among working class women and those with more limited means, such as bingo (Cousins and Witcher 2006). In other words, there are some social spaces for seniors, but older adults who face deprivation and marginalization may be excluded from these as well. This double isolation can increase and exacerbate the pains associated with marginalization and criminalization.

Marginalized women's limited social connections are problematic; these ties can have real value and benefits. Social connections, or *social capital*, can improve one's access to resources, facilitate and prolong independent living, and provide support, reassurance, and companionship (Green 1998; Keating et al. 2005; Putnam 2000). Social capital refers to networks among

people that can provide resources or tangible benefits.<sup>16</sup> Research indicates that older women with high levels of education, good health, and higher incomes usually benefit from large, strong social networks more than those without these advantages (Keating et al. 2005). Recently, the state has increased the burdens placed on these networks, relying on them to provide additional care to elders (Bezanson 2008; Connidis 2002). As friends and family are important for individual autonomy, social engagement and identity, lacking or losing these ties may bring personal hardship (Keating et al. 2005; O. M. A. S. Ontario 2008). Unfortunately, older marginalized women frequently lack most, if not all, of these advantages.

While sometimes touted as the solution to many social problems, social capital is not always beneficial. Social discourses impose norms and expectations; some roles are considered “acceptable” for older women and others are not. There is often a social price to pay for those who are unwilling or unable to conform (Bezanson 2008; Brody and Lovrich 2002). Social networks can also reinforce marginality. If one’s only ties are to others who are disadvantaged, one’s social and economic mobility and access to programs will be limited (Bezanson 2008; Bourdieu 1993; Field 2003; Reisig et al. 2002). For example, homeless adults with addictions often remain marginalized even if they secure adequate housing (McNaughton 2008). In addition, social capital frameworks can place disproportionate responsibilities on women for care and social networking (Bezanson 2008). As such, negotiating the social world can be a difficult daily challenge, especially for those who face the additional pains of (re)integration.

### **Social Integration and the Pains of (Re)Integration**

Criminalization limits older women’s social worlds. While in prison, older women often self-isolate to cope with the strains of institutional life; manage their fears; and to resist the ‘prisoner’ identity (Aday 2003; Bosworth 1999; Kratcoski and Babb 1990; Wahidin 2004). After prison,

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<sup>16</sup> See section 3.3 for a more detailed discussion of social capital.

older criminalized women may remain fearful of the world around them, self-isolating to cope with their relative freedom (Shantz 2008; Shantz and Frigon 2009). In addition, they may avoid or sever ties to others out of shame or fear (Shantz 2008). On top of these personal challenges, probation and parole regimes impose additional limitations and hardships, restricting their choices, movements and activities.

Women on probation or parole may face restrictions on their associations; they may be barred from contacting anyone with a criminal record, sometimes isolating them from family, friends and neighbours. In addition to social limitations, parole restrictions may also limit a woman's mobilities. She may be barred from travelling or frequenting her old haunts, adding geographic dislocation as an additional pain of reintegration. Of note, these hardships are particularly painful for women who have experienced long periods of imprisonment. Older female ex-prisoners, after spending years away from their homes and communities, have often lost ties with their families and friends (Aday 2003; Cohen 1999; Faith 1993; Keating et al. 2005; Novak and Campbell 2006; Office of the Auditor General 2003; Wahidin 2004). While many ex-prisoners try to re-develop these relationships after prison (Comack 1996; Maidment 2006; Richie 2001), many also rely on other ex-prisoners to assist them (Shantz et al. 2009). The importance of ties to other ex-prisoners cannot be underestimated; few understand the psychological trauma of imprisonment and the aftereffects of spending an extended period in prison (Munn and Bruckert 2008). These ties can provide essential assistance and companionship for those struggling to "make it" after release (Braithwaite 2006). While older women are statistically unlikely to reoffend (Public Safety Canada 2008; Uzoaba 1998; Wahidin 2004), these conditions nonetheless limit their chances of "success" in integration.

These challenges are especially salient for women who are released to marginal neighbourhoods; there are few contacts available to them that are considered “acceptable.” Indeed, they may also have difficulty accessing community services due to high demand and the limited number of spaces available (Maidment 2006; Richie 2001). These closed doors and limited outlets for interaction can often lead older women to face loneliness, isolation, and depression.

## **Loneliness**

As we age, our social networks shrink (Keating et al. 2005). Children grow up; friends, spouses and siblings die; neighbours move away; and the aging person’s own abilities to engage in social activities decrease. These changes increase the likelihood of elders’ isolation, as well as experiences of depression and loneliness (Matthews 1979). Loneliness can occur even when individuals have social ties and it is particularly problematic for older people. Distinct from depression, but often coexistent, loneliness involves perceived deficiencies in one’s social relationships, manifested in dissatisfaction with these relationships and desires to improve them (Dykstra 2009). Loneliness is linked to poor relationships, poor relationship standards, and predisposing conditions, such as low self-esteem. Loneliness is frequently associated with poorer health outcomes, increased risk of chronic disease, and earlier death among older adults (Hawkley et al. 2006; Herlitz et al. 1998; Olsen et al. 1991; Penninx et al. 1997; Thurston and Kubzansky 2009). While loneliness is often considered to be part of aging, it adds to older marginalized women’s other challenges and problems, and can make life more difficult for them.

Frequently, one assumes that isolation and loneliness can be cured through social contact. While this is part of the solution, it is not a panacea for loneliness (Dykstra 2009). Social capital research often notes the potential for developing new relationships to battle loneliness, isolation and depression (Cousins and Witcher 2006; Matthews 1979; Putnam 2000; Tulle and Mooney

2002). While community programs and services work for some older adults, not everyone feels comfortable or welcome in these environments; indeed, depending on the woman and her needs, she may not be welcomed into these places. Community engagement is not a panacea for lonely older adults in general, particularly for older marginalized women; social ties can be difficult to create and maintain. Older Canadians also have more difficulty making friends and forming new relationships than younger adults; researchers found that 14% of this group reported having no close friends, and 10% reported having no friends at all (Turcotte and Schellenberg 2007). There are no simple, quick solutions to loneliness and it must be addressed as a serious concern for older adults.

Social networks hold both promise and challenges for marginalized individuals. For older marginalized women, who often find themselves on the boundaries of various social spaces and communities, navigating the social world can be a challenging experience in which they string together various interactions and connections to form a social web. However, this web is often loosely formed, allowing many potential interactions to slip through and missing opportunities for engagement and fulfillment.

## **2.6 Moving Forward**

Older marginalized women, despite their diversity, share some key characteristics. While our knowledge about the group is partial, we do know that they are often poor, age more quickly than average, have limited social circles, and face many structural constraints that limit both their senses of self and their opportunities. While this review of the literature shows us that older liminal women face many challenges, it also highlights the diversity and breadth of their experiences. The existing knowledge raises as many questions as it answers. While we can infer some information about older marginalized women from knowledge about *older adults* and *marginalized women*, we lack a full picture of their lives and realities. Who are they? How did

they end up where they are now? What are their lives like? How do they meet their needs? How do they interact in and navigate the social world? How are they treated? This research will begin to address these gaps, patching in data and individual voices to form a clearer picture of the world as it is experienced by older marginalized women. Before I further explore these questions, however, I first outline the theoretical framework that I use to examine the women's identities and life experiences.

## Chapter III – Theory

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### 3 Theory

I've seen elderly people, and man, can they move. Sometimes they're even stronger than somebody who's fifty years old. They're strong. And they have a right to be able to speak their mind as well. They're not little gossipers, they can teach you things about what they went through in their lifetimes. – Danielle

I don't know the nature of [woman's] mental health challenges, but she's a bit volatile in terms of her moods and how she treats people. She says it's fun to talk to me and that I'm nice, but she also tells me that I'm not as pretty as I should be – I need laser vision correction, and also maybe to lose a few pounds... I just smile (what else can I do?), realizing that power relationships are indeed *constantly* negotiated. – field notes

In order to fully understand older marginalized women's positions in the social world, one must examine their individual identities, how the women navigate social space, and how women's identities and navigations shape and are shaped by social interactions and social networks. I examine these various aspects by first examining the 'new mobilities' paradigm which I will use to structure my analyses. I offer an exploration of mobilities and movement, including addressing how the physical body is implicated in mobilities, identity, and navigations of the social world. Next, I turn my attention to theories of identity and how identities are shaped by the social world, including the role of stigma in identity. Following this, I explore social networks, focusing on social capital and how social capital structures the women's interactions. The following section delves into stigma and its role in identity and social relations. Finally, I examine how women negotiate their social worlds, with their various identities and in and through their bodies, focusing on resistance and resilience as adaptive strategies.

#### 3.1 *Mobility and Movement*

For many years, sociology and its sister disciplines, including criminology and women's studies, focused on individuals and specific spaces or settings. "Movement" in these studies is often seen in the dynamic nature of relationships and their change over time. The social sciences are interactive, working in a dialectic through which they modify that which they study, and they are,

in turn, modified by it (Law and Urry 2004). In criminology, traditional studies often focus on the institutions of criminal justice (e.g., police practices, courts, prisons), the people that are part of these institutions (e.g., police, judges, prison guards), and the individuals that fall under their purview (e.g., “deviants” and prisoners). These studies – with the obvious exceptions of police patrol practices and crime mapping, which do, in essence, implicate movement, motion and geographic displacement (cf. Munn 2009) – tend to focus on individual interactions between people within fixed spaces or, as in the case of prisons, on the settings themselves. While these interactions will inevitably change over time, they are to a large extent fixed in place and often ignore the attributes and meanings associated with those spaces and places.

Recently, though, studies of mobility and movement – sometimes called the “new mobilities” paradigm (cf. Sheller and Urry 2006) – have gained popularity in many disciplines. Along with performance and performativity, they offer a new framework for organizing knowledge and a way of analyzing social phenomena. The perspective does not begin from a ‘grand narrative’ but instead lends itself to an eclectic mix of theories and methods to highlight mobility, fluidity, and liquidity (Sheller and Urry 2006). Monika Büscher and John Urry (2009) further examine the new mobilities paradigm, noting that this new perspective opens researchers to examining movement and its absence in myriad forms. They note that (im)mobility brings meaning – to people, objects, technologies, and ideas. It aids in the understanding of short-lived and fleeting phenomena, including emotions, sensations (sounds, sights, smells), and the results and consequences of movements and actions (Law and Urry 2004). The presences and absences of movement to which these theorists refer include objects held in place (imprisoned); fixed in place (buildings, institutions); objects that facilitate motion (cars, wheelchairs, shoes) as well as those that are portable; and the constitutive elements of a mobility system (e.g., transit network, internet, electricity grid) (Büscher and Urry 2009). Objects and movements may be transitory (a

gathering or event), recurring or long-lasting (a fixed place). The motion in question may be actual or potential, and may occur through space, time, or both. Examining movement allows researchers to study the ripples of meaning, signification, and consequences that surround movement, including the intention(s) behind the movement, the physical motion itself as well as its interpretations and aftereffects.

Movement is a key part of human interactions. Indeed, Urry (2000, 2003) notes that interaction necessitates movement on many grounds: for formal, social, practical, experiential, and emotional reasons. Movement – of bodies, of thoughts, of goods – is necessary to the formation of networks of exchange and circuits of interaction. Examining these social interactions as a form of exchange highlights the movement (and lack thereof) implicated in social exchanges. To highlight the myriad mobilities in social exchanges, I describe an experience shared with me by an interview participant.

Maggie was unable to attend her family's Thanksgiving dinner just before her interview as she had no way to get to the event. Her *lack of mobility* prevented her from being physically present; however Maggie was able to *telephone her family* during the gathering, thus opening a *circuit of communication* with them despite her absence. After the event, her son *transmitted pictures of the gathering to her via an e-mail* that she *walked to the public library to access*. In the *message accompanying the pictures*, Maggie's son indicated that *he would drive to Ottawa to visit her* in two weeks' time (Field Notes, October 10).

This example highlights how human interaction is not limited to face-to-face encounters and oral communication; indeed, the rise of contemporary technology facilitates communication across great distances through varied media, including written communications, telephone and electronic communications (Büscher and Urry 2009). It also highlights how mobilities may be instantaneous or delayed, simple or complex, and how mobilities can function as a cascade of small actions. Actions, reactions, and exchanges need not take the form of a one-to-one, instantaneous interaction. Taking this logic to the examination of identities and social networks, we can see that interactions and identity performatives may become blurred, distorted, and

distended over time and across space; technologies such as videoconferencing, internet-hosted communications (blogs, video postings, etc.) allow the performance to be viewed, interpreted, echoed and responded to by intended and unintended audiences.

The mobilities paradigm is helpful in examining myriad phenomena, including people's movements, forms of communication (spoken word, bulletin boards (real and virtual), text messages, blogs, art) and how people move through and use space (e.g., time-space diaries) (Büscher and Urry 2009). Studies of mobilities and movement naturally lend themselves to examining corporealities. While some mobilities require movement: of machines, of abstractly large quantities of commodities, or of information (e.g., text messages or internet communications) using radio waves, fibre optics, satellites and other technologies, mobilities also implicate physical bodies. Human interactions are not stationary; with few exceptions – such as those whose movements are constrained or heavily circumscribed, including prisoners, shut-ins<sup>17</sup>, or the infirm – individuals move through space in the course of their daily lives. *Space* and *place* become important parts of one's corporeal interactions; in addition to abilities and limitations of individual bodies, the environment – places and the objects and individuals that occupy them – mediate *what* one does (is) and *how* one does (lives) it, but also adds *meaning* to the interaction (Munn 2009). As Büscher and Urry indicate:

Mobilities involve fragile, aged, gendered, racialized bodies. Such bodies encounter other bodies, objects and the physical world multi-sensuously. Travel always involves corporeal movement and forms of pleasure and pain. Such bodies perform themselves in-between direct sensation of the 'other' and various sensescapes. Bodies are not empirically fixed and given but involve performances to fold notions of movement, nature, taste and desire, into and through the body. Bodies sense and make sense of the world as they move bodily in and through it, creating discursively mediated sensescapes that signify social taste and distinction, ideology and meaning (2009:102).

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<sup>17</sup> People who are referred to as "shut-ins" are those who seldom, if ever, leave their apartments or homes. Often, this lack of mobility is linked to physical or mental health concerns, although it may also simply signify a lack of places to go to or limited social contacts.

As the authors note, the spaces inhabited and the process of inhabiting bring together a constellation of factors and phenomena. John Urry further notes the importance of inhabited spaces. Borrowing from Heidegger (1993), he notes the importance of dwelling as an active form of inhabiting a place. He indicates that 'dwelling' implicates *places* and *objects*; dwelling happens through an active engagement with one's environment.

For Heidegger, dwelling (or *wohnen*) means to reside or to stay, to dwell at peace, to be content or at home in a place. It is the manner in which humans inhabit the earth. He talks of dwelling places, as opposed to other kinds of buildings such as railway stations and bridges. People inhabit these public buildings but they do not dwell within them. Dwelling always involves a staying with things (Urry 2000:131).

Urry further notes that dwelling in contemporary times is more complex; instantaneous communications and the mobilities of people, objects, commodities, and culture all serve to unmoor us from this type of 'dwelling.' Urry also notes the conflicts and tensions between different types of dwelling in a place and how different groups occupy a given space. He notes, for example, the migrations of the Roma and the 'right to roam' laws in England that allow travelers access to the countryside, regardless of whether the land is 'public' or 'private.' Contemporary 'dwelling' and interactions with the places and spaces around us include both belonging and movement. As such, ideas of place, "home" for example, become plural, fractured, or *situational* instead of *geographic* (hooks 1990; Urry 2000).

Turning this discussion toward the lives and worlds of older marginalized women, several questions arise. First, how do older marginalized women, particularly those who are homeless, *dwell* in a place when their attachment to the place where they live is limited or non-existent? Many of these women have few, if any, belongings; precarious housing situations, sometimes living in shelters, out of cars, or rough sleeping; and limited access to the physical and social worlds of mainstream society. They may also face resistance, tension or outright hostility when

they do attempt to 'dwell' in a place in the form of "NIMBY-ism"<sup>18</sup> and resistance from neighbours or property owners. The next question that arises is over the differentiation outlined by Heidegger and emphasized by Urry between *places of dwelling* and *other kinds of buildings*. For the homeless and marginalized, this is often a false distinction, yet one that is reinforced by state authorities that seek to demarcate 'private' from public property and also to circumscribe and regulate the use of public property, such as underpasses or parks (Boyne 2000; Button 2003; Casey, Goudie, and Reeve 2008). 'Dwelling' functions as a form of immobility or rootedness, yet its meaning remains relative: for those with tenuous ties to *any* place, or whose ties to place are negative (Manzo 2003, 2005), 'dwelling' may take the form of a temporary encampment in a park instead of a leased apartment and may indeed become, for others who are more entrenched in their state of dwelling, a transitory phenomenon. As noted by hooks (1990), dwelling may also be accomplished through finding positive and welcoming spaces, regardless of whether or not these places and spaces can be considered a 'home' or simply as part of one's environment.

Mobilities, in their presence and absence, provide a framework for daily life, including a person's identity performatives, social interactions, access to the social world, and physical navigations of space. For older marginalized women, questions of performance, connection, access, and movement will be mediated through their bodies in all of their diversity. In particular, class, gender and age, as well as the social signifiers of these and their other statuses are pertinent to the discussion. While the manifestation of these traits varies across the participants' lives and experiences, offering rich ground for analysis, I offer a more detailed exploration of age below.

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<sup>18</sup> "NIMBY-ism" refers to the attitudes and mentalities associated with the "not in my backyard" or NIMBY phenomenon by which individuals, normally property owners or those who are relatively well-off, attempt to limit development in the neighbourhoods where they live and/or work (cf. Piat 2000).

## **Mobilities and Age**

Mobilities have a strong resonance with aging bodies. As the physical body ages, mobilities take on new meanings; activities that women carried out as part of their everyday lives and which were considered mundane for younger bodies become major tasks when those same bodies can no longer move with the same speed, agility and stamina. This can lead individuals to restrict or modify their activities in response to real or perceived limitations; if the person cannot adapt or make adjustments to their activities, however, they may face significant challenges in completing basic tasks and navigating daily life (cf. Barrett and Robbins 2008; Clarke 2001; Kratcoski and Babb 1990; Shantz and Frigon 2009; Tulle and Mooney 2002). Tasks such as grocery shopping, for example, can become major events: walking up and down the seemingly endless aisles of massive big-box grocery stores, reading small print on product labels, reaching for items on high shelves, standing in line, and carrying heavy bags of groceries can prove difficult for women with chronic illnesses, mobility challenges, failing vision, or reduced energy and stamina. Ingeborg Boyens, a journalist and writer, describes how chronic illness changed her body and its movements:

My body, which is supposed to be lithe and beautiful in its feminine prime, is mere ballast outside this pool. I am in my mid-forties, but I totter and stumble through life like one of those frail women in her mid-eighties we used to see timidly teetering along the aisles of the old Eaton's. I walk on invisible stilts; the mere flapping of a butterfly's wings a mile away will inexplicably upset my precarious balance. My hands are muffled in oven mitts; my handwriting has deteriorated to an awkward scrawl that even I can no longer read. My mouth is filled with marbles; the words I try to enunciate come out rattled and slurred.

It wasn't always like this. I used to swim laps, ride bicycles and dance until I dropped. In the flush of youthful conceit, I used to stride about with never a thought for the simple task of locomotion. I took my body for granted, assumed it would pilot me on an adventuresome course through life. However, the hazards of unseen geological events have detoured my route. Yawning, volcanic fissures often split the sidewalk, mountain ranges dredged up by the snowplough appear along winter streets and giant rolling hills emerge from a buckled carpet. Daily life with chronic illness has become a course in extreme adventuring (Boyens 2003:194).

While Boyens would only be considered “old” by the most generous definitions at the time of her writing (cf. Cohen 1999 for a discussion of age demarcations), the challenges she describes reflect the realities of many women living in chronically ill and aging bodies. They also mirror, inversely, Clarke’s (2001) study of older women and identity: for Boyens, her body *looks* young but *feels* old. In both types of bodies, the mismatch of appearances and abilities affect the women’s identities and mobilities: re-evaluations of identity, movement and negotiations of space, time, and perception are all required to navigate the daily world. Through mobilities, *identity performances* take on a new significance. While the performance is always of interest – including the *who, when, why, for whom* and *to what effect* questions associated with it – questions of *how* and *where* take precedence when examining mobilities and corporeality. The disembodied identity is re-concretized in a physical form located in a physical world among a social milieu.

Together, physical capabilities and social networks both have tangible effects on one’s mobilities. One’s social ties may result in access to places and services being granted or denied (Brody and Lovrich 2002; Burchfield and Mingus 2008; Putnam 2000). This can range from the requirement for a doctor’s referral to receive a given program or service, to gaining access to a members-only social club, to mandated treatment or therapy, to participation in community events (including physical communities and communities of affiliation) where inclusion is granted to those with social connections to the group. These inclusions and exclusions affect older adults’ mobilities.

Movement and mobility bring people into contact: by moving through spaces, one encounters diverse others with whom one may interact. Within these interactions, the parties must negotiate their place in the space, manage their own self-presentation, and advance identity

performatives. To understand how older women accomplish this, I now examine older marginalized women's identities through the lenses of symbolic interactionism and poststructuralism.

### **3.2 Understanding Identity**

Attempts at understanding identity and demarcating 'self' and 'other' have long been part of the human experience; philosophers including Plato and Socrates examined the nature of being. René Descartes also famously posed the Latin statement *cogito ergo sum* ("I think, therefore I am") (Baird and Kaufmann 2008). Indeed, developing a notion of self is part of the human developmental process. Despite its central place in our understandings of self and the world, identity is not often explored as a stand-alone concept in criminology. Rather, it is explored in terms of its *effects*: for example, Howard Becker's study of "outsiders" (cf. Becker 1963) highlights how one's deviant status stems from one's actions and how one's criminal identity becomes the grounds on which one is treated differently by society at large. Although identity is not always a topic of discussion in criminology, exploring these sociological and philosophical discussions of identity will help to describe *how* identities are formed and the significance of these identities for older marginalized women. To explore identity, I utilize two approaches: symbolic interactionism and poststructuralism, both of which are outlined in subsequent sections. Both highlight the processes of identity development and identity negotiation and are therefore helpful in understanding older marginalized women's understandings of their identities.

#### **Symbolic Interactionism and Identity Performances**

Symbolic interactionism centres "the self," individuals, and their identities as key themes in sociology. This stream of theory originated in the early 1900s at the University of Chicago (commonly referred to as the Chicago School), and can be traced to the contributions of sociologists such as George Herbert Mead (cf. 1913, 1932, 1934), Charles Cooley (cf. 1902)

and Herbert Blumer (cf. 1969), among others. In contrast to early sociological theories and schools of thought focusing on grand narratives or broad, macro-level trends (e.g., functionalism, Marxism), symbolic interactionism examines micro-level interpersonal interactions and communications in individual settings. It focuses on understanding the meanings attached to objects, events and situations. Symbolic interactionism also notes that individuals are not passive; rather, they play a part in actively creating their environments and circumstances.

Erving Goffman, among others, worked within the Chicago School and examined identity formation and performance. As is the case for many thinkers working from this perspective (cf. Becker 1963; Cooley 1902; Goffman 1959, 1963), he notes that identities are formed and shaped through social interactions. Goffman's *The Presentation of Self in Everyday Life* (1959) examined an individual's interactions in the social world. He uses dramaturgical metaphors, likening the presentation of identity to a theatrical performance. Goffman examines presentations and perceptions; though these are certainly components and signifiers of identity, they do not on their own constitute identity. He does not delve deeply into how identities are constituted; rather he indicates that people have 'true selves' that exist beneath the veneer of various identity performances that are created, attempted, contested, and recreated through interactions with others. Identity performances may vary between situations depending on the likelihood of succeeding in any given performance. He also notes that individuals are constantly engaging in identity performances; a person can only be her true self when "backstage" or out of the social sphere.

Though Goffman does not offer a detailed explanation of identity formation, his work resonates with identity formation vis-à-vis older marginalized women through the process of identity negotiation. Older marginalized women's statuses frequently place them outside of many parts

of the social sphere: at age fifty or older, they are often excluded from work, and their marginalized and/or criminalized statuses further limit the social spheres to which they have access. Therefore, they must negotiate places within physical and social spaces through their identity performances. As identity performances are attempted for different audiences with varying degrees of success, the negotiation of the performance and its acceptance resonates with this research. Goffman's later works delve deeper into identity and the challenges and difficulties in creating and maintaining an identity.

### **A turn to the Performative**

As explored above, Goffman's work centres on identity and the self, rather than the body, and examines the labels (and discourses) applied to it. Turning to poststructural thought flips the direction of inquiry, starting with discourse and then turning to the body and the self. As Stukes (2001:393) explains:

Poststructuralist theory has now effectively established the argument that the human subject does not exist before its constitution by external forces. There is no quintessential core of being or of a real body that stands apart from the human subject's constituted nature.

In this line of thinking, discourse is the matrix underpinning both *what* we know and *how* we come to know it. Simply, the argument is not that bodies and subjects do not exist per se; rather, that discourse *precedes* bodies and subjects, allowing us to understand and define them as such. Poststructuralism and modernism metaphorically each take a different side of the chicken and the egg debate; modernism starts with bodies and the concrete (chickens); poststructuralism takes the opposite track, starting with discourse, power, and the potential to name and identify (eggs). Each perspective offers different insights and ways of knowing; together, they offer multifaceted understandings of phenomena, such as identity performances.

Judith Butler's *Gender Trouble* (1990) and her other writings on gender and identity (cf. 1988, 1993b) marked a shift in feminist thinking about gender, bodies, and identities (Jagger 2008).

Although the notion of a single “female” identity in women’s studies theory had been questioned and critiqued by the time of Butler’s book (cf. Harding 1986), gender and sex were and are still frequently entangled and equated in popular discourses. Butler is a poststructuralist whose work examines discourse in detail, especially as it pertains to the body. Butler’s work, considered one of the foundational writings on queer theory, uncouples gender and sex; she explores gender and sexual identity, noting that gender is part of a system of power that is self-reproducing and hegemonic. While the primary focus of *Gender Trouble* and Butler’s early works is gender and (hetero)sexual norms, her work also includes a detailed examination of identities and identity formation and negotiation. She notes, “gender is in no way a stable identity or locus of agency from which various acts proceed; rather, it is an identity tenuously constituted in time – an identity instituted through *a stylized repetition of acts*” (Butler 1988:519, emphasis in original). This set of repetitions mimics a discursive archetype or ideal form that precedes the consideration of bodies, bodily attributes, and identities. As with gender, other identity attributes and roles are similarly constituted through repetitions. This notion of gender and identities as repetitions weaves throughout Butler’s works. While her work nods to the tradition of symbolic interactionism described above, she does not hold the view that beneath various identities is a single “true self” (Jagger 2008). Rather, identities are constituted through their performance and the performative, and are inherently changeable.

Butler argues that identities and gender norms are inherently changeable through performance, yet that there are also limits to this fluidity. She explains that, while gender performances are indeed unstable, a “sedimentation of gender norms” (1990:187) occurs over time. This sedimentation places limits and constraints on gender performances. As such, while they are open to (re)interpretation, the sedimentary, reified nature of norms entrenches them and creates the heteronormative gender discourses that form the status quo. Instead of infinite potential

interpretations with each new performance, the actor's performance is circumscribed within a narrow field of possibilities and potentialities. For individuals, this sedimentation results in identities and identity performances that are relatively stable from day-to-day and interaction to interaction. While identity performances will vary between interactions, they do so in minor ways; one does not, for example, usually change sexual orientation, political views, or personal roles with every identity performance. The relative stability of major attributes/labels/categories and the essence of the performance allow subjects to interact with one another within established norms and understandings. Although massive changes are not regular occurrences, they certainly may occur on occasion within individuals' identity performances. These, to borrow a metaphor from Foucault (cf. 1972, 1994b), mark 'points of rupture'<sup>19</sup> in an individual's life. Such massive ruptures and identity transformations are infrequent but highly significant, causing – as for other forms of rupture – a necessary refiguring and reconceptualising of many aspects of an individual's life. In practice, and for the purposes of this research, becoming marginalized or homeless may mark a point of rupture for older women experiencing these states for the first time. Conversely, for those who have experienced lifelong marginalization, criminalization and/or homelessness, reaching a point of stability may mark a point of rupture from a tumultuous past (Robert et al. 2007).

Although individual agency has a role in performativity – individuals can, after all, intentionally and self-consciously alter their performances – the discursive framework surrounding individual

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<sup>19</sup> Foucault notes that rupture involves a re-ordering of society, but not a complete transformation. He writes:

There are the epistemological acts and thresholds described by Bachelard: they suspend the continuous accumulation of knowledge, interrupt its slow development, and force it to enter a new time, cut it off from its empirical origin and its original motivations, cleanse it of its imaginary complicities; they direct historical analysis away from the search for silent beginnings, and the never-ending tracing-back to the original precursors, towards the search for a new type of rationality and its various effects.(Foucault 1972:4).

subjects limits the range of their freedoms and constrains the possibilities for their performances. Butler explains:

I would argue that there is no possibility of standing outside of the discursive conventions by which we are enabled. Gender performativity is not a question of instrumentally deploying a 'masquerade', for such a construal of performativity presupposes an intentional subject behind the deed. On the contrary, gender performativity involves the difficult labour of deriving agency from the very power regimes which constitute us, and which we oppose. This is, oddly enough, historical work, reworking the historicity of the signifier, and no recourse to quasi-transcendental selfhood and inflated concepts of History will help us in this most concrete and paradoxical of struggles (Butler 1995:136).

Gender performances – their constitution and indeed their change – are not simply driven by the will of an autonomous subject or actor. In contrast to the dramaturgical performance elaborated by Goffman (1959, 1963) in which the actor makes choices as to how s/he performs identity and also as to the presentation and negotiation of this identity, Butler's worldview offers less individual control and freedom to the actors, placing the emphasis instead on discourse and power regimes. In terms of understanding older marginalized women's identities, this view highlights the social forces that circumscribe their identity performances and also how these forces limit the identity options available to the women.

## **Performing Age**

While Judith Butler's work focuses on gender, her analyses can also be applied to the category of age. Gender and age categories share some similarities; both create reified "ideal" archetypes that individuals emulate (or resist) through their performances of their gendered (and aged) identities. While it must be noted that age and ability are linked to some degree (i.e., older adults are generally less physically able than their younger counterparts due to senescence and age-related declines (cf. Rowe and Kahn 1997, 1999) and the argument transposes imperfectly, parallels exist between these two analytic constructs. Like gender, the effects of age on bodies and identities are neither uniform nor static; they are subject to infinite variations, undergoing constant negotiation and change, and shifting based on individual

attributes and experiences over time. Although identity performances can vary dramatically between situations, they do sediment; some identity elements and self-perceptions may also remain static despite changes in the individual. For example, an older woman may define herself and perform the identity of one who is youthful and active even though these characteristics and identity markers are generally reserved for younger adults in contemporary discourses (Clarke 2001; Clarke and Griffin 2007; Matthews 1979; Tulle and Mooney 2002). Age, like physical differences between the sexes, does not dictate one's abilities. Just as those with female bodies will have more difficulty urinating while standing than males, older bodies will experience more age-related challenges than will younger bodies; this does not, however, preclude a wide range of abilities within each category.

Butler discusses the "sedimentation of gender norms" (1990:178); how, through repetition and imitation, the existing norms and discourses become institutionalized. Much the same can be said of age norms. While there are undoubted linkages between age and ability (i.e., physiological changes will eventually affect all individuals who live long enough to experience their effects), these two attributes are not uniformly linked; a wide degree of variation exists on the spectrum of ability at all ages (Galloway and Jokl 2000; Holstein and Minkler 2003; Rowe and Kahn 1987, 1997). At the same time, discursive representations of age are becoming more diverse as the population ages; older adults are increasingly portrayed as autonomous, vital and energetic, engaging in activities and living active lives. These discursive shifts are, however, partial; despite these developments, discourses are still dominated by images of older women as passive, asexual and liminal (cf. Abu-Laban and McDaniel 2004; Shilling 1993), and of older marginalized women as "mad, sad or bad" (Codd 1998). The partial transformation in discourse highlights a bifurcation in the experiences of older adults based on wealth, status and ability. For those with the means – in terms of physical and social capital as well as material resources

– aging and the discourses surrounding it are becoming less constraining and marginalizing.

Those without these privileges, however, largely remain situated within the sedimented, liminal position created by discourses favouring the young.

How one tries to counteract the sedimented nature of normative and idealized performatives will be examined later. First, however, I turn my attention to the situations and places in which these performances and interactions occur. While identities are recognized as fluid and ever-changing, they are the tools that people use in their navigations of social and physical spaces. I explore the latter theme in the following section, beginning with a discussion of *social capital*.

### **3.3 *The Value of Networks: Social Capital***

Identities are presented and negotiated through performance and performativity. As such, social forces – discourses and norms – are immediately and intimately implicated in identity formation. Indeed, identities are affected by and encapsulate elements of the person’s location, epoch, culture, and social interactions. The latter domain implicates an individual’s social networks. These networks implicate *social capital*, and include connections – both close bonds and tenuous linkages – with others who are part of the person’s life. While definitions of social capital vary, they uniformly refer to the tangible value of social networks or structures that accrues to the individual members of these networks. According to James Coleman (1990:302), for example, social capital is “...not a single entity, but a variety of different entities having two characteristics in common: they all consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure.” Similarly, Pierre Bourdieu and Loïc Wacquant (1992:119) define social capital as: “the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.” These social networks may provide close camaraderie, friendship and support, and also connections to resources and

assistance. Robert Putnam (2000) also studied social capital, noting that the benefits provided can be divided into close support and intimate family ties (bonding social capital), or ties to others that facilitate access to goods or services (bridging social capital). These two types of connections provide different resources and also place different demands on their members, ranging from providing material support and physical care to involvement in social or formal (often contractual) relationships.

In criminology, the value of social capital is often highlighted in ex-prisoners' integration efforts, especially for finding housing and employment, or filling leisure time (Farrall 2004; Reisig et al. 2002). It is also explored through its negative side: social capital can reinforce negative connections as well as positive ones (e.g., gangs) and can be employed by communities to turn criminalized individuals into scapegoats for local problems, as noted above in the discussion of the NIMBY phenomenon (Brody and Lovrich 2002; Burchfield and Mingus 2008; Daly and Silver 2008; Piat 2000; Putnam 2000; Uggen et al. 2004). Indeed, Putnam (2000) highlights how social capital is the key behind social groups ranging from the Kiwanis and Lions clubs to the Ku Klux Klan. Social capital refers to the cohesiveness (or lack thereof) of groups without assigning a moral value; it connects individuals in ways and with causes and ideologies that may or may not be considered socially desirable. In the case of older marginalized women, their social capital may provide friendships and access to services; the same forces, however, can act to isolate and marginalize them within the community. This ostracism represents one of the challenges for the integration of marginalized groups; while the women live *in* the community, they are not necessarily considered to be part *of* it. While its usage in criminology is often circumscribed to deviant networks and ostracism, social capital has a broader role.

Both social capital theorists and symbolic interactionists would argue that a person's social networks affect her identity and capabilities: identities are formed around one's sense of being, physical attributes, preferences, and station in life, but are also a product of one's social relationships, interpersonal interactions, and networks (Becker 1963; Bezanson 2008; Bourdieu and Wacquant 1992; Cooley 1902; Goffman 1959, 1963; Putnam 2000). A strong family network, for example, may lead a woman to form identities around her role as a sibling, mother, grandmother or caregiver. Work identities are similarly important, reflecting one's place in the economic and social spheres; one's occupation is considered to be a marker of one's standing and class, frequently dictates the company one keeps, and, often, is perceived as emblematic of one's identity (Berger 2006; Gergen 1992; Goffman 1959, 1963). Close friendships are also significant; these links can provide many of the same benefits as both familial and work relationships (Green 1998; Prins, Toso, and Schafft 2009). The networks that are formed through social ties are often central to one's social world and navigations through the physical world. Considering these networks vis-à-vis *mobilities*, social capital and social connections become the *reason why* movement occurs; will affect *where* a person moves; may *facilitate* or *block movement* (e.g., receiving a ride or having to stay home to care for an ailing child) and also structure *what* moves – including talk, text, an exchange of gifts, or a woman borrowing money from her sister. Relative to identity performatives, networks affect the content of the performance as well as its reception. As these examples illustrate, social capital can and does have real, concrete effects on a person's daily life.

Social networks – in presence or absence – affect one's capabilities. For example, the presence of a strong social network generally provides individuals with access to increased resources and assistance, physical health benefits, as well as less tangible benefits, such as friendship, a sense of connectedness, and peace of mind (Dykstra 2009; Harm and Phillips

2001; Herlitz et al. 1998; Keating et al. 2005; Olsen et al. 1991; Putnam 2000). Conversely, a weak social network may be linked to isolation, loneliness, blocked opportunities, and also to more negative outcomes such as stigmatization and criminal involvement for those who find themselves shut out of social and economic opportunities, or connected to networks that reinforce marginalization and criminalization (Cattan et al. 2005; Farrall 2004; Putnam 2000; Richie 2001). In addition, a social network that is strong but which is composed of individuals who all are marginalized or have few resources may provide emotional support but may have little value in terms of gaining access to resources (Field 2003; Reisig et al. 2002). In short, social networks are intricately linked to one's status as marginalized, or one's *vulnerability to marginalization*. Canadian data from the General Social Survey, for example, noted the limited and tenuous nature of many older adults' networks; although these individuals may have social ties, the lack of breadth in their social networks leaves them vulnerable to marginalization (Stone and Rosenthal 1996).

While not the case for all women, many older marginalized women's social networks are weak, problematic or non-existent. As this group generally has weak ties to employment and strained or severed family ties, they may have few associations around which to form social networks (Reisig et al. 2002, 2002; Shantz and Frigon 2009, 2010; Shantz et al. 2009; Strimelle 2007; Strimelle and Frigon 2007; Uggen et al. 2004; Wahidin 2004). In addition to the common demands placed on social networks – for friendship, support, companionship and occasional material assistance (Keating et al. 2005), older marginalized women's special needs, which may stem variously from age-related declines, poverty, and physical and mental health issues, among other needs, can tax the social support networks that the women do have, resulting in caregiving fatigue and limiting the value of these networks (Figley 1995; Kasuya, Polgar-Bailey, and Takeuchi 2000). Thus, even older marginalized women with relatively strong social

networks may be considered vulnerable to social isolation or having an inadequate network to meet their needs. As such, the constitution and contributions of these women's social networks are worthy of further exploration.

As previously noted, social interactions and social networks are not divorced from context. Networks are at once *geographically, discursively and physically* situated. The geography across which networks exist is often central to their nature and structure, from the long-distance relationships and connections of diasporic communities to the intimate closeness of street-corner interactions (Urry 2000; Whyte 1943). The distance covered by networks, as well as the peculiarities of their locations may structure both *how* the networks operate as well as *what* they provide to their members. In addition to the geographic specificity of networks, they also occur in relation to social institutions and discourses. That is, the society surrounding the network will naturally inscribe itself on the network, structuring relations and dictating codes for interpreting meaning from interactions. Finally, the physical situation of networks in terms of space and in terms of the corporeal presence (or absence) of networks also affects how they operate. Examining networks in corporeal terms, the performing body cannot be understood outside of its context (Butler 1990, 1993a). To better understand the context of these interactions, the following section outlines the concept of the *risk society*: the environment in which the identity performances are occurring and within which they are interpreted and understood.

### **3.4 *Interaction in the Risk Society***

Before the Industrial Revolution (1750-1850), societies were structured around small communities and featured close interpersonal linkages including kinship and seigniorial ties to family and to the place where one lived (Beck 1997; Castel 1995a; Foucault 1977). During the Industrial Revolution, however, social relations began to change: the rise of cities and changing forms of production and labour served to weaken individuals' ties to smaller communities,

changing the nature of 'dwelling' and interpersonal relationships (Urry 2000), ultimately driving migration to cities. This process created a pool of free labour that was needed to power the growing industries, but also signalled a transformation in social relations. In this system of "free labour," individuals were now increasingly responsible for their own welfare and well-being as communities and extended families shrank in importance and provided less and less support.

In tandem with the changes in social regulation that began in the Industrial Revolution, there developed a need to keep track of the now-mobile population. In an effort to manage local populations and their needs, local and national governments attempted to understand *who* these people were, *where* they were from, and where they were *going*. Many types of data collection emerged in response to this need – tracking the movements of people through censuses; the movement of goods via import and export logs; and various forms of accounting on the parts of business and industry and also by the state (Castel 1995a; Foucault 1977; Giddens 1991). In contemporary western societies, social organization and structures are once again undergoing change. Within the contemporary context of an *information society*, the amount of data collected has grown exponentially. The state in its many forms, as well as businesses and organizations, collect myriad data on *individuals* – including information about one's income, habits, health conditions, shopping preferences and the like – making people and populations ever more knowable. In addition, the same organizations collect data about *populations* and the *world around us*, ranging from climate data to rates of internet usage, traffic patterns, and responses to natural disasters (Foucault 1977). This information can be used to generate a composite picture of individuals, populations, and the world around them. Although this picture is retrospective, data relating to past events can be used to prospectively *predict* the probabilities of events. While not an exact science, the growing knowledge about the world allows for the actuarial calculation of *risk* – the *risk* of disease, the *risk* of crop failure, the *risk* of

a pandemic, or the *risk* of an older woman suffering a heart attack (Giddens 1991). These risks render the world *knowable* and also allow for the *management of risk*.

Within this information society, when detailed knowledge about individuals is commonplace and highly valued, an intensified interest is placed on the *individual*. Now, more than ever before, individualism is a key part of social relations; in the post-Industrial Revolution world, ties to one's community continue to weaken as the focus on individuals grows (Beck 1997; Gergen 1992). In conjunction with this change, we see a transformation of social relations. While once prominent in daily life through overt regulation and various social interventions, the state now plays a seemingly shrinking role in individuals' lives and affairs as its role and manner of governing shifts. This has occurred both through a reduction in the size and scope of social programs and through an increased discursive and social emphasis on individualism, autonomy, and personal responsibility for the risks that one encounters (Dean 1999; Foucault 1991). The state still plays a role in social relations, but this role has shifted and narrowed: instead of providing support to everyone, the state's interventions are increasingly focused on the *correction* or *management* of those who cannot or do not successfully govern themselves – those sometimes referred to as the 'dangerous classes', 'problem populations' or 'social junk' (Cohen 1985; Hannah-Moffat 2000; Spitzer 1975). From the state's perspective, these individuals, who may be considered 'dangerous' are instead classified by *risk* logic, changing their 'dangerousness' into an actuarial calculation of the *risk* they pose to themselves and others (which can be mitigated through state interventions) (Castel 1991; Garland 2001; Wachholz and Miedema 2000). For these groups, governing occurs through state institutions, including the criminal justice and various social service systems that intervene to regulate individual behaviour and attempt to transform these non-compliant individuals into risk-assuming (instead of risk-posing), self-governing citizens (Castel 1995a; Cohen 1985; Foucault 1977).

Whether or not those considered ‘marginalized’ consider risk, risk discourses circumscribe their lives. There is often an increased social interest – seen in the form of frequent and entrenched contact with mechanisms of social control – in ‘problem populations’ that are considered to be risky and problematic for the smooth functioning of society (Cohen 1985; Spitzer 1975). While some members of this group may indeed act in ways that necessitate state interventions, this is certainly not the case for all marginalized people, and particularly for older marginalized women. However, as Ulrich Beck (2009:3) notes, risk logic is a blunt tool:

...the category of risk consumes and transforms everything. It obeys the law of all or nothing. If a group represents a risk, its other features disappear and it becomes defined by this “risk.” It is marginalized and threatened with exclusion.

As such, older marginalized women may be considered riskier than one would expect based on their individual attributes due simply to “guilt by association”: their lack of privilege, coupled with the overall heightened concern with marginalized, homeless and criminalized groups, the poor and those who are aging and who, for any of these reasons, pose a greater burden to society, leads to these groups being considered particularly *risky*, whether or not this label is appropriate to the individuals in the group (Cohen 1985; Cooper 2008; Dillaway and Byrnes 2009). Though older criminalized women are generally considered to be the least risky group in the criminal justice system (Wahidin 2004; Wahidin and Cain 2006), and one might expect similar findings regarding homeless and marginalized women, Beck notes that no one is considered to be “safe” within the framework of risk:

Classical distinctions merge into greater or lesser degrees of risk: Risk functions like an acid bath in which venerable classical distinctions are dissolved. Within the horizon of risk, the “binary coding” – permitted or forbidden, legal or illegal, right or wrong, us and them – does not exist. Within the horizon of risk, people are not either good or evil but only more or less risky. Everyone poses more or less of a risk for everyone else. The qualitative distinction either/or is replaced by the quantitative difference between more or less. Nobody is not a risk – to repeat, everyone poses more or less of a risk for everyone else (Beck 2009:3).

When *everyone* poses a risk to everyone else, the logic (from the state perspective) becomes clearer: risks, from poverty to victimization, are collective and must be managed in the same manner to facilitate the smooth functioning of society (Castel 1991, 1995a; Foucault 1977). As such, those who fall within “risky” categories, yet who are likely to simply have additional needs or require modest levels of consideration, are treated with the same heavy-handed approach as those who may be considered dangerous. These individuals are caught in blurred categories of risk and need, in which even simple requirements may make them appear problematic instead of needy within risk logic (Kilty 2006; Maidment 2006; Shantz et al. 2009).

While these discourses attempt to sort, classify and control risk at a population level, they also have significant effects for individuals (Beck 1997; Foucault 1977; Hannah-Moffat 2001; Lupton 1999). Turning now to the subjects caught up in this framework, what of their identities and social networks within risk discourses and processes? Living in an individualized society where there is a preoccupation with risk has significant implications for the individual. As Giddens notes,

To live in the universe of high modernity is to live in an environment of *chance* and *risk*, the inevitable concomitants of a system geared to the domination of nature and the reflexive making of history. Fate and destiny have no formal part to play in such a system, which operates (as a matter of principle) via what I shall call open human control of the natural and social worlds. The universe of future events is open to be shaped by human intervention – within limits which, as far as possible, are regulated by *risk assessment*. Yet the notions of fate and destiny have by no means disappeared in modern societies, and an investigation into their nature is rich with implications for the analysis of modernity and self-identity (Giddens 1991:109).

As the state provides decreasing support through its social programs (e.g., reductions in eligibility for the Employment Insurance system, the establishment of user fees for various programs, etc.), the focus for the management of life’s uncertainties – illness, unemployment, old age – shifts from the *state* to the *individual*. Simultaneously, a shift in loyalties from *institutions* and *structures* to *the self* as the locus of meaning occurs (Beck 1997). This shift

centres the individual in her own world as never before; connections to community and one's social networks decrease in importance as the focus on the self increases (Gergen 1992; Giddens 1991). At the individual level, citizens must now manage their own 'risks' – or be managed by the systems and institutions of social control if they fail to do so. These personal risks include risks associated with one's physical safety (Stanko 1997); health and lifestyle choices (Raphael 2004; Rowe and Kahn 1997); and the places and spaces one frequents (Button 2003; Ellickson 1996; Piat 2000). This increased burden of risk has implications for identities. Indeed, the emphasis on one's own self (at the expense of a focus on others and community) decreases individuals' awareness of others around them and also reduces intergenerational connections (Shilling 1993). This process amplifies the liminality of older adults; as society is increasingly focused on both youth and individuals, older adults (as a group and as individuals) are given less attention. In addition, any attempt by older adults to live within this risk logic – or to 'age successfully' if one follows the discourse to its self-responsibilizing end – ties success to wealth and ability, and the opportunity to avoid aging-related pitfalls, such as poverty or chronic illness (Dillaway and Byrnes 2009; Holstein and Minkler 2003). For those who do not have these advantages, avoiding risks may mean avoiding the regular and necessary activities of one's daily life: from walking outdoors in winter, to navigating "dangerous" streets or neighbourhoods, to climbing rickety stairs in the poorly-lit stairwell of one's apartment building. Any attempts to avoid these activities, while possibly constituting a prudential avoidance of risk, also results in isolation, further marginalization, and a reduced ability to navigate daily life. As Shilling (1993) notes, one of the consequences of this progression is a society that attempts to ignore aging to the greatest degree possible and that does not make space – physically or discursively – for aging bodies (or aging identities).

Also vis-à-vis identity, the transfer of risk to the individual necessitates a reformation of individual identity performances to incorporate increasing autonomy and responsibility. This process results in individuals who are prudent consumers of risk: who evaluate their actions based on the logics of risk, and act according to their own interests, but also in response to the level of risk that their actions entail (Beck 1997; Giddens 1991). This notion of the prudential consumer is now entrenched in society with respect to older adults; individuals now attempt to “age well” (Rowe and Kahn 1987, 1997, 1999), manage their health (Raphael 2004, 2006), prepare for bodily changes (Burrell 2009; Dillaway 2006), and plan their senior years (Brown and Prus 2004; Service Canada Government of Canada 2011) among other endeavours in the world of risk. One’s networks may also be implicated in this discussion of risk; as the state and its various components provide less support and assistance to citizens, these individuals must instead rely on their own resources, or the resources that they can access through their networks, to receive the support and assistance previously provided by the state and by charitable institutions, such as church parishes (Canada 2002; Castel 1995a; Keating et al. 2005).

Risk also affects how we move through the world. Risk structures and mediates travel and mobilities of all sorts, particularly since the events of September 11, 2001. While the regulation and mediation of mobilities is most recognizable in enhanced airport security, post-9/11 changes to mobilities also affect the movement of goods (e.g., increased screening, prohibitions and regulations on what can be transported and how) and the transmission of data (e.g., notions of data security, encryption, the identification of data sources) (De Goede 2008; Levi and Wall 2004; Uhl 2003). In the context of older bodies in particular, risk management affects movement and mobilities. Older adults are cautioned and educated around the risks of slips, trips and falls as the consequences of these calamities are much more severe for aging and frail

bodies (Aday 2003; Galloway and Jokl 2000; Kratcoski and Babb 1990). Mobilities are also implicated in older adults' fears and attempts to increase personal safety, through limiting one's movements in terms of geographic location and also in terms of time (e.g., avoiding travel to "risky" or dangerous areas or after dark), or through fortifying one's residence with an alarm system or other security measures (Castel 1991; Garland 2001; Stanko 1997). Risk discourses also affect how we 'dwell' or occupy space; older adults are frequently encouraged to move to "age-appropriate" housing to minimize the risks associated with living alone when one's abilities and mobilities are decreasing (Tulle and Mooney 2002). In short, *risk* shapes how we understand the world, how we relate to others, how we perform our identities in it, and how we move through it. *Risk* plays a role in our interactions with institutions, our peer groups, and with our understandings of ourselves. As such, it is an integral part of the discursive world in which we are embedded. To further explore the significance of context and the surrounding environment, I now examine how social reactions affect individuals' lives by exploring stigma.

### **3.5 Stigma**

Anthropologists have long noted that human societies attach great meaning to identification and differentiation (cf. Evans-Pritchard 1969; Turner 1967). As humans, we organize ourselves into groups based on characteristics or attributes that bind us together and that separate us from others, ranging from a shared location to a common language, to particular styles of dress. We naturally seek out those who appear to be *like us* – who look like we do, talk like we do, and act like we do. Those who appear to be different are considered either as part of the 'out' group (i.e., the 'other') or *abnormal*. Attributes – physical, mental, or in one's actions – that make one 'different' may also be recognized as stigmata. These stigmata affect how we see ourselves, how others see us, and ultimately how we navigate the social world.

As noted previously, we navigate our way through the social world by performing identities. Goffman (1959) noted that these performances are negotiated with our audience and may be accepted or rejected depending on the situation, the nature of the performance, and the audience. In *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman delves more deeply into identity and stigma. He notes that a person's identity is built around 'identity pegs' – attributes that are definitional to how the person is perceived by others. These include the person's occupation, personal statuses (e.g., parent, spouse), and also corporeal elements, including the person's physical appearance, self-presentation, and manner of speaking. If a person has a stigmatizing attribute – such as a physical disability, a stigmatized occupation, or a dishonourable status or characteristic<sup>20</sup> – she will have to perform and negotiate her identity in light of this stigma. As Butler (1990) indicates, these identity performances are enacted in relation to archetypal identities and roles – ideals to which we attempt to conform our performances, but which are ultimately unattainable. For those who attempt to adopt and perform these dominant and pervasive identities in their social interactions, there is naturally a negotiation of these performances with one's audience. When the subject's performance of these categories is altered or affected by her physical, mental, or other personal traits, her performances may noticeably differ from the 'ideal' or archetypal performances, possibly opening her to increased scrutiny, criticism, hostility or ostracism.

Goffman notes that highly visible stigmata, such as a missing or deformed body part, must be incorporated into one's identity due to its visibility. Others with "hidden" stigmata – such as a criminal record or a history of mental illness – may attempt to "pass" as normal or be labelled with the stigma and treated as different (and, implicitly, deficient). While marginalized individuals' stigmatizing attributes may be considered by some to be "hidden," Edwin Schur

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<sup>20</sup> Goffman includes former mental patients, ex-prisoners and their families, and homosexuals in this category (Goffman 1963).

argues that simply the status of being of female is considered deviant and stigmatized, resulting in “the reduction of his or her social acceptability, a blocking of important social and economic opportunities, a diminishing of overall life chances” (Schur 1983:38). While the stigma attached to the trait of being female is not uniform between individuals and settings, stigmatizing still occurs in daily life and popular discourse. Schur asserts:

With great regularity women have been labeled – and they still are being labeled – “aggressive,” “bitchy,” “hysterical,” “fat,” “homely,” “masculine,” and “promiscuous.” Judgments such as these, and the social reactions that accompany them, represent a very potent kind of deviance-defining. They may not put the presumed “offender” in jail, but they do typically damage her reputation, induce shame, and lower her “life chances” (Schur 1983:3).

Similarly, a woman’s state as marginalized, poor, or criminalized is seen as another form of deviance that, if brought to the attention of others will also be stigmatized and may be the grounds for social consequences such as isolation or ostracism (Chunn and Gavigan 2004, 2006; Kingfisher 1996). Aside from any physical disability or age-related differences between older marginalized women and others, signifiers of a woman’s status as being poor or marginalized may be seen in her manner of speech; choice of expressions and words; shabby clothes; self-presentation (e.g., hairstyle, makeup); the places and spaces she frequents; or even the way she moves through space. While these attributes may not be noticed by everyone she encounters, they are often noticeable to those with whom she interacts and they can certainly set her apart as *different*.

Goffman’s exploration of stigma has been adopted, adapted, and extended by many theorists and researchers working in criminology (Bruckert and Frigon 2004; Hannem and Bruckert 2012; Schur 1983; Uggen et al. 2004). Stacey Hannem (2012b) and Ian Hacking (2004), for instance, both highlight how Goffman’s work on stigma and interaction complements Michel Foucault’s work on discourse. The authors start from different vantage points (micro and macro), demonstrating how combining the two perspectives allows for a broader understanding of

discourse and its effects at the micro level, and also a structural and discursive examination and explanation of stigma. Hannem argues that Goffman's examination of stigma offers an intimate look at stigma in individual interactions, but that adding Foucault's ideas on discourse allows the reader to connect these individual interactions to broader social structures, norms and discourses. Goffman's work on stigma also adds to the idea of a negotiated and performed identity. An actor's stigmatizing attribute(s) – if detected by the audience – becomes a foundational and definitional part of the performer and performance, regardless of the other identities and statuses that s/he holds and expresses (Goffman 1963). In a similar vein, Howard Becker also examined the stigmatizing status of a criminal identity; he noted that when these statuses were known to others, they became prominent in defining the person and could become her "master status" (Becker 1963). The stigma affixed to the status is the result of moral entrepreneurs who attempt to enforce their own beliefs and moral standards on society. Having a negative or stigmatized master status subsequently affects how the person was seen by others and their negotiations of the social world.

Identity performances, "front stage" and "backstage" selves, and master statuses may not reflect the language commonly used to describe older marginalized women's experiences in and negotiations of the social world. Using this basic framework, however, leads to a position from which older women's experiences can be described and understood. Taking this framework and following the simplified and polarizing depictions of older criminalized women noted by Codd (1998), we see that stigmatized older women may be treated as mad, sad or bad – in practice, as sick, pathetic or dangerous. The stigmatized identity can thus shape an individual's life, for better or for worse. For older marginalized women, many personal statuses may be considered as stigmatizing attributes: while age (Clarke 2001; Holstein and Minkler 2003; Rowe and Kahn 1987; Tulle and Mooney 2002) and poverty (Chunn and Gavigan 2004, 2006; Codd

1998; Flynn 2002) are the most obvious of these, other attributes – such as appearance, class, mental health, abilities and sexuality – may also result in a woman being defined as different or abnormal and ultimately result in her stigmatization.

With the idea of stigma in mind, how do older marginalized women perform identity and navigate the physical and social worlds? The following sections examine some of the strategies that the women may employ in their navigations of the world.

### **3.6 *Navigating the Social World***

Older marginalized women's identities are influenced by myriad factors, including those of a personal nature such as their physical, emotional and mental attributes; social conditions, including paradigms, discourses, and more narrowly, others' perceptions of them; and characteristics of the physical environments surrounding them, their place within these spaces and their movement through them. As discussed, these can be understood through examinations of the women's identity constructions, social networks, and their mobilities through time and space. As older women interact in the social world, they encounter institutions and agents of power, and do so from positions of relative powerlessness. This group is, by definition, marginalized; thus, they must adapt and adjust to the world around them, employing various strategies and identity performatives to navigate the social world. Their relative statuses are positional, varying depending on the circumstances and environment (cf. England 1994; Hirsch 1976). Positionality, a term coined by Fred Hirsch (1976) in economics literature, refers to the varying value of an item depending on its desirability.<sup>21</sup> The term has since spread across the social sciences where it is used to describe individuals' varying levels of prestige or

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<sup>21</sup> For example, a set of winter car tires may have no value to those who do not own cars; hold a marginal value for those who drive but live in tropical climates; but hold a significant value for those who live in northern climates with heavy snowfall and who require them in order to navigate winter roads.

power relative to others in different situations.<sup>22</sup> As older women's positions and power are situationally-based, they must negotiate their space and power within their social encounters. Several approaches and performative strategies are available to the women, including domination, submission, resistance, and resilience. Just as with their relative positions, the practicality and usefulness of these approaches varies between women and across situations.

Domination and submission are both relatively straightforward approaches, although the former strategy of domination is less practical vis-à-vis older marginalized women. Michel Foucault (1982) associates domination with sovereign power, which is the repressive force of the state. In pre-modern times, sovereign power represented the force by which the will of the king was enacted over all his subjects. This force was unilateral; the punishment for resistance was death or banishment (Foucault 1990). As such, it is considered to be power without resistance (Foucault 1982). In contemporary western societies, outside of the state's sovereign power (as represented by the agents of social control, namely police, courts and correctional services), few, if any, individuals can employ domination over others; as people have freedom and therefore the possibility to resist, they cannot be dominated. A caregiver may be able to exercise near complete control over an infant or invalid, for example, but this type of power is limited, as the dominated party generally has some avenue of resistance. Thus, for those who are relatively powerless, this strategy has few chances of success; they are more likely to *experience* domination through their contact with state apparatus than to *enact* it.

The latter strategy of submission is more commonly encountered; it can be employed in the face of sovereign power where there are few, if any, grounds for effective resistance (Foucault 1990).

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<sup>22</sup> For example, a judge may be considered to be a prestigious occupation and a judge holds great (sovereign) power whilst presiding over a trial; he holds equal power over his colleagues who preside at the same judicial level; but he is relatively powerless when his car becomes stuck in a snow bank and he must rely on a tow truck for rescue.

As an example, if an older woman comes into conflict with the law, resisting the instructions of a police officer, judge, or correctional officer is possible, but will likely be met by a display of force that is disproportionately powerful in response. While the term 'submission' carries the signification of defeat and demoralization, in practice the associated identity performative often takes the form of "going with the flow", "picking one's battles" or "taking the path of least resistance." For older marginalized women, submission may be an attractive strategy: as they often lack the means – including financial resources, social capital and physical stamina – to mount an effective challenge to sovereign power, submission can be a calculated response to an unattractive situation (cf. Kilty 2008; Maidment 2006). It may also represent a way to navigate systems of social control with minimal wear and tear (Munn and Bruckert 2008).

In short, domination and submission represent two ends of a spectrum of power relationships, neither of which can properly be considered a relation of power due to the overwhelming force of domination and the capitulation of submission. While they may be encountered and enacted in the social world, they are not normative in terms of power relations. According to Foucault:

In effect, what defines a relationship of power is that it is a mode of action which does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or the future. A relationship of *violence* [domination] acts upon a body or upon things; it forces, it bends, it breaks on the wheel, it destroys, or it closes the door on all possibilities. Its opposite pole can only be *passivity* [submission], and if it comes up against any resistance, it has no other option but to try to minimize it. On the other hand, *a power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that "the other" (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results, and possible inventions may open up* (1982:789, emphasis added).

It is to this "whole field of responses, reactions, results, and possible inventions" that we now turn. This range of experiences and negotiations become part and parcel of older marginalized

women's navigations of community life. In particular, I examine resistance and resilience, each of which provides a more nuanced approach to power negotiations.

## Theorizing Resistance

Michel Foucault (1982, 1990, 1994a) explored power, resistance, and the relationship between these forces in several of his writings. He notes that power exists everywhere in society; it is a key element in all relationships and is bound to them (Foucault 1982). Power is not 'controlled' by a group or person; rather, it circulates and is manifested by all parties involved in the relationship (Foucault 1990). Both violence (domination) and submission represent points in the spectrum of power, but do not constitute it:

But even though consensus and violence are the instruments or the results, they do not constitute the principle or the basic nature of power. The exercise of power can produce as much acceptance as may be wished for: it can pile up the dead and shelter itself behind whatever threats it can imagine. *In itself the exercise of power is not violence; nor is it a consent which, implicitly, is renewable. It is a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action* (Foucault 1982:789, emphasis added).

Power relations are not static nor are the results of a power relationship fixed; power is fluid, with its expression and effects changing within and between situations. Power is not only fluid, it is also *refracted*. Carol Smart (1989) highlights how some manifestations of state power, for example, are codified in laws. These laws demonstrate how power is refracted:

... law does not have one single appearance, it is different according to whether one refers to statute law, judge-made law, administrative law, the enforcement of law, and so on. It is also refracted in that it is frequently contradictory even at the level of statute. Hence legislation to preserve foetal life coexists with legislation which provides therapeutic abortions. Different legislation may have, therefore, quite differing goals; it cannot be said to have a unified aim. The law is also refracted in the sense that it has different applications according to who attempts to use it. ... Finally law may have quite different effects depending on who is the subject of the law. ... So if law does not stand in one place, have one direction, or have one consequence, it follows that we cannot develop one strategy or one policy in relation to it (Smart 1989:164).

Smart's argument illustrates the different manifestations and contradictions of state power. Depending on the lens through which one views a given situation – or the law that one uses to evaluate it, law (state power) may reinforce a person's rights or take them away. Smart's examples highlight the workings of law, but her refracted and multifaceted conception of power has broad applications; refractions can be seen as women navigate their environments and encounter different situations in which they have varying degrees of power, privilege and authority.

One's relative power or powerlessness is positional: it can change as the social setting changes (cf. England 1994; Merriam et al. 2001; Sheppard 2002). For example, while an older woman may hold relatively little power when negotiating with her welfare caseworker, she may have considerable power and authority when mediating disputes within her family. In these situations, the same actor occupies differing positions: the first, of relative disadvantage as she faces the overarching oppressions of age and marginalization in relation to her caseworker (cf. Crenshaw 1991). In the second situation, her position is inverted: she is now an "insider" who holds a respected position in her family. While the extent of the woman's power varies, she has some power in both situations; even where one individual or entity appears to have total power over another, such as a prisoner in relation to a guard, the guard's power is not absolute.

Instead, the prisoner can employ *resistance* to counteract the guard's power. Foucault notes:

Even when the power relation is completely out of balance, when it can truly be claimed that one side has 'total power' over the other, a power can be exercised over the other only insofar as the other still has the option of killing [her]self, of leaping out of the window, or of killing the other person. This means that in power relations there is necessarily the possibility of resistance because if there were no possibility of resistance ... there would be no power relations at all (Foucault 1994a:292).

Thus, resistance can occur anywhere and can manifest in different ways. Essentially, any action that actively or passively challenges an imposition of power shows resistance.

Resistance can be expressed in massive or minute ways: it can be manifested in creativity and art; critical thinking; spitting in the face of a prison guard; or through one's manner of dress or appearance (Bosworth 1999; Frigon 2001; Hannah-Moffat 2000).

Foucault (1982:781) further indicates that there are three basic categories of struggles in which resistance may appear:

...either against forms of domination (ethnic, social, and religious); against forms of exploitation which separate individuals from what they produce; or *against that which ties the individual to himself and submits him to others in this way (struggles against subjection, against forms of subjectivity and submission)*.  
(emphasis added)

He notes that the latter struggle is most prevalent today as power relations are most often negotiated between an individual and others. Although Foucault indicates that interpersonal power relations are most prevalent, the former types of struggles are also important and worthy of note (Foucault 1982). A woman may encounter culturally and socially-entrenched dominations that manifest in negative attitudes and situations (e.g., racism, classism). These dominations undoubtedly influence relationships and situations, shaping the interaction and constraining one's ability to respond and interact (Collins 1991; Crenshaw 1991). However, barring one's involvement in a larger social action, confronting and negotiating these forces happens through individual interactions between actors on a case-by-case basis. The second form of struggle, vis-à-vis exploitation, recalls Marx's examination of estranged labour, in which workers are divorced from both the means of production and the product (Marx 1847). Although these struggles have not disappeared, they are once again expressed through individual interpersonal negotiations and struggles. One may, for instance, face a struggle over one's work that could be linked to exploitation; this struggle, however, will likely occur between a worker and her supervisor and not with the entire capitalist system. For an older woman, for example, relationships with case workers and counsellors, a landlord, an employer, as well as family,

friends, and community contacts all create situations in which power is negotiated. Struggles of domination or exploitation may shape these power negotiations, but the negotiations themselves involve individual actors.

In this research, older women's various social relationships are explored. As they interact in the social world, they become involved in relationships with others – friends, family, acquaintances, caseworkers, service providers, and strangers. In these interactions, they must choose which technique to employ, and how to do so (cf. Bosworth 1999; Frigon 2001; Kilty 2008; Kingfisher 1996). While resistance represents one method for countering power relations, including the power invested in cultural and social norms, it is not uniformly employed. Resistance does not always look the same: within power struggles, the actors' intentions and goals vary; they may employ different techniques; and, the final results or outcomes are not uniform. As it is part of a relationship of power, each interaction holds the potential for submission or resistance (Foucault 1982). In practice, resistance strategies can include opposition, subversion, or deflection. These tactics may be employed – or not – depending on a person's position in a given negotiation; for example, if power relations are relatively evenly balanced an actor may choose to resist through opposition and contestation; in a setting where she has less relative power, the same actor may instead deflect the direction.

Domination, submission, and resistance represent avenues for negotiating power within relationships; they do not address what happens *outside* and *beyond* the interaction or struggle. How does the person reconcile the results of the power struggle, whether successful or unsuccessful? Adaptive strategies, whether employed successfully or unsuccessfully, can have significant impacts throughout a person's life. Returning to the example of the woman in conflict with the law, her actions vis-à-vis her parole officer can have repercussions extending far

beyond this relationship, ultimately implicating her freedom. Similarly, one's interactions with a welfare caseworker can affect how much money one receives, or the types of supervision and monitoring to which one is subjected. Beyond these obvious examples, however, negotiations of power can have dramatic effects on one's *body* and *mind*. Regardless of the outcome, employing resistance or submission may result in negative emotions and frustration. Stress and anger, while often discursively limited to the realm of emotions, can have significant physical effects over time (Rosch 1997; van der Kolk, McFarlane, and Weisaeth 2006). As noted above, submission may thus be seen as a valid strategy due to the need to "pick one's battles"; however, this does not preclude the submitting person from experiencing their position as a failure.

In light of this, I now discuss *how one understands* these interactions and their results. To this end, I examine resilience. Resilience is not unto itself an adaptive measure in a power struggle; rather, resilience is an aftereffect of the power negotiation, representing a method by which an individual can reconcile its result. Resilience has recently garnered significant attention as its prevalence and benefits gain wider recognition.

## **Resilience**

Older women have agency in their experiences of aging: they can seek out activities and places that reinforce their independence, manage their health, adjust their identities and identity performances to reflect their realities, and otherwise care for themselves as they age. An important consideration in identity performance is *how* one responds to changes in one's body and environment. As the women's accounts will highlight, a variety of responses occur, ranging from shock and despair to frustration, and even to being relatively unaffected by the changes; these responses are the products of individual functioning and past history: coping mechanisms develop in childhood, but can change throughout the lifespan based on one's experiences and

understandings of life events (Bonanno 2004; Cyrulnik 2005, 2007; Masten et al. 1999). Often, these strategies are not the product of conscious effort or reflection, but they can also be fostered through teaching, learning and self-work (Cruikshank 1999; Rimke 2000). This process of reframing *how* and *what* one thinks can be understood as a “technology of the self” (Foucault 1988a:18). Technologies of the self are ways of working on one’s body (or one’s mind and thoughts) in an effort to “improve” one’s situation. These ‘technologies of the self’ – including resilience – enable individuals to cope with adversity.

Resilience, described by some as “anti-destiny” (Cyrulnik 2007:15), represents a manner of resisting the negative impacts of adverse events. Resilience can be seen as a form of resistance – not in opposition to an authority figure, but rather to one’s *destiny* – the “predetermined” or most likely course of life events. As an example, we know and understand that poverty is generally cyclical; those who start their lives in poverty generally have less access to education, employment, and other opportunities to alleviate their situations. They thus often remain poor throughout their lives, as do their children (cf. Canadian Council on Social Development 1984; Caragata 2003; Chunn and Gavigan 2006; Comack 1996; Gunnarsson 2002; National Council of Welfare (Canada) 2007). Resistance can be employed against this notion of destiny; it may take the form of head-start programs, pursuing further education, and otherwise showing a determination to avoid the ‘predetermined’ path.<sup>23</sup> Recall from the theoretical discussion of resistance that it can manifest in opposition to three types of force:

...either against forms of domination (ethnic, social, and religious); against forms of exploitation which separate individuals from what they produce; or *against that which ties the individual to himself and submits him to others in this way (struggles against subjection, against forms of subjectivity and submission)* (Foucault 1982:781, emphasis added).

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<sup>23</sup> It is not my intention to imply that those who do not leave states of poverty are all, in some way, responsible for their fate; nor is it my intention to indicate that all those who engage in this type of ‘resistance to fate’ will be successful in their efforts.

As Foucault notes, resistance can be employed against forms of submission; this is, in a way, similar to Cyrulnik's idea of struggling against destiny; although in Cyrulnik's case, the struggle focuses around probable outcomes instead of a person. Foucault's inclusion of forms of domination and exploitation thus reveal the broad application potential of resistance theorizing.

In addition to being understood as a form of resistance, the 'technologies of the self' employed in resilience can also be seen as an *improvement* on individual coping mechanisms. As such, developing resilience can be seen as a way of enhancing one's outlook. Indeed, this is the general principle by which many counselling and mental health interventions, such as visualization exercises or cognitive-behavioural therapy, work (Cameron 2008; Velleman, Aris, and Murgatroyd 2010). It is also the principle behind much of the massive domain of self-help literature and other products of the "empowerment" paradigm, such as television shows (e.g., Oprah, Dr. Phil, etc.) and motivational speakers (Cruikshank 1999; Rimke 2000). These interventions all share the goal of enabling the individual to "improve" herself – through learning about a topic, changing her activities, or changing how she thinks about her actions and her life, thereby becoming a "better" citizen (and selling books, meditation aids, weight-loss products and similar products in the process). Although there are undoubtedly potential internal and intrinsic benefits to finding ways to cope with life's challenges by oneself, these coping mechanisms also fit with the goals (techniques of responsabilization and technologies of the self) of the neoliberal state.

Under neoliberal governance, state intervention in individual lives and the "social safety net" are reduced; instead of relying on the state for assistance, citizens are expected to assume and manage "risk" within their own lives and govern themselves (cf. Castel 1991; Cruikshank 1999; Dean 1999; Foucault 1991; Garland 2001). In practice, this is done through multiple strategies

and tactics: managing one's weight, installing an alarm system, practicing meditation, and using self-help literature all implicate risk management and self-government. This sense of personal responsibility is further normalized and reified through self-help literature and other coping mechanisms. Linking self-help literature to the contemporary neoliberal climate of late modernity, Rimke argues:

Self-help literature aids in the production, organization, dissemination and implementation of particular liberal modes of truth about the social world. The discursive production of 'self-helping citizens' is an effect of discourse naturalizing itself and thereby rendering psychological subjects as natural self-governing objects in a (pre)discursive world (Rimke 2000:62).

While this process of individual responsabilization and "empowerment" can produce self-governing citizens who manage their lives without state intervention, it can also increase individual resilience, thereby producing concrete outcomes in the individual, including positive effects on one's health and mental well-being (Bonanno 2004; Cyrulnik 2005; DeMuth 2005; Hardy, Concato, and Gill 2004; Smith 2009; Stark-Wroblewski, Edelbaum, and Bello 2008). The positive thinking and resilience trumpeted by the legions of self-help quasi-professionals, the psy-professions, and others allows individuals to respond to life's challenges in positive ways.

The other side to the coin of self-responsibilization and resilience, however, lacks the same lustre. On this side of the coin, we see those who struggle in the face of adverse life events, and who often develop maladaptive mechanisms for coping. These "anti-coping" management techniques may lead women to feel overwhelmed, experience significant stress, or to generally struggle through day-to-day life. On a theoretical level, those who are unable to cope and manage are singled out as a target population for "experts" working in the psy-professions, medicine, community services, and social welfare, among others (cf. Cohen 1985; Garland 2001; Hannah-Moffat 2000). As Stanley Cohen (1985) outlines, these experts aim simultaneously to correct or improve the subject (turning her into a responsible, self-governing

citizen) while also reinforcing their position as “experts” in their given domains. In short, the work of the experts aims to transform the individual, in thoughts and actions, to fit within the neoliberal framework. This process aims to create citizens who are capable of self-governing, although who may still require the ongoing intervention of experts, thus increasing the authority and influence of this group. Those subjects who cannot or do not conform to this framework become subject to the purview of the social control and criminal justice systems and therein another realm of experts (Cohen 1985). At this end of the continuum are individuals such as “Million-Dollar Murray”<sup>24</sup> (cf. Gladwell 2006), who find themselves ensnared in multiple layers of state control and intervention, bouncing on a weekly, or even daily, basis between the social service, health and criminal justice systems.

Resiliency and negative coping strategies do not represent a bifurcated system of coping/not coping; rather, these states occur on a continuum. Methods of coping with everyday events, and stressful ones, are myriad and situational; for example, a woman may be able to calmly brush off criticism from her employer, but be deeply affected by the same criticism from her mother. Similarly, she may find that adversity affects her more dramatically as she ages. In short, a woman’s coping strategies affect her identity, interactions and navigations of the world.

### **3.7 Putting it Together: “Getting by”**

In summary, older marginalized women form and perform identities based on their personal attributes as well as the discourses and environments surrounding them. While their identities and identity performances are fluid and ever-changing, the *sedimented* nature of past identity performances, contemporary discourses, as well as the women’s physical and social locations,

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<sup>24</sup> “Million Dollar Murray” was the nickname given to Murray Barr, a man who struggled with chronic homelessness, alcoholism. In his article, Gladwell (2006) notes that the management of Murray on the street involved police, courts, prisons and hospitals. The costs of Murray’s homelessness were staggering in comparison to the costs that would be incurred to provide him with housing and addictions services.

narrows the horizons for identities and identity performances. Within the sedimented discourses and identity categories surrounding older marginalized women – based on gender, age, class, ability and other statuses – the available identity possibilities may be neither desirable nor appropriate. Instead, the options may be stigmatizing or otherwise unreflective of the women's experiences and realities. Within this field, however, the possibilities for identity are never fully pre-determined; older women may continue to perform, re-form, and recreate the categories as they live in and through them.

Older marginalized women's identities and identity performances are situated within social, physical, discursive, and temporal settings. The women move through these settings and engage in their everyday activities in a dialectic relationship with their environments; the places and spaces that they frequent shape and constrain their actions and they, in turn, can act on and affect their environments. Their relationships to the people and spaces surrounding them are shaped and modulated by discourses of risk, and also by discourses that classify them as *other* or as *stigmatized* individuals. In the physical world, the places and spaces open to the women are the product of their interests, social networks and stations and as such are generally narrower than those of individuals who lead more privileged lives with a greater access to opportunities and resources. Their physical worlds are also social worlds and are populated with other actors – both those known to the women and strangers. In this frame, older women form and maintain social networks. Just as for any other group, older marginalized women's social networks are one of the key determinants of their lives; their networks offer a constellation of choices and opportunities that may be broadened or constrained based on the size, strength and constitution of their networks. These networks have real, tangible value to the women. Like their identities, the women's networks are dynamic, growing, shrinking, adapting, and evolving as the women navigate the world.

Older marginalized women's social positions are not usually considered to be powerful, although they are not completely bereft of power or agency. From their marginal positions, they navigate their environments and "get by" using a combination of submission and resistance strategies depending on the relationships of power in which they find themselves, and on the countless variables within each of these. The results of these power negotiations reflect the women's relative power, as well as the broader circumstances in which the power negotiation occurs. Whether the result of the negotiation is positive or negative, the women must respond and cope with the circumstances and situations in which they find themselves. While the nature of the challenges they face and the power negotiations in which they engage will shape how they cope, the women have a constellation of responses available to them. Although some of these involve resignation and negative coping mechanisms (e.g., addictions, etc.), resilience, or thriving despite adversity, is also an option. In short, "getting by" involves performing identities within physical, social and discursive contexts.

Having now highlighted the framework through which I will attempt to understand and analyze the experiences of older marginalized women, I now outline the process by which I undertook the research. The following section outlines my approach to the research and several special issues that I addressed in the research process.

## Chapter IV – Methodology

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## 4 Methodology

You could always announce, “HI! I’M AN OBSERVER! Oh no, I’m just here observing – okay, you guys just carry on doing what you normally do, no that’s okay, I’m just going to write it all down. No, say what you were going to say to that woman... that was ‘fuck’ or ‘fuckin’? Yeah, I’m just trying to get this down here.” – Brenda (offering a critique of my research methodology)

And to fit in with people, you learn to play the part, to fit in, until people like you and whatever. Okay? And that’s how we have to get through. – Deborah

When conducting research or solving mathematical problems, the validity and value of one’s work is measured not only by the end result, but also by *how* the results were found. In other words, the *process* used to create knowledge deserves consideration. Interrogating the process through which research is conducted provides the reader with an understanding of what, exactly, the researcher did to reach her conclusions, highlights both the strengths and weaknesses of the approaches chosen, and allows the research results to be understood in context (Berg 2009; Reinhartz 1992). In order to offer a “behind the curtain” look at what I did and how I did it, I describe the methodology I chose to conduct the study, outlining the *who*, *what*, and *how* of my research. I begin this section by sharing my personal position vis-à-vis my study. In the following sections, I outline the epistemology from which this research is conducted; define my key concepts; and outline the methodologies I employed. Following an exploration of ethical considerations and a consideration of my dual role as a researcher/worker, I discuss my recruitment strategy, including the recruitment locations and methods and the fieldwork done while meeting potential participants. The chapter also describes how I analyzed the data that I collected, including a discussion of how I examined narratives in which I found myself questioning the ‘truth’ of participants’ accounts. Finally, I also include a discussion of my research sample, highlighting participants’ attributes and providing some context to their remarks and to the analysis that follows.

#### **4.1 Reflexivity and the Researcher**

Traditional empiricist research in criminology focused on finding the causes of crime through positivistic methods. Under the paradigm of empiricism, one uses a scientific approach to attempt to uncover the root causes of “criminal behaviour”, and then, presumably, determine the policy antidote or individual intervention required to eliminate it (Smart 1990). This process relies on definitions of “crimes” that can be highly arbitrary (i.e., linked to class, gender, race, culture or political will) and usually locates the “problem” in individual behaviour without examining how social structures and relations of power are implicated. Smart (1990), among others, argues that we must think outside of this box, realizing that the “Truth” which is sought is a product of our location: in culture, class, time, space, ideology and in our physical bodies (Harding 1986; Stanley and Wise 1983). As such, “Truth” - in the singular sense - is non-existent; rather, there are myriad truths reflecting different paradigms and understandings of the world (cf. Kuhn 1962).

Criminology has begun to move out of the narrow box described by Smart, with significant research interest focused on the mechanisms of social control, power relations in criminal justice, and the construction of deviance. Researchers in women’s studies and in the social sciences in general, including many prominent feminist researchers, have examined the research process, demonstrating that researchers both influence and are influenced by their research. Researchers’ opinions, biases and interests all figure in the research process, influencing the choice of research topic, methodology, analytic frame and the interpretation of results, making “objective” research impossible (Harding 1986; Reinharz 1992). While this is a common refrain among feminist researchers, other prominent sociologists have also put holes in the positivistic notion of “true objectivity.” Indeed, as Howard Becker states,

This dilemma [of objectivity], which seems so painful to so many, actually does not exist, for one of its horns is imaginary. For it to exist, one would have to

assume, as some apparently do, that it is indeed possible to do research that is uncontaminated by personal and political sympathies. I propose to argue that it is not possible and, therefore, that the question is not whether we should take sides, since we inevitably will, but rather whose side we are on (Becker 1967:239).

To better understand and reflect on the role that I play in the research process (cf. Deutsch 2004; Smith 1974; Stanley and Wise 1993), I present a short description of my personal background, beliefs, biases and baggage relative to this project and also provide some analysis of how this background may affect my research (Kirby and McKenna 1989). I am a privileged person: not only do I enjoy the benefits associated with being born in a wealthy country, having white skin, good health, a supportive family, steady (although sometimes precarious) employment, physical ability and relative youth, I have also benefited from years of post-secondary education. This background places me in a position of power and privilege relative to many of those who I encountered in my study (Olson and Shopes 1991; Riessman 1987).

Although I have had times in my life where money was short and resources were scarce, I have always had a roof over my head and have never spent time in a homeless shelter as a resident. In fact, I likely have at my disposal more pathways out of poverty than do many others. I have struggled with sometimes debilitating mental health problems throughout my life, as have many others in my family. While I have had the good fortune to have avoided hospitalization and the stigmatization of many psy-labels and interventions, my struggles give me an intimate understanding of the social, structural and symptomatic barriers faced by those with mental health problems. These experiences do provide some insight regarding older women's encounters with similar phenomena, but may also create bias, making me interpret others' experiences as similar to my own, whether or not they actually are.

My personal, work and academic backgrounds led me to choose older marginalized women as a research topic. My close relationships with many older women have taught me the

importance of their experiences; I have seen the effects of poverty, addictions and mental illnesses in this group first-hand, but also know of their resilience and determination. As a worker at Cornerstone Women's Shelter, I regularly interacted with older women; often, fifteen to twenty per cent of the shelter's residents are women over the age of fifty. My interactions with these women made me want to learn more about their pathways into and out of homelessness and marginalization and the broader structural forces that they encounter along the way. I have also gained past research experience examining older women in conflict with the law (cf. Shantz 2008, 2010) and examining poverty issues in general. In addition, I am a member of the City of Ottawa Poverty Issues Advisory Committee, a citizens' committee that provides advice to Ottawa City Council on poverty issues. In this role, I have the opportunity to examine and provide input on poverty issues within Ottawa and the city's priorities, plans and responses to local issues and concerns. Regardless of my actual knowledge or feelings about the labels applied to me, to some these experiences mark me as an "expert" or a researcher with privileged knowledge. My work experiences also bias me to seeing older marginalized women and attempting to understand their lives through an institutional lens instead of understanding their realities as they see them.

My personal philosophy leads me to recognize individuals' best efforts and personal successes, no matter how small or marginal the success. I try to give the speaker/agent the benefit of the doubt and to use supportive responses instead of punitive ones whenever possible. In my research, this may lead me to be overly optimistic about respondents' discussion of their lives and circumstances and also may cause me to give the benefit of the doubt when others may not. At the same time, my work experience has given me a good understanding of marginalized women, allowing me insight into the places, spaces, and situations they encounter, the language they use, the barriers they face in finding housing, as well as the role that mental

health issues can play in their interactions. I have a good understanding of how the realities of street life, the impulse to survive and individuals' own agendas can change their stories; these factors may serve to twist, tangle, and blur real and fictional or perceived events, amplify the urgency and importance of events that may seem small or insignificant, reinterpret others' behaviour as threatening or offensive, or otherwise create additional challenges in understanding lived realities.

In short, in answer to Becker's question, "Whose side are we on?" I come down firmly on the side of the women who participated in my research. While I presented myself to research participants as an outsider (in terms of both age and life experiences) who is simply interested in hearing their stories (while also disclosing my position), the fact remains that, to some, I am an "expert" or "staff" with all of the baggage – good and bad – that accompanies these roles. While I cannot know how participants will interpret my background, the research study, or me I am conscious that who I am does affect how participants interacted with and perceived me.

## **4.2 *Epistemology***

In order to learn about older women's lives, I used a standpoint epistemology to bring respondents' voices into research (cf. Comack 1999; Harding 1986, 1997, 1991; Hartsock 1983; Smith 1974, 1987, 2005). Standpoint epistemologies note that individuals in marginalized positions – including women, the poor, the disabled, people in non-western countries and visible minorities, among other groups – have different understandings of the world than those expressed in the empiricist paradigms and discourses that dominate academia, research, popular culture and contemporary consciousness (Comack 1999). While empiricism is grounded in the concept that there can be objective truth standpoint epistemologies seek out alternative knowledge accounts and bring them into academia to challenge traditional,

“objective” sciences that attempt to uncover a central, empirical “truth”, which Sandra Harding (1986:25) called “science-as-usual.”

Standpoint feminism does not have one clear path of development; the ideas and concepts that underpin it emerged concurrently in several different disciplines – including the natural sciences, sociology, and political science, among others – in the 1970s and 1980s in tandem with the second-wave feminist movement. Despite their separate evolutions, all of these iterations emerged in opposition to traditional academic thought and science-as-usual; they formed a radical approach to academic knowledge, which was at the time largely controlled by privileged white men working within positivistic knowledge paradigms. In their earliest iterations, standpoint theory and epistemology posited that women’s perspectives were different from the mainstream (male) and therefore more “objective” and capable of providing a truer picture of reality (Hartsock 1983). Some of these accounts argued for a single “female” standpoint, overlooking differences within and between women. This opened standpoint epistemology to criticism not only from academics working within traditional paradigms, but also from within the feminist research community. Feminist researchers noted that race, class, and the privileges (or lack thereof) associated with other statuses needed to be considered, where assuming a single female standpoint masks, and thereby perpetuates, these inequalities and the oppressions that all too frequently accompany them (Collins 1991; Harding 1991; Hekman 1997; Mohanty 1997).

In the 1990s, postmodernism and poststructuralism supplanted Marxist theory in feminist debates and dominated academic discourse. These perspectives challenge modernist notions of shared experiences and meanings, concrete realities, and master narratives, instead reflecting a plurality of viewpoints and understandings of the world. While some argued that

these developments meant that standpoint feminism had run its course and should be seen as an interesting analytic tool and little more (cf. Hekman 1997), many researchers who have worked and continue to work from standpoint epistemologies challenged this assertion, noting that the perspective is not static; it has changed and evolved to remain contemporary and to acknowledge and address the criticisms levelled against it (Collins 1997; Harding 1997; Hartsock 1997; Smith 1997).

While stemming from the second-wave feminist movement<sup>25</sup> (cf. DeVault 1996; Harding 1986; Hartsock 1983; Smith 1974, 1987), standpoint epistemologies have developed and evolved, becoming popular with researchers across the social sciences who work with a variety of marginalized groups – such as the poor, prisoners, older persons, and members of visible minority groups – that are often overlooked in knowledge production (cf. Clarke 2001; Comack 1996, 1999; Crenshaw 1991; Frigon 2002, 2003; Kingfisher 1996; Maidment 2006; Richie 2001; Wahidin 2004). These contemporary standpoint epistemologies challenge conventional ideas about “truth” and knowledge production, noting that multiple truths exist, all of which have claims to validity (Comack 1999; DeVault 1996; Reinharz 1992). Indeed, today’s standpoint epistemologies see research participants as possessors of subjugated knowledge and as “experts” in the domains of their everyday lives and lived experiences; thus, researchers must go to these individuals if they wish to learn about their realities (Comack 1999; Reinharz 1992; Smith 1987). These multiple standpoints are seen as valid in their own right although the knowledge and truth they provide – as with all others – will be partial. When these accounts are collected, analyzed, and woven together with theory and critical analysis in the research

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<sup>25</sup> Of note, taking different standpoints as part of a research strategy did not emerge solely from the women’s movement and indeed was taken up by many critical scholars (cf. Becker 1963, 1967; Goffman 1961, and others); however, the women’s movement was instrumental in connecting these different standpoints in a large-scale political strategy.

process, they can offer a critique of contemporary mainstream knowledge and dominant or normative discourses (Comack 1999).

As I am investigating identity and social networks, topics that are inherently personal and experiential, a standpoint epistemology allows me to capture individual lived realities and present these as a key source of knowledge about older women. In this case, few could argue that any group besides older marginalized women would be considered “experts” about who they are and how they negotiate their lives. At the same time, I combine their standpoints with other knowledge sources – including experts’ viewpoints and policy and legislation – to gain a well-rounded understanding of their lives, but also the environment (physical, social and policy) in which they live. This approach will also help to ensure that I privilege older marginalized women’s understandings as a key knowledge source while holistically examining my research topic.

### **4.3 Definitions**

Here, I outline the key terms used in this research project. While some of these terms are commonly used, many, such as “marginalized,” are somewhat vague and are rarely defined. As such, I have defined the key terms I use to ensure clarity.

For this research, “**older women**” are women aged fifty and older. While fifty may seem to be a relatively young age at which to be classified as “older,” researchers studying marginalized populations often use it as a demarcation point due to the chronic health problems and accelerated aging associated with being older and marginalized (cf. Aday 2003; Cohen 1999; Wahidin 2004, 2006; Wahidin and Tate 2005; Washington 2005). The Correctional Service of Canada, prison services in the United States, and the Home Office in the United Kingdom also

use this age as a reference point as health costs for prisoners and ex-prisoners over age fifty dwarf the expenses of all other groups (Aday 2003; Uzoaba 1998; Wahidin 2006).

**“Marginalized”** people are those who face social ostracism, isolation, and blocked social and economic opportunities resulting from addictions, criminalization, the aftereffects of imprisonment, homelessness, poverty, discrimination (e.g., ageism, classism, racism, and sexism), mental and/or physical health issues, or social disinvestment in them and their communities. They often lack ties to employment, and rely on state assistance to survive. These physical, social and economic conditions leave them vulnerable to further deprivation, isolation and hardship and block opportunities for their social integration (cf. Castel 1994, 1995b, 2003; Paugam 1991; Schnapper 1996; Smyth et al. 2006; Strimelle and Frigon 2007). While this definition is rather broad, I employ it nonetheless to highlight that women’s pathways into marginalization are many and diverse; marginalization is not the sole domain of a small or easily defined group. I wish to capture a range of experiences that fit within this category to acknowledge and emphasize this diversity.

**“Identities”** are the ideas, conceptions, attributes and categories that individuals use to construct themselves in their relationships with others (Gergen 1992; Giddens 1991). Identities reflect one’s relationships to the social world, including to one’s family, friends, authority figures, acquaintances and others; to one’s personal history (biography), background, and major life events; to one’s work and daily activities; and to one’s own body. Our identities are formed through our relationships and “webs of interconnection,” through which we construct shared meanings and understandings, and they are influenced by discourses, social positions, and others’ conceptions of us (cf. Gergen 1992:158; Giddens 1991; Goffman 1959, 1963).

**“Social networks”** include one’s relationships to family, friends, colleagues, acquaintances, and to one’s community (i.e., one’s neighbourhood/geographic area and social community). Social networks provide individuals with interactions and social contacts, as well as with tangible resources and assistance (cf. Bourdieu 1993; Putnam 2000). As noted on the discussion of social capital, these networks can be of mixed benefit to individual participants; they may provide assistance, create burdens, and constrain or broaden individuals’ opportunities. These networks, while working on a micro level, also reflect women’s relationships to macro structures and to society as a whole.

#### **4.4 Institutional Ethnography as a Methodological Approach**

For my research, I chose to use institutional ethnography to study and make sense of older marginalized women’s lives and experiences. I chose this method because I wanted to adopt a qualitative, ethnographic approach that would allow me to interact directly with the individuals in whose lives and experiences I wished to investigate. In practice, my research involved a document review as well as ethnographic field work and interviews. Following the spirit of Dorothy Smith’s work on institutional ethnography (Smith 1987, 2005), I decided to interview a range of individuals with different views and expertise on older marginalized women. As Smith has detailed, “institutional ethnographies” examine the social world and social institutions from minority vantage points, which are contextualized by mapping the social terrain and the institutions at play within it (DeVault 1999; Smith 1987). The term “institutional ethnography” has a specific meaning in Smith’s work beyond being a specific type of ethnographic study.

With respect to *institutions*, she explains:

I am using the terms “institutional” and “institution” to identify a complex of relations forming part of the ruling apparatus, organized around a distinctive function – education, health care, law, and the like. In contrast to such concepts as bureaucracy, “institution” does not identify a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus (Smith 1987:160).

In short, “institutions” are not limited to bricks-and-mortar buildings or formal agencies of the state; rather, institutions are a form of relations that include these agencies but also the complexes of systems, discourses, and structures that support and reinforce these agencies.

Turning to the concept of *ethnography*, Smith continues:

Ethnography does not here mean, as it sometimes does in sociology, restriction to methods of observation and interviewing. It is rather a commitment to an investigation and explication of how “it” actually is, of how “it” actually works, of actual practices and relations. Questions of validity involve reference back to those processes themselves as issues of “does it indeed work in that way?” “is it indeed so?” Institutional ethnography explores the social relations individuals bring into being in and through their actual practices. Its methods, whether of observation, interviewing, recollection of work experience, use of archives, textual analysis, or other, are constrained by the practicalities of investigation of social relations as actual practices (Smith 1987:160).

Just as institutions are not confined to narrow categories, neither are ethnographies in Smith’s account. While the traditional trappings of an ethnography are undoubtedly one part of many institutional ethnographies, these studies are broader than merely watching, listening and reporting on what one sees. This study follows a similar path; this research uses several of the types of knowledge creation outlined by Smith, including observation, interviewing, recollection of work experience, and textual analysis to examine the totality of older marginalized women’s identities, navigations of the social world and experiences of community life.

The institutional ethnography approach was ideal for several reasons. First, to examine and understand older marginalized women’s realities, one cannot access a large amount of relevant information – or sometimes any information at all – through traditional data sources, such as census data, statistical databases or surveys. As this group is narrowly defined based on both qualitative and quantitative criteria (e.g., age, social relationships, class, etc.), it is not well-covered by existing surveys and statistical data. Although these data sources can provide some basic information, such as an estimate of the size of the population, they offer little, if any, additional insight into older women’s lives and experiences. Also, as the research question is

qualitative in nature, a more in-depth inquiry is warranted, rendering potential quantitative data sources out-of-scope for the inquiry. In addition, institutional ethnographies generally examine topics, settings, and situations not explored within “traditional” or “science-as-usual” sociological approaches. Smith’s early work in this area stemmed from her own experience as a single mother attending school and raising her children. In her first institutional ethnography (Smith 1987), Smith focused on the role of women’s unpaid labour in the school environment; to do so, she interviewed mothers at local public schools, as well as the teachers and school administrators to examine how women’s labour was used in the educational system. This research was augmented by her own experiences and understandings of the phenomena she studied. My work mirrors this approach in several ways. First, my topic is one that generally receives little attention and explores issues of which few people are aware. While my research did include ethnographic fieldwork, it was not limited to this and instead included a range of research methods and techniques. During the research, I reviewed policies and procedures from the organizations serving older marginalized women. I also interviewed older marginalized women as well as a mix of professionals including front-line workers, managers and administrators to provide many points of view for the analysis. Finally, my work and research data were augmented by the knowledge I gained from spending four years working in a women’s homeless shelter. This multifaceted approach to the research allowed me to gain a better understanding of older women’s stories and the general needs of this group, as well as the broader context in which their accounts are situated. Below I outline the components of my institutional ethnography, including field work, interviews and a document review.

### **Ethnographic Field Work**

In order to recruit women for the study, as well as to better understand the women’s realities, I chose to enter the environments in which the women live and spend time, namely the shelters and drop-in centres exclusively serving women in Ottawa, Ontario. Entering the field allowed

me to meet potential participants; observe the settings in which they live and spend time; take part in the facilities' activities; and share experiences with the participants (Berg 2009; Reinharz 1992). In these settings, I attempted to meet older marginalized women, explain the study to them, and also to introduce and 'demystify' myself. As members of this group have frequently been required to share their stories with unknown others – including shelter workers, social workers, child protection workers, and social assistance administrators among others – due to their multiple involvement in social welfare and control systems (Chunn and Gavigan 2004; Comack 1996; Maidment 2006), I wanted women to have an opportunity to meet me in a non-threatening and comfortable location, ask questions about the study, and decide for themselves whether or not they were interested in participating and wished to once again tell their stories.

I was not able to blend in or go unnoticed in the shelters and drop-in centres; at the drop-in centres, despite dressing in a similar manner to the participants (i.e., wearing jeans, a t-shirt and a baseball hat on most of my visits), my appearance made me stand out: the regular participants commented that I stood out due to my age, height, weight and tattoos, all of which set me apart from the other participants. Most importantly, I was *new* to the environment whereas the majority of the women were regulars, or at least well-known, at the sites. In the shelters, where normally only residents and staff are allowed within the building, my appearance became even more noticeable; in these cases, I identified myself immediately to the women before taking part in activities or starting conversations. When interacting with the women, I positioned myself as a student conducting a research project who was interested in learning about the drop-in centre, the people within it, and in meeting people who might wish to take part in my research project.

Participating in activities at the different locations also gave me an opportunity not only to meet potential participants, but also to become familiar with the environments in which the women lived and spent time, allowing me to better understand aspects of their narratives that highlighted daily life or particular events in the shelters or drop-ins. Aside from the scheduled activities that I attended while at the facilities, I chatted with the women and also took part in impromptu card games, arts and crafts, drinking tea, and reading newspapers. The organized activities in which I participated included playing bingo at The Well – the most popular activity at the facility; arts and crafts night at Hope Outreach – an event scheduled immediately after dinner to attract as many women as possible; the morning breakfast and coffee time at St. Joe’s Women’s Centre – which is especially busy on food bank and bingo days; and attending program registration day at The Good Companions where centre participants come to sign up for programs and activities. In addition, I spent several weekend mornings meeting women at Cornerstone women’s shelter. As Cornerstone shelter offers less activity space and fewer planned activities, I opted to come to the shelter on Saturday mornings as many of the women stay in and relax at the shelter during the morning and the quiet weekend routine also guaranteed that a room was available for private meetings. I chose these events and times due to their popularity; these events ensured that many women were in the facilities at the times I visited, giving me the opportunity to meet and interact with as many women as possible. I made detailed field notes after each visit and activity, describing the atmosphere, events of the day, any significant conversations I had, and also my personal feelings and reactions. The process of writing field notes allowed me to reflect on and reflexively examine my experiences, ultimately allowing me to gain a better understanding of the settings.

## **Interviews**

To examine older women’s identities and experiences, the logical experts for this research are those who have direct, first-hand experience – older women themselves (cf. Hartsock 1983;

Reinharz 1992; Smith 1987). To honour this experience and to keep others' opinions and judgments (including those of professionals) from colouring or taking prominence in my analyses, I began by interviewing older women. Following these interviews, I then conducted a second round of interviews with the workers and managers of the facilities where older marginalized women live and spend time. While older marginalized women made up the bulk of the sample, the professionals are an important component of the research design; they often have significant experience working with older women and are able to provide insight on their lives from this perspective. As some of the professionals work with shut-ins, women in supportive housing, older women who do not speak English, and those who have been barred from some of the other service environments, they also have contact with a wider range of women than those who I encountered in the shelters and drop-ins. These individuals are also attuned to the social structures, discourses, and policies that affect these women, as well as to the policies and procedures of the agencies and organizations for which they work. Professionals can provide insight on the women's lives as key informants from their dual roles as assistants and social contacts; in previous studies, researchers have found that professionals often form significant components of older women's social networks (Maidment, 2006; Richie, 2001; Severance, 2004).

I chose to use semi-structured interviews with the older women. This approach allowed the women to develop a narrative of their experiences and daily lives while also allowing me to direct their reflections and comments towards the key themes of the study (Berg 2009; Reinharz 1992). In practice, the format proved helpful for many women who were not accustomed to being asked open-ended questions in an interview and repeatedly asked, "What do you want me to talk about?" This technique is more structured than an oral history, but still allows the researcher and participants to interact freely and for participants to respond thoughtfully and to

discuss topics, ideas, and anecdotes within predetermined categories relevant to the research (Reinharz 1992). After obtaining informed consent from the participants, the interviews began with a preamble explaining the purpose of the study and an invitation for the women to tell me their stories. This allowed the women to describe and reflect on their personal stories and the pathways that led them to the interview. Depending on the individual's story and their responses, I asked a series of follow-up questions that examined the women's daily lives and social networks. These questions were used to elicit further reflection and insights when these topics were not covered in the women's initial stories or when I was interested in additional details. These questions also allowed me to clarify and gain a better understanding of their narratives, reducing the likelihood that I would misunderstand or misinterpret their stories (Borland 1991; Devault 1990; Riessman 1987).

In order to minimize the distance between the researcher (myself) and the researched (participants) and make the interview more egalitarian, I invited participants to ask any questions they had about me or my research at the beginning and end of the interview (Phoenix 1994). While my openness and sharing does not eliminate the power imbalance within the interview it does help to foster reciprocity in the interview setting in the same manner as my initial fieldwork and casual social introductions to the women allowed them to become comfortable with my presence and research agenda (Cotterill 1992). Of note, the participants who posed questions to me generally asked about my age, where I worked, my studies, my tattoos, the neighbourhood I lived in, my hobbies, and what I planned to do when I completed school. In short, they used the opportunity to start social conversations and ask me the same questions that I asked of them.

In contrast to the open format adopted with the older women, the interviews with professionals were more heavily structured. These interviews followed a set format for two key reasons: first, the information in which I was interested was more specific; and second, the participants were often fitting the interviews into busy schedules and wished to share information with me and complete the interview as quickly as possible (Berg 2009). During the interviews, professionals were asked to describe their own jobs and the various programs and activities that their organizations offered, allowing me to gain an understanding of the basic workings of the organizations (cf. Smith 1987). They were also asked about their 'clients'<sup>26</sup>; other community resources for older women; the policies and procedures at their organizations and in the community; and general attitudes towards their clients as seen in social and media discourses. Before and during the interviews, the professionals were specifically asked not to disclose identifying details about their clients; this was done to ensure that the interviews would respect the organizations' confidentiality requirements.<sup>27</sup>

## **Document review**

In the interviews with professionals, I asked participants to describe and share their organizations' policies and rules for using or residing at the facilities. I collected policies, procedures, and codes of conduct that governed the women's presence in the various facilities or their participation in programs to gain a broader understanding of the spaces available to the

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<sup>26</sup> While I use the professionals' language regarding 'clients' in my discussions, I recognize that this term may be considered derogatory or belittling to those who are put in the position of being a "client." The language surrounding those who access services is, however, often problematic: terms such as "service user," "recipient," "patient," and "case" (as in part of a caseload), among others, may all be experienced as negative terms by those who are on the receiving end in service relationships (Dudley 2000). Although I have had several discussions with homeless and marginalized women regarding these terms (both inside and outside of the research context), there is no wide consensus as to which terms are more/less appropriate or respectful. As such, I use the word 'client' in concordance with the remarks of many of the professionals.

<sup>27</sup> In practice, these requests were included in the initial interview guide as I also felt that this would encourage organizations to participate; indeed, many organizations asked to review the interview guide in advance and several commented that the interview would be allowed because I did not want specific information about individual clients.

women and how these spaces are regulated. The professionals shared their organizations' codes of conduct and other procedures when these existed; for many organizations, however, a formal, written code of conduct did not exist. In these cases, I asked participants to describe how they regulated these spaces in terms of both who is eligible to receive services and what conditions accompany receiving services.

As interviewing municipal, provincial, and federal policy makers was beyond the scope of my interviews, I also collected various policies on social assistance and aid programs and other policies pertaining to older marginalized women, such as legislation and policy documents from the Government of Canada, Government of Ontario and the City of Ottawa. These documents include information on the eligibility criteria for certain programs, background information, and other policies that affect older women. All of these documents were reviewed and analyzed to improve my understanding of the women's realities and the social and policy milieu in which they found themselves.<sup>28</sup>

#### **4.5 Ethical Considerations**

This research project raises several ethical challenges. First, as mentioned above, I had to examine my own role as a researcher who is also a shelter staff member. While I could not change the fact that I am a familiar face for many homeless women who have been in the Ottawa shelter system over the past few years, I did attempt to create distance between my role as a researcher and my role as a shelter worker. To do this, I took a ten month leave of absence from my position as a support worker. My leave began seven weeks before I began conducting interviews, and a full ten weeks before I conducted interviews at Cornerstone shelter. The other ethical dilemma created by my role as a worker is that I have had access to privileged information about shelter residents – including potential research participants. In a

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<sup>28</sup> A list of these documents is included as Appendix F.

very small number of cases, the interview participants were well-known to me; with these women especially, I ensured that they were well aware that I was not working at the shelter at the time of the interviews and that their information would not be shared with other staff.

In terms of the research participants, the main group of interest, older marginalized women, is a vulnerable population; these women are likely to have faced difficult and/or traumatic experiences in their lives (cf. Comack 1996; Frigon 2003; Maidment 2006; Richie 2001). Often, these experiences have a significant impact on how they perceive themselves. As the interviews involved discussions of participants' identities, they had the potential to lead participants to recall troubling or traumatic experiences in their lives. In order to minimize potential harm, participants were interviewed in locations familiar to them – shelters, drop-ins, and in a few instances, in their own homes – to ensure that they were comfortable in the setting (Berg 2009). If participants became uncomfortable or upset during the interview, the interview was paused, participants' feelings and emotions were acknowledged and a new line of questioning was opened to minimize potential emotional harm. Participants were also given a list of local groups and organizations that offer both emergency and longer-term counselling services at no cost (e.g., Ottawa Distress Centre, Royal Ottawa Hospital Crisis Line, Ottawa Rape Crisis Centre) that they could access after the interview if they experienced any distress.

In addition, in the few cases where the women appeared to be upset, sad, anxious, or depressed during or at the end of the interview, I spoke with the participants after the interview ended, indicated that I was concerned about the feelings they were expressing and engaged them in a brief motivational interviewing session using the skills I normally employ in my work with homeless women. I began these sessions by indicating clearly that the interview was over, turning off the tape recorder and saying that anything else we discussed was not part of the

research and was “off the record.” I indicated that, although the interview was over, I wanted to address their feelings and ensure that they had not been troubled or upset by sharing information with me. Next, I asked the women to identify what was troubling them and how they were feeling. I then initiated brief conversations focusing on positive, concrete actions that they could take to solve problems, cope with stress, deal with their emotions or improve their self-esteem. I completed these sessions by reminding the participants about the resource list that I had provided to them as well as the counselling and support offered by the shelters and drop-ins, and inviting them to talk with me again when they saw me at the shelters or drop-ins.

In contrast to the older women, the professionals I interviewed occupy positions of relative privilege and in some cases, due to my arrangements to access sites in the field, had authority over me. In short, they are not considered to be a vulnerable population as the risks they face from the research are minimal. The professionals were asked to talk about their relationships with their clients<sup>29</sup> and about their roles in their clients’ lives. As these topics reflect the professionals’ day to day work and interactions, I did not anticipate that answering questions on these topics would pose any potential harm. While the participants were not at risk of harm from the interviews, participating in an interview was, for some, an inconvenience. Many of the professionals with whom I spoke are extremely busy with their work and their clients; they fit the interviews into their very busy schedules. To minimize the impact of the interviews on the participants, I met with professionals at their workplaces whenever possible to eliminate travel expenses and the need to take additional time off work. The interviews were scheduled at the professionals’ convenience to ensure that they had the time required to complete the interview;

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<sup>29</sup> The term ‘client’ is often used to denote the users of various services in the community, from shelters, to drop-in centres and counselling services. While the aim of the term is to reduce the stigma of being a “service user” or a “homeless person”, it simultaneously signals the increasing professionalization of fields such as social work and community intervention that seek to create the image of practitioners with clients, just as in the psy- and medical fields (cf. S. Cohen 1985; Garland 2001)

as such, in contrast with the interviews with older women, those with professionals were often scheduled several weeks in advance.

## **4.6 Recruitment**

### **Older Women**

Older marginalized women do not fit into a neat category – they may be employed, have stable housing, close connections with family or friends, a steady source of income, or none of these things. As this is an inherently difficult population to define, it is also difficult to access. For this reason, I chose to limit my study to individuals who were marginalized and were living in homeless shelters or supportive housing, attending drop-in centres, or both. To participate in the research, a woman needed to be, at a minimum, fifty years old and must also self-identify as marginalized. In practice, individuals considered themselves to be marginalized if they were homeless, received social assistance, were members of a minority community, or if they fit several of these criteria.

Women were recruited through posters and word-of-mouth through the two shelters exclusively serving homeless women in Ottawa (Shepherds of Good Hope and Cornerstone Women's Shelter); two drop-in centres serving women (St. Joe's Women's Centre and The Well/La Source); through one seniors' centre (The Good Companions); and through community development workers at one community resource centre (the Overbrook-Forbes Community Resource Centre). I placed posters at all of the recruitment facilities that gave a brief description of the study and my contact information. As noted above, I attended activities at most of the recruitment locations, allowing me the opportunity to meet the women and recruit

participants for my study. The exception was the Overbrook-Forbes Community Resource Centre, where, due to the nature of the facility,<sup>30</sup> only posters about the study were displayed.

During the times when I entered the facilities, I interacted with the participants, identifying and positioning myself as a researcher who was interested in the environment and the everyday activities occurring there. I did not fully align myself with the participants; instead, I listened to their stories, engaged in conversations, and tried, rather unsuccessfully, to learn new card games. I also attempted to avoid connecting too closely with the staff while I was in the facilities. This was especially difficult at times as I am acquainted with many of the staff in the different facilities and I was aiming to build rapport with the individuals and organizations assisting me with my research. As such, I made sure to “check in” and identify myself at the beginning of each of my visits to the drop-ins. In the shelters, I had to immediately identify my presence and the purpose of my visit as access to the facilities is more tightly controlled.

Although recruitment posters were placed in the facilities, these proved to be a very ineffective recruitment strategy. Only two of the participants telephoned the number provided after seeing a recruitment poster; I met the majority of participants through my participation in activities and my presence in the facilities; others heard about the study through word of mouth from the other participants, and some, particularly at the homeless shelters, were identified through staff. Of note, in the cases of staff referrals, staff identified older women who were eligible to participate in the research and introduced me to the women when I was in the facilities; the staff indicated that I was a researcher and neither encouraged nor discouraged participation in the research.

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<sup>30</sup> The Overbrook-Forbes Community Resource Centre includes many programs and services, many of which are based out of the centre but run in the community through health nurses and community development workers. The centre does offer some programs on site, including a medical clinic and food bank, both of which are less-than-ideal settings in which to meet potential participants due to privacy concerns and the need to protect confidentiality of the service users.

I recognize that my data collection strategy could not identify or reach older marginalized women who are employed – formally or informally – and otherwise occupied during the daytime when the drop-in centres are open. I also missed women who are shut-in or who have been barred from shelters and drop-ins, as well as those who are unwilling or uninterested to access services or are unaware of the services available to them. My recruitment strategy also limited my contact with older women from minority communities; many of these individuals – for cultural, linguistic and other reasons – do not use the drop-in services even if they could be beneficial. While these do represent gaps in my sample population, I again highlight the difficulty in accessing this population and note that significant additional barriers exist to identifying and interviewing older marginalized women who do not use shelters or drop-ins, including finding and identifying these women, building trust and conducting interviews without the legitimacy of a familiar shelter or drop-in, as these endorsements resonated with participants more so than academic credentials or university approval. I attempted to address these gaps through the interviews with professionals, where I included individuals who work with women who are shut-ins, live on the street, have been barred from the drop-ins or otherwise do not access shelter and drop-in services. While not a perfect substitute for their voices and views, these interviews did afford me a partial glimpse into their circumstances and situations.

## **Professionals**

To recruit professionals, I used a snowball sampling technique that included a mix of personal and referral contacts. First, I telephoned and e-mailed some of the professionals that I had met through my fieldwork who had experience that was relevant to the project. Additionally, I followed up on recommendations made by older women in their interviews. My questionnaire asked older women about the organizations they found to be helpful, regardless of whether or not they worked specifically with either women or older adults. I followed up their

recommendations by telephoning and e-mailing the organizations that they found to be helpful. I also took recommendations from professionals, who sometimes recommended that I speak to other individuals within their organizations or with whom they had worked collaboratively in the past. Of note, some of the professionals required the approval of their managers or other internal bodies (e.g., ethics boards) to participate in the research. In these cases, I provided the interview guide to the professional and asked her/him to forward it to the correct individual. I also shared the interview guide in advance with participants who asked to see it.

My data collection strategy did not cover all the organizations that the participants indicated were helpful. While I eventually interviewed 16 professionals, I had only planned to interview ten, as I recognized that I could not possibly speak to everyone who had experience relevant to my project. I spoke with individuals working in various positions in local and community-based organizations. While I did receive positive responses from many organizations, some organizations, despite my repeated attempts to establish contact, did not respond to my requests for an interview. In other cases, the professionals recommended a large number of individuals from their networks and time and resources did not permit following up with all of these potential sources. In addition, some individuals recommended that I speak with provincial and federal policy makers and politicians; these recommendations, however, went beyond the scope of the project.

#### **4.7 *Identity management in the field***

While this research focuses on identities and social networks for marginalized older women, I recognize that I am also engaging in identity performances as I interact in the research setting (Gluck and Patai 1991). Carrying out the research created an interesting positional challenge: I have an academic knowledge of older marginalized women, but have also learned a great deal about this group through my job as a relief support worker at Cornerstone Women's Shelter. In

this capacity, I cover shifts for other shelter staff on an on-call and as-needed basis. While at the shelter, I engage with the residents, providing support and counselling, mediating disputes, assisting with day-to-day tasks, and providing positive interactions. I also perform other administrative and support tasks as necessary, including reception services, preparing and serving meals, performing bed checks, and working with other staff and managers to support the women. The social network of agencies serving the homeless is relatively small; many workers are employed by several agencies, or have worked for a number of different organizations in the past. My role as a relief worker allowed me to meet many older homeless women, but also many professionals working with this group.

My position as a worker places me in a position of trust and power; when at work, I have access to case files, am often told personal information by residents, and, with other staff, I take part in decision-making that can result in a woman facing being barred from the shelter or facing other disciplinary actions for rule breaking or inappropriate behaviour (e.g., bringing drugs or drug paraphernalia into the shelter, drug trafficking, fighting with or threatening others, etc.). Before I began the research, I was concerned that my position as “staff” would result in me being perceived negatively by current and former residents, as an authority figure who must be obeyed, or as someone who can grant special favours or privileges. I was also worried that the women may feel that there would be negative consequences associated with not participating or that I would not respect the confidentiality of the information shared with me. To minimize the chances that my position would interfere with the research, I took a leave of absence from my position at Cornerstone that commenced approximately two months prior to the start of my research. This allowed for some turnover of residents, and also allowed me to establish some distance between my role as a worker and my role as a researcher. In addition, I began my recruitment activities at other facilities well in advance of my first entry into Cornerstone shelter

as a researcher; at which point, due to word-of-mouth information sharing, there was a degree of recognition of my research in the homeless community, and with that the news that I was a student working on a project for school, not on behalf of an organization.

While several of the participants knew me as shelter staff, many of the women were unaware of my position. This information was freely disclosed to the women if they asked about my background or indicated that I looked familiar. In these cases, I indicated that I worked at the shelter but was currently on leave in order to conduct my research. While it is impossible to know how my position may have influenced the respondents and what they shared (Deutsch 2004; Reinhartz 1992), a few women indicated that they knew me and that my multiple roles did not concern them. One woman, for example, had met me when I first started to work in the shelter several years before and indicated that she felt I was a “good person” who had proven my worth and character through work experience. Another woman who also knew me through my job, however, warned me that she was talking to me as a researcher, not a staff person, and reiterated several times that she did not want her interview to be shared with staff, even though I repeatedly assured her that the interviews were confidential.

Identity management with staff in the facilities also posed challenges. On several occasions, I was asked to act in the role of a staff or volunteer, by answering the door; providing information on resources or rules to clients, residents, and staff; or helping staff in de-escalation and conflict resolution. Interestingly, this happened not only at Cornerstone shelter, but also at some of the other venues where I carried out research even though I was not, and had never been, a staff or volunteer at these locations. I tried to minimize the time I spent helping out by reminding staff that I was at the facility to meet women for my research and was on a leave of absence from work. At the same time, I did attempt to help out when requested; as I was a visitor in the

settings and was receiving help and assistance with my research from these organizations, I wanted to show my gratitude for being allowed into these places and spaces. When I did assist staff, I took a minor role so that I would not be mistaken for a staff person and attempted to complete the task asked of me (e.g., taking messages, retrieving information on resources, etc.) as quickly as possible so that I was not distracted from the main purpose of my visit.

#### **4.8 Research Process**

The research was approved by the Research Ethics Board of the University of Ottawa in September 2010 and conducted in concordance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*<sup>31</sup> (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada 2010). Informed consent was received from all participants prior to the start of each interview.<sup>32</sup> Older homeless women can be considered a vulnerable population; as such, I was careful to ensure that participants fully understood the goals of the study and what was required of them. Due to potential problems obtaining written consent from some participants because of the women's low literacy levels or their concerns for privacy and anonymity, the women were offered the option of signing a consent form or verbally consenting to participate. In either case, a copy of the consent form was given to the participant for their information and was also read aloud and explained to them at the beginning of the study to ensure that they were well-informed of their rights. Participants were also informed that they could opt out of the research at any time or skip questions if they did not wish to discuss certain topics. In practice, only two women chose to skip questions or sections of the interview. The process of conducting the interviews is described in more detail below.

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<sup>31</sup> The ethics approval is included as Appendix A.

<sup>32</sup> The interview guide for older women is included as Appendix C; the guide for workers is Appendix E.

## **Data Collection**

My research involved both ethnographic fieldwork and interviews. For the ethnographic portion of my work, I did not take notes while directly in the field to ensure that note-taking was not a distraction for me and that it did not pose a concern for the people in the setting. Instead, I wrote detailed field notes as soon as possible after exiting the observation site and after each interview. I attempted to capture a “thick description” of the site and the interactions that I observed within it and of the interview proceedings (Geertz 1973). These field notes were typed and reviewed to determine what questions they raised or where I needed further clarification or observation to gain a full understanding of the environment, including the interactions and/or institutional routines and practices that I observed (Berg 2009; Geertz 1973). With the interviews, these notes also helped me to reflect on how the interview had progressed and to critically examine how I was conducting interviews, including any mistakes or oversights in my questions, timing, or the overall interview style (Devault 1990; Reinhartz 1992; Riessman 1987).

In conducting interviews, I ensured that all interviews were scheduled at the convenience of the participants. To the greatest extent possible, participants were offered their choice of both meeting time and location. In practice, meetings were scheduled so as to accommodate participants’ schedules as well as my own, to fit within the normal operating hours of the drop-in centres and within daytime or early evening hours at the shelters, and also to accommodate the women’s interest in participating as soon as possible after their first contact with me. This latter consideration was extremely important, as many of the women were interested in participating only if the interview was conducted on the same day or a subsequent day.

For women currently staying in homeless shelters, the interviews were conducted in these facilities. In these cases, I reserved a room in the shelter in advance – usually an office or an

outreach room used occasionally by caseworkers and other professionals – and met with women individually. My visits to the shelters were coordinated to minimize any disruption that I might cause in the facilities; I ensured that I did not require staff assistance during shift changes or stressful times of the day (e.g., when maintenance was occurring, when workers from outside agencies were present, etc.), and that the women would be able to complete their interview without missing meals, scheduled activities, group sessions, or other meetings and appointments outside the facility. In practice, this entailed spending many weekend days as well as some weekday evenings at the shelters to meet with the women.

I also conducted interviews on-site at the two drop-in centres. Here, the staff offered me an available quiet room in which to conduct the interviews; the room varied depending on the day and the space available. This was often a quiet area secluded from the drop in, such as a lounge or a children's playroom. In these cases, I ensured that the area was private, quiet, and had a door that could be closed. In addition, staff helped to ensure that I would not be interrupted by informing the staff team that the room was in use.

Several participants wished to be interviewed in their homes. In all cases, these were various subsidized housing buildings, ranging from fully staffed supportive housing to complete independent living units. In these cases, I booked the appointments with the women in advance and then called several hours before the appointment to confirm the time and location. Where the buildings were staffed, I checked in with the staff person when I arrived. When the buildings were not staffed, for my own safety I ensured that I carried a mobile phone and that another person (e.g., a friend/co-worker) knew that I was going to be conducting an interview at a given time and at a certain address, although they did not know the name of the interview participant.

At the beginning of each interview, I gained permission to audio record the interview and assured the participant that only I would have access to the recordings. Then, once the recording had begun, I provided the participant with the consent form. I provided participants with a copy of the form and also explained the contents of the form to them. This was particularly important as the women's levels of literacy, as well as their ability to see, varied dramatically; some women could read and understand the form without my assistance, while others were functionally illiterate, had poor vision, or both. Depending on the participant's preference, they then either signed the form or verbally consented to be interviewed; their verbal consent was audio recorded.

Once the interview started, I attempted to let the conversation move at a speed that was comfortable to each participant. This approach led to interviews that lasted anywhere between thirty minutes and two hours. The interviews started with the women's narratives and then progressed through the pre-determined questions until all of the questions and topics had been discussed. At the end of the interview, I asked women if they had anything to add. I then asked them to pick a pseudonym that would be used to identify them in the research. Finally, I thanked the women and provided them with a \$25 honourarium and a list of community resources to contact if the interview had made them feel upset. In the cases where women appeared to be emotionally distressed or upset after the interview, I engaged in a short motivational interviewing session that was not recorded in order to ensure that they did not experience any harm as a result of the interview. These sessions drew on the skills that I had learned in working in the shelter environment and focused on calming the women and helping them to understand and process their emotions. In these cases, I also strongly encouraged the women to follow up with staff or counsellors if they continued to feel upset.

A similar practice was followed with the professionals that I interviewed. All of these interviews occurred in the professionals' workplaces. I began the interviews by requesting permission to audio record the interview and by reviewing the consent form with each participant. Instead of inviting the participants to share their personal narratives, the interviews were much more structured. As some of the participants requested the interview guide in advance, they often had some knowledge of the topics that I wished to discuss and were able to supply information both about their organizations and about relevant services in the community. In general, the balance of the interviews were conducted in the same manner as for the older women, although none of the professional participants required follow-up counselling at the end of the sessions.

## **Transcription**

The interviews were transcribed verbatim and in full. While the words one speaks are the primary means of transmitting meaning in an interview, what is not being said, but is instead being conveyed through tone of voice, gestures, pauses or silence, can be as important as what the participants choose to share (Devault 1990; Oliver, Serovich, and Mason 2005). They can also be the signifiers of counter discourses or hidden discourses that are important to the research and understanding participants' lives (Foucault 1990; Kingfisher 1996; Scott 1992). As such, I chose to type the interviews verbatim, attempting to leave the "messiness" of the conversation intact, including: slang terms, swearing, self-corrections and emotional signals. As all of these convey meaning and messages, leaving them intact allowed me to better grasp the meaning of the women's words (Devault 1990). Once all of the interviews were typed, I removed names and identifying details about the participants and others that they mentioned, including family, friends and acquaintances. I changed their names to the pseudonyms that they selected. While I removed personal details, I did, however, leave intact information about the places and spaces where they lived, spent time and sought support.

For the interviews with professionals, the same process was followed with one exception: all personal information about the participant was removed, but information about their workplace was retained as this was the focus of the interviews. The professionals are identified by generic titles, such as “worker,” “manager” or “nurse” and by their workplace; these titles were used in place of pseudonyms as the professionals’ varied relationships to their clients (i.e., as a manager or worker) reflect how they interact with their clients and to the information they provided to me. In all cases, I ensured that the way I chose to identify an individual did not inadvertently identify her/him. For example, if the participant was the only manager in an organization, I referred to her/him instead as a “senior staff person” – a term descriptive of several individuals in the organization – to ensure that s/he could not be identified. In practice, this only required changing the titles of two participants.

With respect to the field notes, the transcription process was much simpler; it included typing my own words, including summaries of what I saw, as well as my feelings, ideas, theories, and questions that I had based on what I saw or the environment in general. These transcripts were often very detailed; I used them both to remind myself of what I had seen and heard in the field, but also to express how I felt about my interactions, particularly during the interviews.

### **Analytic Process**

Once all of the interviews were transcribed and anonymized and the field notes were typed, I re-read the transcripts and notes to re-familiarize myself with the women’s accounts and events in the field. While I had listened to the women’s stories as they were told during the interviews and during the process of transcription, another reading of all of the transcripts allowed me to begin to look at the transcripts through an analytic lens instead of from the perspective of an interviewer attuned to the participant and her story or from the standpoint of a transcriber/typist trying to accurately capture not only the women’s words, but also their inflections, hesitations

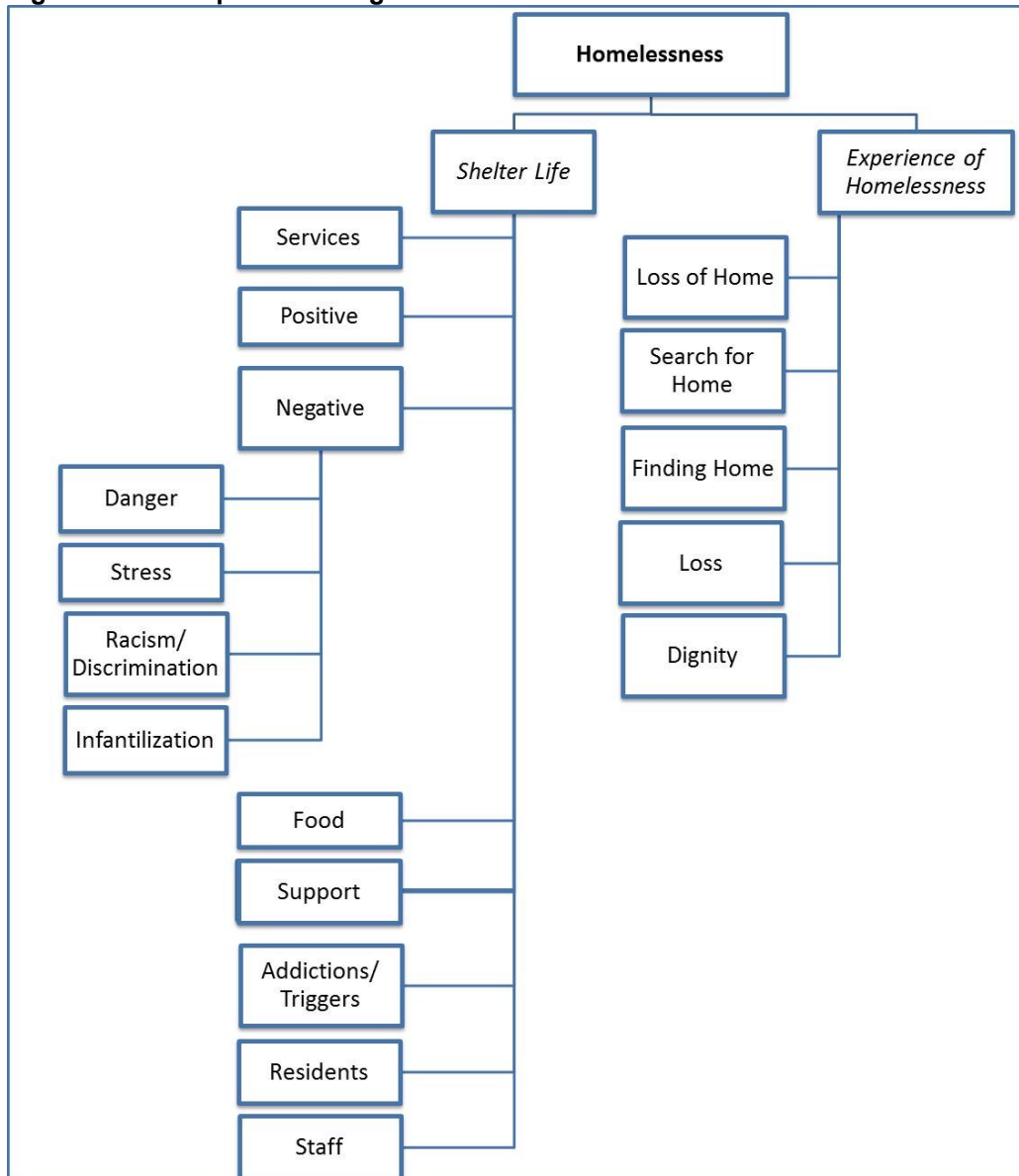
and manners of speaking (Oliver et al. 2005; Reinharz 1992). After this review, I began to code the data. Before beginning, I separated the women's and workers' transcripts and the field notes so that I could analyze each group separately. This allowed me to tailor my coding frames to the questions I asked and settings I observed, and also to ensure that women's voices were not overshadowed by my voice or the voices of the professionals and experts.

With the older women's interview transcripts, I used an open coding technique (cf. Corbin and Strauss 1990; Corbin and Strauss 1998; Glaser and Strauss 1967) that relies on the participants' narratives to generate coding categories (in vivo coding). This technique was especially beneficial due to the diversity in the women's accounts; as they had many different pathways into marginalization and life experiences, there were large variations in the topics that were covered. In my first round of coding, I reviewed the transcripts and highlighted key themes and insights offered by the women, separating the text by category and topic. In this initial round of coding, the coding frame roughly followed the interview script that I had developed, beginning with discussions of identity, then discussions of the world around the women, their social networks, and so forth. In subsequent rounds of coding, I created sub-themes and added additional themes to better reflect the women's narratives and experiences, as well as to capture the broader messages that their narratives imparted (Gluck and Patai 1991; Reinharz 1992). As I grew more familiar with the transcripts, I delved deeper into the themes that emerged, creating additional subcategories to better capture the nuance of individual accounts. This process was facilitated by my past experience working in the shelter; while I do not claim to be able to fully comprehend the experiences that the women described (cf. Merriam et al. 2001; Riessman 1987), my familiarity with street slang, well-known members of the service community, and the common names by which local organizations and landmarks are described, all aided me in understanding the context and content of the women's remarks. In total, I

conducted three complete rounds of coding of all the transcripts; due to their length and complexity, however, some transcripts were coded a fourth time to ensure that the meanings and nuance were captured.

To conduct the analysis, I used Weft QDA, a freeware qualitative data analysis software package. This software allowed me to review transcripts, create coding categories and mark and classify text segments into these categories. Like most qualitative data analysis packages, it allows users to generate coding reports, search for themes and check for cross-coding (Fenton 2011). Within the software, I created coding categories and sub-categories to broadly, and then more narrowly, organize the women's words into themes and sub-themes (Corbin and Strauss 1998). In total, the coding frame included 15 categories and 93 sub-categories. A sample of the coding frame used to organize and code the older marginalized women's interviews is shown below.

**Figure 4.1 – Sample of Coding Frame**



Coding can be a difficult exercise due to the nature of talk: we naturally talk about many topics, often all at once (Devault 1990). This was especially true in this study, as the women were asked about topics – their identities, experiences, and networks – that naturally flowed into and merged with one another. Due to the intimately personal and interrelated nature of the questions asked and of the women’s responses, there was overlap between some of the coding

categories; for example, discussions of the community services accessed by the women often naturally led to discussions of social networks and how these locations were implicated in the women's social worlds. As such, some of the interview segments were coded to more than one category. This also occurred in instances where an interview segment implicated multiple categories, themes, or ideas. An example of such a segment is shown below.

**Figure 4.2 – Sample of Coding**

Interview 6: Bev	Coding Categories
<p>What's really nice is I've got my own place now and I can shut out the public again. You know, I – living here was okay. They were all good to me – I have no complaints that way. But I don't trust a lot of the women here. Okay, and they've proved it. Last month when I was here I got ripped off for forty bucks. Yeah, my wallet. I had to get a new bank card. That's what's nice about having my own place. Because I can come here – and spend all day here – not a problem. But I want to go home at night. Yeah, when I shut that door and lock it, I can lock out the rest of the world and that's what's important to me.</p>	<ul style="list-style-type: none"> <li>• Shelter Life</li> <li>• Shelter Life &gt; Residents</li> <li>• Shelter Life &gt; Negative</li> <li>• Experience of Homelessness &gt; Finding Home</li> <li>• Housing &gt; Positive</li> <li>• Housing &gt; Safety</li> <li>• Victimization</li> </ul>

A similar process was used for analyzing the professionals' transcripts and field notes. When coding the professionals' transcripts, I started by coding the transcripts to the themes and categories in my questionnaire before once again using an open coding technique to uncover additional details and sub-themes. This coding frame was much smaller than that used with the older women's transcripts due to the more structured nature of the information requested from participants. In total, the coding frame for experts' interviews included six categories and 25 sub-categories. For the field notes, the coding frame was once again simpler, including five main categories and 15 sub-categories focusing on my impressions and reflections of the settings and the events that I observed.

## Analytic Strategy

My analyses began with a basic content analysis. That is, I began by conducting a systematic analysis of a set of cultural texts, namely organizational policies and procedures, as well as two sets of interview transcripts<sup>33</sup> (Krippendorff 2004; Reinharz 1992). This analysis focused on finding meaning within the women's words and the thematic categories into which the text had been coded, offering an understanding that extended beyond the analytic categories to uncover the personal and social meanings embedded within the texts. While this analysis was immensely helpful in understanding the relevance and content of the narratives and policy documents overall, analyzing the women's words alone only tells one side of their stories. In order to make my work an institutional ethnography and gain a deeper understanding of the power relations and institutional structures that circumscribe the women's lives and affect their day-to-day realities, I also used critical feminist discourse analysis to examine the discursive framework in which the women are situated. As Reinharz (1992) notes, content analysis and discourse analysis are closely linked; though the tenets, foci and goals differ slightly, as explored below, the similarities between the methods enable their complementary usage.

Content analysis focuses on a set of texts of one sort or another – be they images, written words, legislation, songs, or videos. Meaning is derived from examining the texts as part of a group. Discourse analysis, in turn, examines the texts and also the broader context into which they fit. Foucault and others argue that discourse brings shape and structure not only to conversations, but also to social settings; in short, it shapes both *what* we talk about and *how* we talk about it. Thus, in this study, discourse shapes both the texts I analyze and the lenses through which I understand and interpret them. As such, to analyze discourse one must examine not only what is said (i.e., the contents of speech), but also look to *how* it is said: in

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<sup>33</sup> While interview transcripts are not necessarily considered to be “cultural texts” as they are created for the purpose of research, the method of gleaning meaning from these documents is similar, focusing on both *what* is said and *how* it is said.

addition to the actual words spoken, the context in which the speech occurs (personal, social and political) and the structures shaping and framing it are important to the meaning. In understanding the multifaceted reach and impact of discourses, Foucault (1972) highlights four roles of discourse. First, functioning as a paradigm, discourse shapes the world around us, influencing how we understand it and what we do in it. Next, discourse generates and regulates knowledge and “truth” as these are not true universals, but constructs that function through language. Third, discourse communicates meaning about what is said, but also about the person who is saying it – telling of her culture, age, class, gender, and life experiences as she speaks. Finally, as Foucault notes in many of his works, discourse is intimately linked with power, structuring relationships and the negotiations through which power is exercised and contested (cf. Foucault 1972, 1982, 1990).

Discourse analysis, in turn, is the examination and study of these discourses. Specifically, critical discourse analysis examines what is said, and how these utterances relate to the relations of power that are linked to the discourse. Critically examining discourses from a feminist perspective further leads one to look at how gendered relations play into this field. As Lazar (2007:142) indicates, the goal of feminist critical discourse analysis is “to show up the complex, subtle, and sometimes not so subtle, ways in which frequently taken-for-granted gendered assumptions and hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities.” Simply, feminist critical discourse analysis explores the analytic texts, but also the social and institutional structures surrounding them, with a particular focus on gender, class, and power.

Together, these methods allowed me to begin with a basic content analysis that examined *what* was said and the basic context in which the speech occurred. This was then extended using feminist critical discourse analysis to include a deeper examination of *how* it is said – the words used, the manner and style of speech, the semiotic meaning attached to the words, and the broader setting – physical, social, political, and gendered – in which the speech occurred (Georgakopoulou and Goutsos 2004; Lazar 2007; Wood and Kroger 2000). In particular, my discursive examination of the text highlighted how interview participants experienced and navigated the social world, including the forces, institutions and situations that enabled and constrained their identity performatives and movements. As the subsequent chapters demonstrate, the technique illuminated the nuance in the women’s words and the institutional environments in which their accounts were situated.

While I found content and discourse analysis to be enlightening and helpful, these methods do require researchers to show reflexivity and an awareness of the role of discourse in their own lives and in the research process. Particularly, in using discourse analysis, one must be reflexive of the fact that the process of designing a research study, conducting fieldwork and interviews, and analyzing and presenting the results are all shaped by the discourses surrounding the researcher and her subjects (cf. Gluck and Patai 1991; Reinharz 1992; Stanley and Wise 1983, 1993). That is, the researcher is not only examining the texts for discourses, she is also working within and through these discourses. As Dorothy Smith (1987:116–117) explains,

[We name] our two characters, subject and sociologist, One and Two. In the everyday work of observation, Two observes One driving a dray, waiting for a motorbus, cutting wood, or standing on a knoll by the railroad. Or perhaps Two interviews One, who answers Two’s questions. If so, One does just that. She does not tell Two what questions to ask her, and she is not a participant in the discourse to which Two will return from the field with her trophies. Like it or not, Two speaks from and assumes the privileges of her participation in a discourse embedded in relations of ruling. The latter are immanent in Two’s observations,

in the way in which her interview is conceived, in her use of the “material” she collects when she takes it back home and works it up, and as we have seen, in the texts that are her product and the methods of writing them.

As I analyzed the contents and contexts of the women’s narratives, I attempted to remain reflexive about the discursive world affecting the texts that I reviewed, the personal background that I brought to the research project, and also the physical, social and political setting in which my review of the texts took place.

### **Making sense of mental health and muddled ideas of “truth” and “fiction”**

For some of the older marginalized women that I interviewed, mental health concerns played an important part in their lives and narratives. Overall, many of the study participants disclosed or exhibited the symptoms of mental health disorders. In the cases of most participants, these disorders included depression and anxiety, feelings that are not uncommon among the general population and that are certainly reasonable and to some extent expected among homeless and marginalized women (Cohen 1999; Cohen et al. 1997; Washington 2005). Indeed, considering the precariousness of the situations faced by many of the women, these conditions could well be considered *normal* instead of *abnormal*.

In many cases, these women’s mental health issues were apparent in their narratives. This ranged from women expressing loneliness or sadness, to excessive worry about the events of their daily lives and their plans for the future, to delusions and paranoia that were interwoven throughout otherwise calm, measured, and ordinary conversations. Those discussing their mental health were, for the most part, up-front and reflexive about the role of mental health in their day-to-day lives and recognized how it affected them and their social interactions. In the cases of several women with more severe mental health disorders, however, some segments of their personal stories were muddled, contradicting, or downright confusing. For example, one participant calmly discussed her daily routine and everyday activities, but indicated that her days

would be much more relaxing if she were not being followed constantly. Another woman (who I first met while working at the shelter several years before) appeared to be very physically healthy, yet described how she had arrived at the shelter for the very first time two weeks before the interview after being pulled, injured and unconscious, from a fiery car crash. In some of these latter cases, the women's personal stories and discussions of their day-to-day activities were extremely articulate despite the inclusion of information that was obviously not true.

In these cases, I had to strike a difficult balance between honouring a woman's story and acknowledging her mental disorder. While some of the narrative was obviously coloured by the woman's experience of mental health distress, I did not want to silence her by removing it completely from the analysis. As those with mental health disorders are already heavily stigmatized and often infantilized or ignored in society (cf. Baggett et al. 2010; Flanagan and Davidson 2009; Kisor and Kendal-Wilson 2002), I did not wish to continue this trend in my own research. In instances where a part of a woman's story was obviously the product of a mental ill-health, I coded these interview segments into a separate category 'identity/self > mental health.' I then proceeded with my regular coding scheme for the rest of the interview transcript.

Addressing women's mental health issues was not the only challenge encountered in the research. In a few instances, I was unsure as to whether certain parts of a participant's story were true or fictitious. In some cases, these were simple embellishments that positioned the individual in a better light – for example, hearing about the wonderful Christmas she was planning or hearing about a seemingly never-ending stream of accolades that the woman had received throughout her life. I had anticipated hearing such accounts as these instances are rather common in the research process (Devault 1990); however, I also had to make sense of accounts that were much less clear-cut. In one more extreme case, for example, a participant

told me about multiple instances in which her family members were murdered, including one particular family member who was apparently murdered on more than one occasion. While some of these stories were obvious fabrications, others are simple plays on truth and fiction, similar to what occurs in regular conversations when participants wish to portray themselves in a positive manner (Devault 1990; Hecht 2007; Reinharz 1992). Although some of these occurrences were blatant and obvious and could easily be excluded from the analysis, others were much more subtle.

While this is a definite challenge for coding and analysis, it is not unique to my research project or to research involving marginalized populations. Indeed, research is a process of telling stories. The research process relies on the “truth” of participants’ narratives, which may be blurred by memory, limited by what they wish to disclose to the researcher, or embellished or fabricated to present the participant and his/her story in a certain way (Hecht, 2007). In qualitative research involving interviews and ethnographic interactions, the researcher looks to his/her research subjects for data; as a result, the researcher and the research project are largely at the mercy of these participants as the project is based on the information that they provide (Berg 2009; Lincoln and Guba 1985; Reinharz 1992). While I, like other researchers, can attempt to ensure the “truth” of my research through asking participants for their honest experiences, opinions and thoughts and ensuring that I conduct my work with methodological and analytical rigour, my analyses and results are based on what the participants offer in the way of data; I can never be fully certain about the truth (or fiction) of what I hear.

When the “truth” of the woman’s narrative was in doubt and where “truth” and “fiction” appeared to have been blurred or combined, I attempted to discern the woman’s story following the approach of Tobias Hecht (2007), who notes that while a participant’s story may not be

completely *factual*, the experiences related are often *true to the participants* and hold elements of truth even amidst fabrications. I also looked for how the accounts and the themes that emerged resonated with the rest of the research findings, using the overall patterns of the research and my knowledge of the places and spaces described to help separate plausible and implausible events (Lincoln and Guba 1985, 1986). As such, I excluded interview segments containing obvious and blatant fabrications of events, but left the women's experiences and insights in the research in the form in which they were shared with me.

With these issues and challenges in mind, I now provide an overview of my interview sample. In the next section, I give a brief description of the two groups of participants as well as a few key details relating to the older marginalized women.

## **4.9 Interview Sample**

### **Older Women**

While I initially intended to interview twenty-five older women, I included twenty-seven (n=27) women in the study due to the high level of interest. I originally planned to conduct interviews throughout the fall of 2010, but all of the interviews were conducted in September and October due to participant demand.

Once the interviews were completed, they were audio recorded and fully transcribed.

Participants were offered a copy of their transcript once it was completed; of the women interviewed, twenty requested transcripts. They also received \$25 in compensation for their time.<sup>34</sup> For participants who wished to receive a copy of their transcript, I arranged in advance

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<sup>34</sup> It must be noted that this amount of money can be considered significant for some homeless people; those who are staying in shelters receive, at a minimum, a personal needs allowance (PNA) of \$4 per day (paid weekly) from the City of Ottawa if they have no other sources of income. Many, however, have

to meet them in person at one of the shelters or drop-in centres to pick up the transcript. As I could not guarantee a date by which I would have the transcript completed, I printed the transcripts and placed them in sealed envelopes. I carried these with me when I visited the shelters and drop-ins to give to them in person. While not an ideal distribution method, this did ensure that the women received the transcript directly from me and that no other individuals had access to the transcripts. It also allowed me an opportunity to check in with the women and provide some follow-up about my research. The following chart shows some of the characteristics of the sample.

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much higher incomes due to receiving ODSP, CPP disability, other disability or pension benefits, or through earning money on the street (e.g., panhandling, sex trade, drugs, etc.).

**Figure 4.3 – Participant Attributes**

Participant	Age	In Shelter	History of Homelessness	First Nations, Inuit or Métis	Visible Minority	Severe Mental Health	Francophone	Non-Anglophone	Addictions	Volunteer	Employed	Looking for Work
Danielle	50-54	✓	✓	✓			✓	✓				
Lacey	50-54	✓	✓						✓			
Adele	60+	✓	✓									
Dina	50-54	✓	✓							✓		
Maryann	55-60	✓	✓	✓	✓				✓			
Bev	55-60		✓						✓	✓		✓
Brenda	55-60	✓	✓									✓
Amanda	55-60			✓				✓			✓	
Evelyn	55-60	✓	✓			✓						
Anna	50-54	✓	✓									
Catherine	60+			✓	✓				✓	✓		
France	55-60						✓	✓		✓		
Jane D	60+											
Deborah	50-54		✓						✓	✓		
Kristin	50-54	✓	✓						✓			✓
Sherry	55-60		✓				✓	✓		✓		
Mary M	55-60	✓	✓									
Joy	50-54	✓	✓		✓						✓	✓
Marie	60+			✓				✓		✓	✓	
Ekatarina	60+	✓	✓									
Sara C	55-60		✓						✓			✓
Tracey	50-54	✓	✓						✓			
Savannah	50-54	✓	✓	✓					✓			
Joan	60+	✓	✓			✓						
Maggie	50-54	✓	✓									✓
Ashley	50-54	✓	✓						✓		✓	
Louise	50-54	✓	✓	✓		✓			✓			
<b>Total (n=27)</b>		<b>18</b>	<b>22</b>	<b>7</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>5</b>	<b>11</b>	<b>7</b>	<b>4</b>	<b>6</b>
<b>%</b>		<b>67%</b>	<b>81%</b>	<b>26%</b>	<b>11%</b>	<b>11%</b>	<b>11%</b>	<b>19%</b>	<b>41%</b>	<b>26%</b>	<b>15%</b>	<b>22%</b>

The participants ranged in age from fifty to sixty-five, with the women’s ages fairly evenly distributed within this range. Of note, some women younger than fifty asked to participate in the study; indeed, some younger women tried to schedule appointments, claiming to be several years older than they actually were. In the cases where a potential participant’s age was in

doubt (i.e., she looked to be younger than fifty), her age was verified using a bed list<sup>35</sup> if she was staying in a shelter, or using photo identification if she contacted me by telephone or met me at a drop-in centre. At the shelters in particular, staff used the bed lists to identify potential participants and inform them about the study. The bed lists were also used to confirm that the woman was still at the facility in cases where I scheduled an appointment with a woman in advance.

Although the original focus of the study was on marginalized women in general, the vast majority of the participants (n=22; 81%) indicated that they were currently homeless or had been homeless within the past two years. While many were or had been homeless, their pathways to and from this state were diverse; some participants had experienced homelessness throughout their lives, whilst others had raised families, maintained steady employment, and had become homeless for the first time as older adults. Of note, the trends in homelessness among this group appear to mirror trends among older prisoners highlighted by Aday (2003) and Uzoaba (1998), among others. In studies of older prisoners, most find that some prisoners experienced imprisonment as a lifelong condition, others experienced it intermittently throughout their lives, and the majority experienced it for the first time as older adults.

Of the participants, over one quarter (n=7; 26%) indicated that they were of First Nations, Inuit or Métis descent. Two respondents (7%) indicated that they were either Black or biracial. In terms of language, three participants (11%) identified as Francophone or indicated that they spoke French on a daily basis. Three others indicated they were fluent in an indigenous language (e.g., Cree, Inuktitut, etc.) in addition to speaking English. To examine the

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<sup>35</sup> Shelters use bed lists to keep track of residents' room and bed assignments. The lists indicate the resident's name, date of birth, bed assignment, and the date on which they were booked in to the shelter for their current stay.

representativeness (or lack thereof) of my sample, the most recent census data available from Statistics Canada (cf. Statistics Canada 2006) provides a convenient reference point. Characteristics for the population of the Ottawa Census Metropolitan Area (CMA), while now somewhat dated, provide a good overview of the local population. While the statistics apply to the entire age spectrum (0-100+), they are a good proxy for the composition of the population of women aged 50-65. According to the 2006 census, 14% of Ottawans are Francophone (versus 11% of participants), 63% are Anglophone (81%), 1.5% are of First Nations, Inuit or Métis ancestry (26%), and 4.8% are Black (7.4%). As such, my sample slightly underrepresents Francophones, over-represents Blacks and Anglophones, and significantly over-represents Aboriginal peoples. I did not ask about annual income, but due to the number of women who indicated they received welfare or had no income, it is safe to assume that my sample is poorer than the general population.

Just as the participants' backgrounds are diverse, so too are their current living situations. While most (n=18; 67%) were currently living in a shelter, one third (n=9; 33%) had housing in the community, with half of this group (n=5; 19%) living in subsidized housing. Of these women, all but two lived alone; the others lived with spouses or male partners.

Four respondents indicated that they were formally employed, while six more wanted to work and were looking for jobs. In addition, 7 respondents (26%) indicated they were active volunteers in the community, many volunteering at the shelters and drop-in centres that they themselves currently use or previously used. A handful of respondents also indicated that they spent time providing care for family members, including parents, adult children, grandchildren, and nieces and nephews. Many respondents indicated that their primary source of income was city (Personal Needs Allowance (PNA)), provincial (Ontario Works or Ontario Disability Support

Program) or federal (Canada Pension Plan or Old Age Security/Guaranteed Income Supplement (OAS/GIS)) social assistance or disability payments. Aside from these official income sources, others relied on panhandling to supplement their other sources of income.

### **Follow-Up Interviews**

Six (n=6) videotaped follow-up interviews were conducted with women who expressed interest in participating further with the research. While not part of the original research plan, several of the women indicated to me that they wanted to tell their stories to a broader audience and send a message to policy-makers, researchers, students, and other women about their experiences. Only individuals who participated in the first phase of the research were invited to participate in the videotaped interviews. For these interviews, the same protocols were followed as for the initial interviews, including obtaining informed consent, explaining the consent form in detail to participants, and providing \$25 in compensation. The interviews lasted between five and twenty minutes and allowed the women the opportunity to read their writing, share artwork and photographs, and communicate messages and information that they wished to share to a broader audience. The interviews were not anonymous; the women were identified by their first names only. As such, the interviews are not used in the analyses as they could possibly link a woman's anonymous first interview with her non-anonymous second interview; rather, they were used to help communicate the research results to women who had experienced homelessness.

### **Professionals**

During their interviews, older women were asked about the programs and agencies in Ottawa that they found helpful. Based on their recommendations, as well as snowball referrals and recommendations from the professionals themselves, I interviewed sixteen (n=16) professionals working with and for older marginalized women, representing ten (n=10) service agencies in Ottawa. These interviews were conducted between December 2010 and March 2011. The

service agencies and programs represented include homeless shelters, supportive housing, recreation centres, francophone services, an Aboriginal service agency, health services, and support services for marginalized adults. The organizations included: The Aging in Place Program; Centre 454; Cornerstone Housing for Women; The Good Companions; Ottawa Inner City Health; Ottawa Innerscity Ministries; Ottawa Public Health (the public health branch of the City of Ottawa); The Shepherds of Good Hope; St. Joe's Women's Centre; Wabano Centre for Aboriginal Health; and The Well/La Source<sup>36</sup>. While this is not a census of community organizations, the participating organizations represent a broad cross-section of the services available to older women, including services that provide shelter (temporary and permanent), meals, recreation, physical and mental health services, peer support and material goods. In many instances, the missions and mandates of the services overlap, but together these organizations provide a broad range of services.

Participants from these agencies included a mix of front-line workers, managers, and administrators. In several instances, I conducted interviews with two individuals from the same agency who either worked with different clients or in different programs or branches (e.g., a front-line worker and an administrator) or had different job positions (e.g., a manager and a caseworker). Two participants had worked for less than two years in their positions, but most had spent many years working with marginalized women or older adults – sometimes spending more than 20 years in the field. The questions asked of workers focused on the workings of their organizations – including their roles, the programs and services the agency/organization

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<sup>36</sup> Of note, Shepherds of Good Hope includes many different programs, including Hope Outreach, a women's shelter; Brigid's Place, transitional housing for street-entrenched women; The Oaks, a supportive housing project for older adults; as well as several other supportive and supported living residences. Similarly, Cornerstone Housing for Women includes the women's shelter and three supportive housing buildings – McPhail House, 515 MacLaren and 314 Booth. Ottawa Inner City Health also operates in many facilities serving both men and women, including many of the Shepherds of Good Hope facilities; the Cornerstone buildings; The Mission; and the Salvation Army shelter, among others.

provided, codes of conduct/rules of stay for participants/residents, and service gaps that they identified. The interviews then moved on to discuss services available in the broader community in general – both services for women and for other groups, and also any gaps in these services that the workers or others had identified. In addition, I asked the participants for basic, non-identifying information about their clients and their clients' needs, including how clients learned about services and examples of the most common service needs; social perceptions and stigma; and social and public policy.

As many of the professionals I interviewed were acquaintances whom I had met either through my previous work at Cornerstone shelter or during the first stage of my research project, the majority were aware of my position as a student and a shelter staff member. As with the interviews with the women, this information was disclosed to participants if they indicated that I looked familiar or inquired about my background. The interview guide was also provided in advance to the organizations that requested it.

With this methodological and research design in mind, in the next chapter I turn to analyzing the narratives and responses of the older marginalized women and the workers that I interviewed. The following analyses highlight some of the key themes that emerged from the narratives. I use this information to explore the women's identities and their worlds, including their everyday lives, social networks, experiences of community life, and the physical and discursive world around them.

## Chapter V – Looking In: Identity

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## 5 Looking In: Identity

I just consider myself a sixty-five year old person who still feels like a twenty-five year old and doesn't know what to do about it. – Adele

Forty was good – the time of my life. I just enjoyed it every day. Since then it's just been living alone, being alone and then I'm stuck in – insulation too much. Like, *no life*. – Anna

As I have noted many times, my research focuses on women over the age of fifty who face marginalization, criminalization, and homelessness. I classified and identified older marginalized women with three criteria: potential participants had to be (a) women; (b) aged fifty or older; and (c) self-identify as marginalized, which in practice meant that they were residents of a homeless shelter or second stage housing and/or accessed services at one of the women's drop-in centres in Ottawa. Following these criteria made the process of identifying participants easy from my perspective as the researcher looking out at others; however, this same process of identification became extremely difficult for some participants when they were asked to identify themselves. This section explores older women's identities, first highlighting the role of mobilities and risk in identity, before moving to an examination of identity trajectories and sedimentation. Aging and its role in identity change follows. The final sections of the chapter explore how women manage identity changes, highlighting the role of resiliency as well as negative coping mechanisms such as addictions and depression.

### 5.1 *Identity Trajectories and Mobilities*

While some women confidently told me who they were, identity proved to be a challenging concept for many participants for several reasons. First, "identity" is not a singular, stable entity; rather, it is plural, dynamic and fragmented; these identities are also positional and sometimes conflicting or contradictory (Butler 1988, 1990; Calhoun 1994; Giddens 1991). Further, identities vary in importance over time and between settings (Manzo 2005; Moore 2000). Explaining identity was also difficult as many of the women were experiencing new states of being (e.g., homelessness, isolation), physiological changes (e.g., entering menopause), and

social changes that altered their identities and identity performatives and necessitated re-evaluations of *who* they were.<sup>37</sup> These processes are both a product of aging (cf. Berger 2006; Calasanti and Bowen 2006; Clarke 2001; Henwood 1993; Wahidin and Tate 2005) and of contemporary times (cf. Beck 1997; Garland 2001; Giddens 1991; Shilling 1993; Young 1999), yet they remain disconcerting to those experiencing the changes as they represent uncertainty relating to the self, and thus to one's world and worldview (Berger 2006; Giddens 1991). Finally, explaining identity was difficult due to its deeply personal, intimate nature. Though many women readily told me about marginalization or homelessness, the stigma they faced, their health conditions, or even personal relationships, many participants found it difficult to discuss their identities and identity performatives, or how they went about being in the world. For a marginalized woman, sharing *with a stranger* how she sees the world, feels about herself, and her goals, dreams and fears can be challenging and unsettling (cf. Gluck and Patai 1991). Despite this, most of the women did share these feelings with me and explained how they coped with changing identities.

All identities change to some extent through their performance; for some, however, identities remain relatively static while others experience frequent changes (Butler 1990). Identity change and transformation can be understood as a type of mobility: identity transformations involve the movement of *ideas, messages, and often bodies*. This is the case for those who physically relocate to a homeless shelter, a friend's home, or who begin 'rough sleeping'<sup>38</sup> after becoming homeless, for example. Similarly, identity changes may lead a woman to change *where* and

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<sup>37</sup> The nature of an identity change is not always what a person desires; some may wish to see changes in their lives and identities, while others are comfortable and content with their various identities, positions and life circumstances – *who* they are in general – and wish for these attributes, identities and statuses to remain relatively stable. However, just as with major events, such as the beginning or ending of a relationship, changes in identity are not necessarily something that can be predicted or avoided.

<sup>38</sup> Rough sleeping refers to sleeping outdoors in parks or alleyways, in abandoned buildings, or in other places that are not normally considered to be suitable for habitation.

*how* she moves; for example, she may no longer travel to a workplace if she becomes unemployed. Similarly, she may avoid a drop-in centre that she previously frequented if she is barred for breaking the rules or if she has a falling-out with other participants (Shilling 1993). She may also physically change *how* she moves as arthritis limits her ability to climb stairs or osteoporosis and the fear of broken bones prevent her from walking outdoors in the winter (Burnett and Lucas 2010). On a more positive note, a disability or her increasing age may qualify her for a subsidized transit pass or a mobility aid such as a walker, scooter, or wheelchair, allowing her to travel around her community with greater ease and thus broadening her world (Burnett and Lucas 2010; Larsen, Urry, and Axhausen 2006).

Aside from the *physical* and *corporeal* movements mentioned above, mobilities also implicate thoughts, ideas, and communications (Büscher and Urry 2009; Urry 2000, 2003). These latter movements affect how individuals perceive and understand the world and how they adapt to the various circumstance and challenges that they face. They also affect individual identity performatives: as identities are fluid and ever-changing (in minute or major ways) (Butler 1990; Jagger 2008), the performance is a message or communication that is transmitted to its audience via performatives. In addition to the original purpose of the interaction, one's performatives communicate *who* one is, *what* one believes and *how* one relates to the world. For example, a woman may visit a clinic to discuss a health matter; her visit and performative, however, also communicates messages about her gender, social position, class, and other signifiers of her identity. To understand identities and their transformations through mobilities, I first examine identities as performatives.

## **5.2 Static and Dynamic Identities**

Erving Goffman's exploration of self and identity included both a dramaturgic look at "identity performances" (1959) and also an examination of stigmatized identities (1963). In his latter

work, identities are portrayed as being relatively stable although potentially subject to upheaval if one gains a stigmatized status (e.g., comes into conflict with the law, becomes disabled, etc.) or if a latent stigma becomes known to others. This notion of such a single, relatively stable and enduring identity rang true for some participants. Dina, for example, noted “I’ve slowed down a lot. But I still feel seventeen years old in my heart.” Deborah echoed this sentiment:

I’m just shifting into second gear! You know what I mean? I’m just growing up. I missed a lot of life. I ain’t old! Seriously, I’m not going to let myself get old neither. No! No. [I’m] fifty five, and you know what? There’s no way I’m letting myself get old. I’m not ready for that shit yet. The only time you’re going to see me [age] is unless the cancer eats me, that’s about it. Other than that, I’m motivated.

Dina and Deborah’s experiences highlight individual resilience (cf. Bonanno 2004; Cyrulnik 2005); however, their stable performatives were anomalous within the sample. In contrast, the majority of the women experienced identity changes as upheavals – often, very significant ones.

As Judith Butler (1988, 1990, 1993a) argues, identity is not a stable commodity; rather, it is fluid and performed. Each identity performance is a repetition that emulates, without duplicating, an ‘ideal type’ or archetype. Just like repetitions of a dance routine, identity performances can and do shift over time and between repetitions; while similar, the performances are never identical. These changing performances allow for movement and transitions in one’s identity; however, performances are also *sedimented* and constrained through the process of repetition. To put these sedimentations in perspective, sedimented identity performances can be likened to dance recitals where the same routine is performed over and over with minute variations as the dancer changes her costume, changes venue, leaps higher, loses sync with her music, or has to rebalance herself. Here, the movements are routinized and the portrayal is sedimented. Many of the women’s identity performatives and performances remained fixed for long periods, accompanied by routinized mobilities that saw them frequent the same places and spaces; however, they also were subject to significant upheavals, movements, and moments of rupture

(cf. Foucault 1972). These changes often centred on major events or developments in the women's lives, especially surprising or unwanted changes.

Following through with Butler's (1990) metaphor of sedimentation, we turn briefly to the natural sciences. Here, sedimentation refers to how particles settle out of a fluid in which they were suspended. For example, if left undisturbed, muddy water will become clear as the soil suspended in it settles against a barrier – such as a dam in a river or the bottom of a container – burying or immobilizing objects against which it falls (Grotzinger et al. 2009). Dislodging items that become stuck in the sediment is not impossible; the items, however, can become extremely mired and may be difficult to dislodge. As such, they are *sedimented* in place. Returning to Butler (1990), despite constant opportunities for identity transformation, most individuals' identities are relatively stable from day to day. While these repetitions of idealized norms can be constraining<sup>39</sup>, not all experiences of sedimentation are negative. Sedimentation can be, and often is, experienced as comfortable, everyday, safe, or “normal.” This is especially the case in the context of a risk society, where deviations from ‘normal’ are seen as problematic (Adams 1997). Just as the soil settles out of the water, one's identity becomes normalized over time, as the individual forms bonds and associations – with people, toward work and other activities, and moves through certain places and spaces – that provide a sense of routine. Repetitions of identity that change this pattern are certainly possible, but not necessarily desired.

It is important to recognize the difference between *identity* and one's routines and daily life as these two things are connected but not synonymous. Examining identity leads to interrogations of *who* one is, while the latter category speaks to *what* they do. The two are interrelated;

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<sup>39</sup> This is especially the case for Butler's population of interest – the lesbian, gay, bisexual, transgendered and queer (LGBTQ) community, who, as Butler notes, often find identity categories to be inconsistent with their experiences and therefore incongruous, uncomfortable or worse (Butler 1990, 1993a, 1993b).

identities often incorporate aspects of day-to-day life, such as one's occupation, hobbies, family status or even where one lives (Moore 2000), but identities are not formed around the day of the week on which one does laundry or one's preferred breakfast cereal. These mundane parts of daily life, however, do help individuals to form a sense of self and constitute part of an identity performative, not because of what they are, but because of their repetitive and cumulative nature and the structure and routine they bring. While a woman might be "retired" or "disabled", for example, her daily activities – reading the newspaper, doing chores, shopping, cooking, meeting friends or visiting a drop-in centre – can offer a sense of purpose, reinforcing her identity as an "active" person. Routines provide stability, comfort, a sense of normalcy and predictability. As such, routines are considered important in aging in place<sup>40</sup> (Riche and Mackay 2009); happiness and normalcy in family relationships (Downs 2008; Rathunde and Csikszentmihalyi 1991); maintaining physical activity and ability (Galloway and Jokl 2000); and managing mood disorders (cf. Frank, Gonzalez, and Fagiolini 2006; Goodwin 2007). Jane explained the comfort offered by her routine:

J: I can't say I look, what you'd say, *forward* to anything. It's just one day at a time. Get through today and see what tomorrow brings. I can't say I basically look forward to anything. Every day is the same, for me it's the same routine.

L: What's that like?

J: Come here, poker once a month, euchre once a month, and I go to church on Sundays. ... It's the same routine. And actually that's the way I want it. I don't want any – if you offered me a trip, I'd go, "No, thank you." So I can't say I have anything to look forward to, it's just the same routine which I'm quite comfortable with. So no, I can't say I really, basically look forward to anything. No, don't look forward to anything, just go in a circle, that's all. One seven day circle.

For Jane, routines provide calm and order, but also offer a way to avoid *risk*. While she still navigates risk in relation to her physical health and unpredictable life events, the minimization of risk or uncertainty in her life allows her to maintain a sense of normalcy (Hunt 2003). Routines also provide Jane with roles and a positive self-identification: as a regular at the drop-in centre

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<sup>40</sup> Aging in place refers to programs and supports designed to assist adults to grow older in their own homes and delay or avoid institutionalization in nursing homes or long-term care facilities.

and her church, she can avoid loneliness, add structure to her days and use her participation in these activities as “identity pegs” – attributes and statuses around which she can form and perform identity (cf. Goffman 1963). With Jane’s and other sedimented identity performatives, however, change can occur and is a constant possibility.

## **Digging into the Sediment**

Returning once again to sedimentation, we know that moving sedimented objects is often difficult, but possible. The objects can be dislodged, but are now altered: they may be waterlogged, covered in algae, or eroded by the water’s current. The dislodgement also changes the surrounding water; the movement stirs the sediment, sending it swirling back through the water once again. In older women’s lives, the additive effects of physical, emotional, or situational changes can serve as ‘points of rupture’ (Foucault 1972) that stir the sediment of their lives. Such uprootings and upheavals highlight how navigating *risk* and *mobilities* have become central to many older women’s lives (Beck 1997; Hunt 2003). For the women, identity upheavals included experiencing physical or mental health issues; losing loved ones; losing employment; and losing housing. For many, arriving at a shelter or a drop-in was the result of a confluence of such events, as it was for Sherry. Over a span of 20 years, Sherry encountered multiple, competing challenges that rippled through her life:

I was in some vehicle accidents before that happened [having to quit work]. It changed my brain and my personality, and I think my mental capabilities. Because I’m not the same person I was before the three accidents. The other thing that happened from that time, after the vehicle accidents and working on computers... most of it was designed for the men so it was too big for me. I ended up getting arthritis, fibromyalgia, stuff like that, which I still have.

As with a newly acquired stigma (Goffman 1963), Sherry’s health issues affected her identity, routines and employment; her identity performatives changed as she could no longer perform within the discursive categories of work ability and able-bodiedness. Her health constrains her movements, limits her mobilities, and blocks her access to work (Speare, Avery, and Lawton 1991). On top of physical illness, her husband’s unstable mental health adds challenges:

I've got a really horrible home situation right now. My husband is mentally ill. And he gave notice to the landlord on our apartment for October 31<sup>st</sup><sup>41</sup>, so we have to be out by October 31st. He's planning to go live on the streets. And I love him so much but I don't know what to do. I've tried before and I've gone through this with him before many times and I don't know what to do. I really don't know what to do.

Here, risk and uncertainty overwhelm Sherry's day-to-day life, robbing her of any sense of stability or normalcy that she once enjoyed (Wilkinson 2001). Coupled with her limited mobilities and financial means, finding housing becomes an acute challenge. She continues:

[Husband] could be fine and then all of a sudden, like that [claps]. He'll turn in his notice. And usually I can talk him out of it. But this time, he didn't talk to me about it. He just turned it in to the landlord and got the official date and everything. He told me when I came home at the end of the day and I didn't believe him. He's done stuff like that before and it wasn't true, so I didn't believe him. I didn't believe it until the landlord put up a sign on the building saying, "Room to Rent" or "Unit to Rent" or something like that.

Sherry's situation exemplifies the transformations, mobilities and potential mobilities – *physical*, *spatial* and *discursive* – implicated in changing identity performatives. While insecurity and uncertainty are part of modern life, the extent to which Sherry's life is ruled by these forces is overwhelming. Despite the responsabilization inherent in risk discourses (Beck 1997, 1999; Hunt 2003), Sherry has few avenues available to mitigate or reduce her risks, short of divorcing her husband or winning a lottery. Sherry's story offers a dramatic example of how 'sedimentation' can be undone, the risks and vulnerabilities of older marginalized women, and of how quickly one's status as an *integrated* person can shift toward *vulnerability*, *isolation* or *disaffiliation* (Castel 1994, 1995a). Sherry's formerly "normal" everyday life is now hardly discernible, obscured by the rupture signified by her experiences.

Not all of the women interviewed had experienced such a severe string of diverse and life-altering events; many women's arrivals at shelters and drop-ins can be traced to single events, such as a falling out with family; a lost job; or a severe illness. This seemingly simplistic

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<sup>41</sup> Of note, Sherry's interview was conducted in early October, less than a month before she would lose her housing.

trajectory does not lessen the significance of these changes to the women. Just as with women experiencing prison for the first time (Aday and Krabill 2011; Wahidin 2004), for a woman who is new to homelessness or marginalization, going to a shelter is an assault on her identity and often a crossroads in her understandings of her life and herself. A worker at Hope Outreach illustrated how her clients may come to find themselves at the shelter:

I've had women here who've been 75, who've been in the community and who've been widowed or never been married. Went along very, very well in life until a certain – a medical condition – it could be a simple little thing like a UTI, a urinary infection. What ends up happening is that they end up deteriorating because there's no one; they're actually very, very isolated. We had one woman in particular; I had to go to her apartment. She was a hoarder. Her health was in very bad, bad condition. She had dementia. We thought, just from her – totally undernourished, absolutely. She was evicted from her apartment at Ottawa Housing. ... So the police bring her here. She comes in [to the shelter] with one little bag, no ID except for her little purse. ... This woman, it turns out, we thought she was younger, it turns out she's 78. We don't know anything about her ...

This example illustrates the steep and dramatic trajectory between *vulnerability* and *disaffiliation* (Castel 1994, 1995a). While the woman's situation was far from ideal – hoarding generally signals significant problems in one's life (Steketee and Frost 2003, 2007) – being physically relocated and removed from her daily routines is a major assault on her identity. These changes could also lead to declines in her health and functioning; familiarity and continuity are important for “healthy aging” and “aging in place” (Keating et al. 2005; Riche and Mackay 2009). While the fluidity of identity can be liberating as Butler shows vis-à-vis gender, it can also be deeply unsettling. As for the woman described above, change and transformation were not easy or welcome for most participants; sudden (often undesired) upheavals of identity alter the smooth course of the women's lives and leave them feeling lost, as Ashley explains:

How has [my identity] changed? *I'm just lost in life.* Here I am, 50 years old, and I'm moving back in with my Mom because I can't afford to live on my own. It's like I – I feel like a little kid again. I don't know; being kicked out of the house [by ex-partner] was one of the worst things I think that's ever happened to me. When I went out I had nowhere to go. Because I was determined I wasn't going back with my Mom, 'cause I was determined I wasn't going to tell her that I took sleeping pills and drank and that I was an alcoholic.

Ashley not only faces identity struggles, she also worries about being found out as a 'secret deviant' or stigmatized person (Becker 1963; Goffman 1963). For her, there are few positive elements around which one could attempt to reframe these events (cf. Cyrulnik 2007).

Kristin's experiences illustrate how women may resist changing their identity performatives and also resist the labels associated with homelessness and marginalization. She had been homeless before and arrived unexpectedly at a shelter after a falling out with a friend. Kristin reflected on the comforting power of her routine and how she struggled in its absence. For her, familiar surroundings, such as her neighbourhood away from the shelter, brought a sense of calm and helped her to maintain a sense of identity and continuity:

I had to go pick up some contacts, get my hair cut, stuff again that was around my area. But I also like being around that area, because I feel that that's my normal routine; it makes me feel better. It's kind of like, I tell myself, "It's okay, Kristin, be patient, hang on, because this is where you're going to be back." And then I come back here [to the shelter].

Kristin resisted the assaults on her identity by emulating elements of her previous routine and life; continuing in her routinized movements and identity performatives by frequenting the same places allowed her to view her dislocation as a temporary inconvenience instead of a true point of rupture (Cyrulnik 2005; Foucault 1972). Mirroring old routines did not necessarily make her shelter stay easier, but her activities provided her with hope of restoring normalcy. She likened her shelter routine to the coping mechanisms and resistance strategies she learned in jail:

But what I'm trying to do – I've been in jail before. The way to get through it with the minimum wear and tear is instead of saying, if I were at home right now what would I be doing? ... A friend of mine beside me who was a real old-timer, she'd been to jail, she said, "Don't do that, because you're going to be tearing your heart out." She said, "Focus on the here and now. Forget about home, this is where you are now. Get through this as it is now." So I'm trying to do that here. And one of the things that I find really helps, is I keep my nose in a book. So I'm reading this one book, and I've only read it three times in the last two months, or something. ... It's big, and it keeps my mind off, "Oh, I want to get out of here!" Yes, I want to get out of here, but I can't do that right now. So stick my head in – and some of the books are just hopeless, but that's fine, I'll just read them again. But that helps.

Kristin's prison-inspired coping technique allows her to view her shelter stay as temporary and transitory (Matthews 1999). For her, coming to the shelter was a "wake-up call" and an assault on her identity that transformed her, spatially and officially<sup>42</sup>, into a "homeless person." Indeed, Kristin employed a "technology of the self" (Foucault 1988a:18), using internalized discipline to regulate her days and maintain control over her identity.<sup>43</sup> Her 'discipline' involves identifying and following a coping strategy and routine; through this technique, she rejects the stigma and identity of homelessness (Figueira-McDonough and Sarri 2002; Goffman 1963). Instead of seeing herself as homeless, she indicated that she was in the process of getting out of the shelter and moving back into her community.

The processes of becoming marginalized or homeless are not the only factors that affect one's identity. Aging, the *temporal* movement through life, has significant effects on identity and may similarly instigate changes in a woman's previously sedimented and stable identity and life.

### **5.3 Aging Bodies and Uprooted Identities**

The events of aging – including changing family relationships, leaving the workforce, and declines in one's physical body – all implicate identity. These changes do not affect everyone in the same way, but they can and often do have significant effects on how older marginalized women are perceived by others. Laura Hurd Clarke (2001) notes that older women may feel young, yet their aging bodies lead others to see them as "old." These perceptions are tied to the physiological signifiers of aging bodies, such as wrinkled skin or greying hair. These signifiers are outwardly visible, but may also signal changes in how one's body *feels*. Simple activities, such as getting dressed, may become difficult as one's abilities decline. While this is a normal and natural process, it is often seen as a *deficiency* or a *risk to be managed*,

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<sup>42</sup> By coming to a shelter, an person is counted as being officially "homeless" in Ottawa's homelessness statistics. Of note, these statistics do not capture those who are technically homeless, but who stay with family or friends; sleep rough – outdoors, in vehicles, or in public spaces; or who otherwise avoid shelters.

<sup>43</sup> This is explained further in Section 5.4 – Navigations of Coping and Identity.

especially as the societal focus on youth, vitality, and sexuality amplifies the frustration, sadness, and resignation sometimes associated with aging (Clarke 2001; Clarke and Griffin 2007; Galloway and Jokl 2000; Shilling 1993).

When combined with marginalization, criminalization, poverty, and homelessness (Cohen 1999; Raphael 2004; Wahidin and Tate 2005), aging accelerates, amplifying its assaults on identity. As with the stirred sediment in the creek bed, the upheavals of aging and marginalization muddied the previously clear water, leaving the women to question who they are. This was especially true for women who were newly homeless and, after many struggles faced ruptures in their personal narratives and identity performatives. Bev explained how these changes affected her.

L: I'm also interested about your identity, or who you are –

B: I'm not sure who that is anymore.

L: No?

B: No. No, I've been going downhill since I hit fifty. I don't know why. Social skills – I've always had them – I'm good with the public in that sense because I've always worked with them, but as far as finding somebody to be with – not gonna happen. Not in this lifetime anyway. I don't – I don't know, I just don't feel useful anymore. I've been in so much pain since I turned fifty. It seems like my body is letting me know that it's eighty-five and breaking down. And I don't feel eighty-five, just in my body. In my mind, I'm still twenty-five and my body can't do it anymore, so. It's bad. They put me on anti-depressants because I wasn't feeling – I still don't feel useful.

The multiple upheavals and assaults on identity that Bev experienced left her with few social or personal referents by which to identify herself, showing how a fluid identity can be frightening, not liberating (Butler 1990). In addition, Bev's problems were medicalized when she sought help (Horwitz and Wakefield 2007). In short, her *need* for purpose in the face of major upheavals is transformed into a health problem, or *risk* contributing to the negative feelings she describes (cf. Hannah-Moffat 2001). Sherry's experience was similar; she noted how stress, marginalization, and limited resources altered her identity and her body:

Your body changes. Your energy level really, really drops. ... My energy level did change in my 40s. And remember too, I have fibromyalgia, so maybe for other women it's not as bad. And then I hit my 50s, right? Holy shit! [laughs] It's even worse. Oh yeah, it's hard. It's even worse. And it's my personal belief once again that it's one of those things that money would help. Money would really help, and I think people really underplay that. I think for people – if people don't have the money to go out and make their life easier and smoother to handle, then the community has to step forward and provide services. ... And when you think about it, our population – the largest group right now is the ones that's aging. They're the ones, like sometimes I'm wondering right now – do I have Alzheimer's? I don't know. Or is my memory problem something to do with senility? I don't know.

Age and poverty can have significant impacts on one's life and abilities, creating overarching and intersecting challenges (cf. Raphael 2004). While these intersectionalities have been discussed at length in women's studies literature (cf. Collins 1991; Crenshaw 1991; Mohanty 1997; Yuval-Davis 2006), they are relevant to women's experiences of aging. In addition to the intersections of racism, sexism and classism, the barriers are *corporeal* (arthritis, osteoporosis, physical decline etc.), *emotional* (depression, dementia, etc.), and *temporal*, reflecting changing abilities over time and through space. Sociological and feminist literature certainly discusses these barriers, notably able-ism (Flanagan and Davidson 2009; Goffman 1963) and ageism (Abu-Laban and McDaniel 2004; Shilling 1993). Mary highlights how these barriers converge, affecting how she is seen by others:

As far as my identity, I used to have a good reputation. I was always involved of my community. President and secretary of many boards of directors, and now I don't find I – I don't *fit* anywhere. I don't feel comfortable going to family gatherings because of my homelessness. My children are – I think ashamed. They don't come to see me here. So it's affected my family life. I don't work; I've been on CPP disability. I've tried working and I'm not a dependable employee. So you lose – like I lost my identity. I'm a mom, but I'm not. I don't see my grandchildren anymore. ... I'm struggling right now just trying to find where my identity is. Not being useful. Not using my brain. My body's shot, but my brain's still pretty good. So I don't feel like I have any peers either, particularly in this shelter.... I had the pension and all of that, then lost my home, lost my business, lost my family, lost, lost, lost.

Mary alludes to the physical changes associated with her health condition and aging and how these become *vulnerabilities* or *risks* for homelessness and marginalization (Beck 1997; Castel 1994). Furthermore, mother and grandmother labels are emotionally powerful (Mandell 2004a);

the inability to perform these roles is understandably distressing and represents a dramatic emotional shift in her sense of self and removes her from family-related identity performatives that are often considered essential to those who perform these roles. Mary explained further how contracting liver disease and the concomitant changes in her body have affected her life, emotions, and ultimately her identity:

I contracted hepatitis C ... Due to illness, I've sort of – my marriage broke up about seven years ago, and I – it's sort of been a slow downhill. ... I had surgery two years ago, so I moved in with a friend because I had difficulties recovering from the surgery ... I went into a deep, deep depression. I've been in quite a depression. I find myself still at a crossroads. ... I had a biopsy on my liver last October [2009] and I'm now in the early stages of stage four. If I don't get this treatment, I will go on to have liver failure and die. I've dealt with that because I've had this for fifteen years. ... So right now the doctors cannot treat me because I'm at a shelter. ... So the homelessness is affecting me on every level. Every level. I feel like I'm losing my mind.

Confronting death on a regular basis affects Mary's identity; her illness brings both urgency and fatalism to her movements and performatives; having a chronic and eventually terminal illness curtails her hopes and plans for the future. The experiences of Bev, Sherry and Mary highlight how women's physical and mental health issues can be amplified and exacerbated by aging, poverty and homelessness (Cameron 2010; Hurt 2007; Wasserman and Clair 2011).

Following through from the assaults on one's identities and abilities described above, women may also face reduced independence as their abilities change in older age. These changes are frustrating for women who were previously *caregivers* instead of being cared *for*, and also raise questions as to who will take on their caregiving burdens (Bezanson 2008; Calasanti and Bowen 2006). Often, declines in independence are linked to health conditions (Calasanti and Bowen 2006; Galloway and Jokl 2000; Raphael 2004). This linkage is particularly problematic for older marginalized women, who frequently have chronic illnesses (Aday and Krabill 2011; Baggett et al. 2010; Wahidin 2004; Washington 2005). France suffers from arthritis and

asthma, among other conditions. After spending many years caring for her husband, aging mother, and growing children, her health now limits her independence:

Besides my asthma, my asthma's gotten worse – that's another thing I have to deal with. I just go up the stairs and I'm out of breath. And then at home, doing cleaning in the house, it's a no-no. So what I do in the house is dusting. I do my laundry because I have my own machine. And now, the days are good to put your clothes on the clothesline, which I love to do, and it's too much back and forth, back and forth, so my husband does that for me. I think I lost a bit of independence to work in the house because of my arthritis and my back.

France's health conditions limit her abilities and mobilities, making her performative dependent on others. While her husband provides support, many of France's peers do not have a spouse or other person who can help them with day-to-day tasks. As such, their *needs* for assistance instead may be seen as *risks* in the context of independent living (Tulle and Mooney 2002).

Although some of the women highlighted declines in abilities or struggles with day-to-day life stemming from aging and changing health, these difficulties were not the same for all of the women surveyed. Some of the women experienced few negative effects of aging, yet found that the discourses and popular understandings of aging created negative environments. As Clarke (2001) indicated, discourses create stereotypes about older persons that often do not fit with their realities. Despite a disconnection between ageist stereotypes and personal experiences, popular discourses affect the women's lives and identities. Evelyn, who had stayed at shelters on and off for several years, indicated that ageist attitudes affect how she is treated by others and how she sees herself:

And a lot of the, them in here talk about their aching muscles and that kind of thing. I don't know why, but... that's part of it. So as you age, your skin ages a bit and it sags. So when you're happy sometimes people think you're not. So then they go by and say "ooh, you smell" or some of them do that here. ... That's one thing about the aging. Well, I don't know about, it changes as every year passes. When you get older, you lose your looks. You know, you have to accept these things.

Evelyn highlights the major role that appearance plays in women's lives as they age. While older men's appearances – including wrinkles and grey hair – are often considered to be

dignified, distinguished, or marks of earned seniority, the same is not true of older women (Abu-Laban and McDaniel 2004; Shilling 1993). Women are often judged harshly based on their looks; instead of being dignified, they are seen as being worn, haggard or just simply *old*. Anna illustrates how these discourses affect her:

I'm happy on the inside but I don't know about the outside. And I used to look in the mirror and say, oh, you're not so bad lookin' – fix yourself up. And now when I look, I go, oh, you're ugly and you're grey and you're stupid.

As she navigates her social world and struggles with bullying in the shelter, Anna's once positive self-image deserts her; she comes to see herself as “ugly” and “grey.” Although these self-evaluations highlight her current negative situation and experiences, they are telling of the normative discourses about aging women (Minkler and Estes 1991). These discourses have concrete consequences, ranging from Evelyn's resignation to “lose her looks” to the loss of self-confidence experienced by Anna, to the frustration and discrimination that Ashley faces:

Nothing gets easier. ... The older you get, for one thing, the harder it is to find a job because they just don't want to hire you. I've gone to interviews for different jobs – like one for Giant Tiger in the warehouse. They didn't hire me because of my age. They didn't think I could handle the work. She basically said right out that that was why. It's not easier when you get older; it's harder. Yeah. Do you ever figure out life like my Mom says? No, I don't think so. I try to sit and think about my future and where I'm going to be. I hope I'm going to be back with [boyfriend], but if I'm not, I don't know where the hell I'm going. I have no idea where I'm going or what I'm going to be doing. Life sucks. It really does.

Ashley considers herself to be relatively young and able bodied. She highlights how contemporary discourses and stereotypes about aging – about older adults and “happily ever after” love stories (Dillaway and Byrnes 2009) – do not fit with her experiences. For her, life does not have the fairy-tale, happily-ever-after ending of retirement, vacations, and life partners. Although her experiences are likely more realistic than the ideal types she describes, the juxtaposition between an idealized middle-class lifestyle and of “getting by” leaves her feeling uncomfortable and unhappy with aging, her identity, and this discursive dissonance.

Although many of the women shared negative experiences regarding aging, health and identity, these views were not universal. For some, aging was a positive and liberating experience. Indeed, in many cultures – including some First Nations and Asian cultures, aging is considered a rite of passage that garners a woman respect and deference (Donaldson 1996). Marie, a Cree woman, highlights both the pitfalls and positive aspects of her situation:

I'm just afraid someday I'll be sick. Oh my God, I don't have time for it. I don't like to be sick when I'm living alone. There's nobody to take care of you. My pride gets in the way, so when I'm sick I don't want to bother nobody. ... I wish somebody would come and make me soup. I wish somebody would go to the store and get me some ginger ale. But yeah, it always usually passes and I'm okay. I think I manage to take care of myself pretty well. So, I'm not going to lie down. Like I said, I don't feel like I'm 62 at all. I like it, 62, I like it. Yeah, I'm going to be 65 in three years; what will I be doing? I hope I feel like this when I'm 65.

Marie manages health and aging by focusing on her abilities and remaining as active as possible. For Marie, keeping a positive attitude toward aging is a key part of growing older and “aging successfully” (Holstein and Minkler 2003; Rowe and Kahn 1987, 1997). Marie was not alone in remaining positive and upbeat. Brenda, for one, indicated that while she was unsure about her future, aging was not the root of her challenges. For her, aging was:

Freeing. Absolutely freeing. ... I do find that it garners me a certain level of respect, being older. It gives me a licence to be incredibly playful. [laughs] No, truly, truly it does. I can walk up to a total stranger on the street and say, “You're incredibly hot. Don't suppose you've got an hour and a half to spare, do ya, hon?” And they just sort of go ha ha, whereas if you did that they'd probably be pretty worried. Oh my god, that young woman's after me – fuck! But yeah, and I certainly use it when I have to, sort of like, I changed your diapers missy, don't you be talkin' to your elders like that. It's very freeing being older. I just love it.

Brenda's performative of aging serves as a way to differentiate herself from others and also as a strategy of resistance to stereotypes about older adults. Through her verbal and physical performatives, she subverts discourses that place her on the margins of society and social spaces (Bosworth 1999; Kingfisher 1996; Shilling 1993; Tulle and Mooney 2002). These latter experiences speak to the range of tactics that the women employed for coping with aging, managing their social worlds and navigating their communities. Some methods of adaptation available to the women are explored next.

#### **5.4 Navigations of Coping and Identity**

While upheavals and altered identity performatives are difficult for some women to accept, these same changes prove to be very positive for others. How a woman perceives change – as either positive or negative – tends to be tied to how the change affects her day-to-day life, not only in terms of her material needs (e.g., food, clothing or shelter), but also in terms of her outlook on life. Boris Cyrulnik (2005, 2007) explains that how a woman understands and makes sense of life events – the stories that she tells herself about her life – can reinforce her attitudes, fostering resilience, despair, or anger. The ability to frame adversity as surmountable is a mark of resilience and can foster physiological benefits in health and functioning (Bluglass 2007; Hardy et al. 2004; Smith 2009; Stark-Wroblewski et al. 2008; Wells 2009). One's attitudes and ways of understanding develop in childhood but, like the human brain, show plasticity and adapt with a woman's changing outlook (Cyrulnik 2005).

Two study participants, Dina and Deborah, highlighted how resilience allowed them to thrive despite negative circumstances. Both women experienced multiple traumatic events at young ages, including family breakdown, homelessness, and institutionalization, yet these traumas have had limited negative effects on their outlooks. Their attitudes speak to the power of resilience (cf. Bonanno 2004; Cyrulnik 2005, 2007) and the ability to overcome hardship. For example, Deborah shared some of the negative experiences that shaped her life:

I've been on the streets since I was nine years old; this [transitional housing] is one of my first places ever. I went through 21 foster homes, being molested in 13. I went through the penitentiary when I was sixteen. I did 25 years in jail, off and on, off and on, off and on. Then I finally decided to try to slow down off the drugs, all right, because I've been a drug addict since I was nine, too. And I moved here, I was hoping I could get, open up and finally talk to someone. Because when I was growing up, people would never think you'd do something like that, because you're an upstanding citizen. Nobody would believe you were molested in a foster home. I wasn't running away for nothing, you know?

Although Deborah experienced abandonment, abuse, and criminalization, she still expresses hope for the future. Similarly, Dina left home at 14 and has lived in marginal circumstances ever since, including stints in youth correctional and mental health facilities. She reflects:

I'm on disability. I fell 23 feet and I fell 18 feet. I fell two different times. The first time I was, I was – when you're under 18 you're not legally allowed to be on the street, eh? ...I ended up in Montreal and the police caught me. They put me in a detention centre until they could take me to court .... I took some macramé string and I made a rope and I tried to escape out the window. And I slipped down the rope and landed on my butt, eh? I broke a couple vertebrates in my back. But they locked me up for the weekend and then they flew me back to BC. To my parents. And I have been in two or three provincial nuthouses for that, for being picked up by the police because I was too young. ...This was in the '60s, '70s - or '70s. But I'm an overcomer. I overcome most of my hardships. I'm not tied down by the hardships I face. I try to enjoy my life because you only live once.

According to the literature on resilience, their positive outlooks at this stage of their lives, being an “overcomer” in Dina’s words, reflect the coping strategies they developed as youth (Masten et al. 1999). The aftereffects of abuse and homelessness experienced in youth can echo through women’s lives, affecting them decades after the initial traumatic experiences (cf. McGowan et al. 2009). The women’s coping strategies – running away – shows *resilience*, but also *resistance* to the victimization that they experienced. While this strategy removed them from situations of harm, it did not provide a means to escape suffering. Dina and Deborah’s resilient performatives, however, helped them to cope with and overcome the ongoing homelessness and criminalization that they experienced (Bonanno 2004; DeMuth 2005; Eisold 2005; Hardy et al. 2004). These experiences undoubtedly shaped their life trajectories, but have also contributed to their resilience, positive outlooks, and stable senses of self.

For some of the women interviewed, aging brought major changes to their lives that taxed their personal stamina as well as their health and overall well-being. These changes included experiencing homelessness for the first time, losing close family or friends, developing physical or mental health problems, or several of these. Women whose life journeys included these

challenges, but who had also changed their attitudes or outlooks to cope with these events, however, frequently accepted their challenges and expressed optimism and hope about their lives and futures (Cyrulnik 2005). These women's experiences show evidence of changing and fluid identities – indeed, sometimes including significant traumas or points of rupture – yet they express the same sense of optimism about the future and resilience of spirit shown by Deborah and Dina. While Dina and Deborah found resilience early in life, for others, including Marie, resilience develops at an older age:

I found Minwaashin Lodge. That's when I started going to talking circles, you know, trying to – I didn't know I was carrying a lot of garbage with me from the way I was brought up and the residential schools. My mother was a residential school survivor, too. It was all like church, they taught us a lot about church and sins and heaven and hell and nuns. Oh my God, it was just so crazy. They almost ruined my life, those nuns, those missionaries. ...I'm still in my healing journey. I like my spirituality. I'm practicing all that again – I'm going to ceremonies, full moon ceremony, pipe ceremony, naming ceremonies.... And I go to sweats, too and all that. I just started that in 1998 or 1997. I like it. I like it a lot. Because I feel like I found a little bit of peace, love and happiness. When I was young, nobody showed me love and I didn't know how to show love.... I made myself sick working so I didn't have to think. Think about anything or, what do you call it? Coping. So I wouldn't have to deal with anything.

After being disconnected from her culture and heritage for most of her life, Marie has found her place in her culture and has begun to address the trauma she faced as a child in residential school<sup>44</sup> and in her adult life as the wife of an abusive and alcoholic husband, challenges faced by many First Nations women and men (Royal Commission on Aboriginal Peoples 1996). Now, her cultural connections enhance her resilience and confidence. Brenda also developed resilience as she aged. While she faced many challenges as a younger adult, a change to her attitude and outlook led her to describe herself as growing *younger* instead of older:

Age is a state of mind. I was so *old* back in [Southern Ontario]. I was unemployed. I couldn't get a job in my field ... I get out of university with my degree in my hand, very confident that I am going to build myself a new life after

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<sup>44</sup> Residential schools operated in Canada from the 19<sup>th</sup> century until 1996. The schools were designed to educate and assimilate children of First Nations, Inuit and Métis heritage, thus solving the government's "Indian problem." Instead, many students experienced abuse, the loss of their culture, and even death. The effects of these schools echo through First Nations communities to this day (Royal Commission on Aboriginal Peoples 1996).

my divorce, and Harris takes over. ... I ended up on social assistance, I was raising two small children, I was slightly overweight. I was not "fat" fat – I was probably 155 pounds, 160 pounds. But I was so old. *I was so old*. And I was looking – if I was looking on a dating site, I was looking for men who were sixty. Sixty or older. And it just, once I [moved] and got a job ... I lost ten years. In the first year, I was ten years younger. My daughter came to visit; she was looking through my wardrobe going, "Whoa, you never had cool clothes like this when you were living with us!" And I said, "That's because when I was living with your brother and you I was old and fat, and now I'm young and hot."

Brenda's description of feeling "old" highlights how one's perceived age often has little to do with one's chronological age, but is instead linked to one's outlook and abilities (Eisold 2005; Hardy et al. 2004). This mirrors the common mismatch between social perceptions of older adults and how they actually feel (Clarke 2001). As an older adult, Brenda describes the changes she has experienced as she ages, reflecting that they are "freeing." In many ways, she is indeed "free": she no longer faces the caring burdens of raising young children, the stigma of being a "welfare mom" or the struggles of trying to earn enough money to support her family (Bezanson 2008; Gavigan and Chunn 2007). As an older woman, she is able to instead pursue her own interests without the same level of responsibility for her children. Resilience may be developed early in life, or may be something toward which women's identity trajectories proceed. Resilience is not, however, part of all women's coping mechanisms and identity performatives. Other, less adaptive strategies also prevailed in the women's lives.

## **Negative Coping**

A large body of literature highlights the significance of resilience and learning how to manage negative life situations (Bonanno 2004; Cyrulnik 2005; Eisold 2005). As noted, resilience can be seen as a type of self-government, the product of a technology of the self that eases the challenges associated with aging and life's struggles. While resilience is seen as an ideal form of coping due to the positive physical and emotional benefits associated with it (Bonanno 2004), it is certainly not the only form of coping. The older women highlighted many different coping strategies, not all of which were positive. Coping mechanisms that are maladaptive, while

representing a *need* for assistance of some sort, may instead be seen as a *risk* for health problems or criminalization and lead to interventions by “experts” to “correct” the person and her behaviour (cf. Cohen 1985; Hannah-Moffat 2001). Many different negative coping mechanisms – such as addictions<sup>45</sup>, aggression and violence, running away or escapism, self-injury, and general depression and despair – can all meet women’s needs to “get by” or struggle through a situation (Kilty 2006, 2008, 2011). Of note, these strategies are not mutually exclusive; a woman may employ different coping strategies in different situations and at different times in her life. Next, I explore addictions and despair in detail; along with resilience, participants overwhelmingly highlighted these strategies as techniques for coping with adversity. It should also be noted that most of the women recognized that these behaviours were both maladaptive and dangerous to their health.

Many of the women in the study indicated that they currently or previously struggled with addictions, including gambling and using substances such as alcohol, street drugs, and prescription or over-the-counter medication. Addictions can have severe and negative short- and long-term effects on the body, but they may also represent a coping strategy and a performative that focuses on survival and pain avoidance. Addictions are often a way to cope with traumatic events as they numb (physical and emotional) pain (Dell, Fillmore, and Kilty 2009; Maté 2008; McNaughton 2008; O’Connell et al. 2007; Sutherland et al. 2009). Similarly, Charles Karelis (2009) argues that for those with few resources or ways of escaping negative situations, addictions and negative behaviours provide short-term relief to problems that seem insurmountable. Brenda, who had not experienced addictions herself, explains Karelis’s theory:

You know, I never understood why one would rather hit a pipe than hit the road.  
... But then I was trying to get a ticket to Ottawa when I was in Halifax and I had  
a potential job interview here, and I could not find a resource that would come up

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<sup>45</sup> While the term ‘addiction’ implies an illness, not simply drug use, and is thus value-laden, I use the term as it is one that many of the older women used to describe their relationships with alcohol and drugs.

with the money for a ticket for me, the \$150. And by the time I found a resource, the job was gone. The job had already left. *But the frustration of trying to be gone, trying to be out of there, just sort of gave me an understanding of why a twenty-dollar, twenty minute escape might seem like the right thing to do for somebody. You know, this whole – once I reached the point where I was finally destitute – as destitute as anybody else that's living in the shelter with me, then I started understanding the frustrations at a different level than I understood them before* (emphasis added).

Addictions served this purpose for many participants, offering a temporary escape from a difficult reality. Brenda's frustration pales in comparison to the much more severe circumstances from which some women wished to escape. Savannah explains:

My father was an alcoholic. ... My Dad's side is all alcoholics. I'm an alcoholic and my sister's an alcoholic. My dad was very abusive to my mother and my mother's a saint. We moved around a lot, from city to city so we never really had a home. We never really settled down until I was 13 and we moved to Northern Manitoba. There was also sexual abuse and stuff. I started drinking, I think, when I was in grade 5. We'd steal the liquor from our parents when it was Christmas or any holiday. I really started into the drinking when I was 16. We used to get our money together and get someone older to buy our booze. Smoked my first – smoked pot the first time when I was 16 and didn't really like it. ... Got into cocaine when I was 28, banging cocaine. I was able to stop it for a while, like I'd go eight years without doing it.

For Savannah, addictions have helped her to live through multiple traumatic experiences (Maté 2008). Despite her reliance on addiction to struggle through life events, she recognizes the negative effects of alcohol and drugs on her mind and body. She, and many of the other participants with addictions, recognized that their addictions were often one of the key drivers behind their homelessness and criminalization. She continued:

Four of us got arrested for trafficking and possession [of crack]. Went to – John Howard got me out. Of course, Savannah went on a drinking binge again. So I had a warrant for my arrest; they caught up with me. ... But they went and put an alcohol order on me and I'm a chronic alcoholic. Plus my boyfriend lived in Vanier, and that's my red zone. So every time I got caught – I always used to blame him, because when he would drink, he wouldn't take his meds. He'd start yelling and screaming and stuff until they finally realized, 'Well, Savannah, you're going to Vanier – you're not supposed to be there. You're drinking – you're not supposed to be drinking.' So I'd be out of Innes [Road Jail] for three days, go back for another 28. Out four days, go back for another 28; out two days, go back for another 28. And, which I didn't know that I could have talked to the judge and said, "Look, I'm a chronic alcoholic, you put a no alcohol on me; I'm going to be in jail" and that's exactly what happened.

Addictions can be central to a cyclical pattern of poverty, criminalization, and homelessness (Comack 1996; Maidment 2006). Savannah's account highlights how addiction can ensnare women in "the system," oscillating between jail and homelessness, all the while causing harm to themselves. It should be noted that alcohol and drugs offer a means of coping with jail and homelessness; as few alternatives exist, the temporary comfort of drugs and substances help to mask the pain of these experiences (Karelis 2009; Kilty 2008; Maté 2008).

The stressors of marginalization and homelessness provide many reasons for a person to seek out comfort in the form of substance use – shelters are generally stressful and sometimes dangerous environments that are not conducive to healthy living (Brassard and Cousineau 2000; Deward and Moe 2010; Barge and Norr 1991). Interestingly, homelessness and shelter life can unlock women's understandings of their addictions. Homelessness can be seen as the "rock bottom" from which women can find pathways to recovery (MacKnee and Mervyn 2002). At this low point, and with readily available resources, some women start along pathways to recovery. Ashley reflected on the insight into her own addictions that she had gained while staying at the shelter and working with the addictions worker:

[Addictions worker]? Oh God, she's great. I mean, she actually made me realize – because it wasn't just alcohol I was addicted to; I'm more addicted to pills. ... Sleeping pills, prescription sleeping pills, Tylenol 1 and any kind of night-time medication - anything to bring me down. I've been on them since I was sexually abused and I've been taking them ever since. She actually made me realize that I was taking them to suppress my feelings. ... I would tell myself and my doctor that I can't sleep; I couldn't sleep without taking them. But since I've been living here and kinda sorta forced not to take them, I'm kind of surprised at how good I can sleep without them. I'm now sleeping dead to the world. They come and unlock the door at one in the morning to do bed checks; I don't even hear them! Whereas before, a pin hitting the floor would wake me up; now I sleep dead. Now that I'm not taking any pills.

Just as in the prison, the relatively easy access to services in shelters – from food to healthcare – can offer a net benefit to the women (Robert et al. 2007). Ashley was not the only person for whom the shelter became a place of reflection. Kristin, also a recovering alcoholic, noted that

her drinking was the key reason behind her shelter stay. She rationalized homelessness as a way to remind herself of her goals:

I kind of needed a wake-up call, that no matter what kind of emotional things I've got, I've got to keep things going. I'm a recovering alcoholic, and that's been – basically for the last ten years or so that's been a challenge. ... I've spent a lot of time trying to get some kind of recovery program going for me. So I've worked less to try to get my recovery feet under me. I knew initially, in 2004, I knew at that point that it wasn't the time for me to return to work. I just had enough trying to figure out how can I make the AA program work for me? Learn the literature and all that. Because it's a lot, a big lifestyle change.

While Kristin is committed to recovery, she notes that addressing her addictions requires significant lifestyle modification and effort: to be successful, she needs to employ technologies of the self (Foucault 1988a), such as following the Alcoholics Anonymous program (cf. Valverde 1998), to understand her addiction and adopt healthier, more adaptive identity performatives.

In addition to addictions, most of the women indicated that they were depressed or had lived with depression in the past. Depression was often related to the upheavals and assaults on identity discussed above – aging; physical or mental health issues; relationship breakdown; disability; and experiencing marginalization or homelessness. Depression and despair were mechanisms of anti-coping; many of the women indicated that depression prevented them from improving their lives and seeking help, essentially sedimenting them into identities, identity performances, and lives that they disliked (Boyens 2003; Cameron 2010). These reflections are supported by medical literature that indicates negative emotions impact *body* and *mind* (MacHale 2002; Rodin and Voshart 1986; Wulsin, Vaillant, and Wells 1999). Mary, who was once very outgoing, found that depression prevented her from reaching out to others:

There's a lot of things I'm thinking about getting involved in, but I think the depression has just got me stymied right now. So my routine is not much of a routine at all right now. It's just surviving and trying not to go crazy and trying not to get too depressed. The sun is shining today, so thank you, Lord!

Depression affected not only the women's mental health, but also their bodies. These corporeal changes included frequent minor health concerns, prolonged illnesses and even significant

physical pain. While some of these issues could also be attributed to the women's aging bodies and lifestyles, depression can certainly amplify these symptoms (MacHale 2002). Anna found that depression exacerbated her other health conditions, including a heart problem:

I don't know how to start it because there's so many angles. It's been tough. Really tough, yeah. And lonely. ... And I just came out of the Heart Institute three days ago. Because of the stress, yeah. Because I don't know where to go or nothing, so I'm just trying to get over this too, now so I'm just starting to get dressed and walk around, you know. But um, I don't know. I feel very, very, very, very alone.

In light of her depression, Anna's sense of self and her identity performatives were narrowed and constrained. In her case, depression amplified her other health concerns. Anna's experiences lend support to research findings that depression decreases individual health and also the body's ability to fight disease and recover from illness. MacHale (2002) and Hippisley-Cox et al. (2001) note that patients with chronic diseases such as diabetes and heart disease are at increased risk for depression. They also indicate that these same patients have greater rates of mortality – an ongoing preoccupation for several of the women interviewed.

Depression is linked to increased mortality in patients with physical illnesses such as heart disease, but also may be linked to mortality through increased rates of suicide (Wulsin et al. 1999). Unfortunately, suicide may be seen as an option to women who face multiple barriers in the community, including physical and mental health issues, poverty, and limited opportunities, and who have few avenues to improve their situations. While youth suicides have received heavy attention over the past few years, the highest rates of suicide occur among older adults (Bartels et al. 2002; Turvey et al. 2002). Catherine spent many years struggling with alcoholism, depression and mental health distress. She indicated that, although she tries to cope, her depression can become very severe and life-threatening. She explained that, in the past, when she has felt upset or stressed:

I'd go take a drink and that didn't help, so I'd be suicidal. I said [to doctor], "I'm on the fourteenth floor. My son's afraid, he's put up chicken wire and they've put on awnings so you don't really see that." That's not the really the way I think I want to go; maybe some pills or something. I did try to commit suicide back in Montreal a few years ago with a bottle of Ativan. I woke up a couple of days later, so I didn't die. I've had a lot of unravelling, so I'm on a lot of antidepressants.

Catherine uses the phrase "unravelling" to describe how her mental health temporally deteriorated. While Catherine now has a better handle on her moods, her experiences are far from isolated. Ekatarina also described the cumulative nature of life events; she found that coping became harder as she aged:

It's hard to relive experiences. Because when you put them in the back, it's like they don't exist. Sometimes they – they kind of pop up there. I never had that problem before. I guess when you get older, it's harder to keep them at bay. They sort of – it's like a concrete wall: if it's not sealed from the outside, it seeps through. That's what I feel like. Like an old concrete wall that's absorbing like a sponge. Before I could talk and it wouldn't have brought any emotions, but I find now that I'm older, it's hard to control the emotions. It seems to go right down. It penetrates right to the root, to the source. That I find hard.

For older marginalized women, negative coping mechanisms have a cumulative effect, slowly taking a toll on the women's *bodies*, *minds* and *identities*. As such, their identities and identity performatives are compromised; the women may have previously performed their identities in a routinized way – similar to a dancer following a pre-set routine – but now find that their scripts have deserted them. In light of aging, homelessness and marginalization, they have had to redefine themselves, once again finding the answers to questions about *who* they are, *how* they understand the world, and also *how* they perform their identities and negotiate life. Older marginalized women are, by definition, marginalized and isolated. While they may not be, or consider themselves to be, *of* the community, they still reside *in* it. The following chapter explores the women's social networks (or lack thereof) and their social experiences in the community.

# Chapter VI – Reaching Out: Social Networks

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## 6 Reaching Out: Social Networks

I like to go out, I like to smoke pot, I like people. Like, I like spending time with friends. Because to me my friends are my jewels; they're my treasure. They're worth more than gold or silver to me; they're my treasures. – Dina

My youngest daughter, she's schizophrenic. She was pregnant; she said, "Mommy, when you move back you're going to stay with me, right? Come help me." ... So I said, okay I'm going to go stay with [daughter] and help her out with her pregnancy – the one that's schizophrenic. And it ended up, she didn't tell me she wasn't taking her medication, and she kicked me out – *in a blizzard* – with no coat, nothing. – Maggie

Daily life is not simply a reflection of one's identity, statuses, physical body or activities; the outside world in which the person is situated – and to which she contributes through her engagement – is also important and significant. In particular, relationships, connections and social networks – together, social capital – form an important part of a person's day-to-day life (cf. Bourdieu and Wacquant 1992; Coleman 1990; Putnam 2000). In this chapter, I investigate older women's social networks, their composition, and their value to the women. The chapter begins with a discussion of social capital, followed by an examination of women's family ties, or lack thereof. An analysis of their communities follows, including an exploration of the role of community for leisure and as a surrogate family. The chapter concludes with a discussion of the role of community organizations in the women's social networks.

### 6.1 *The Value of Networks: Social Capital*

While definitions of social capital vary, they uniformly refer to the tangible value of social networks or structures that accrues to the individual members of these networks. These social networks may provide close camaraderie, friendship and support, and also connections to resources and assistance. In criminology, social capital's value is often noted in ex-prisoners' reintegration efforts, namely, finding employment and filling leisure time (Farrall 2004; Reisig et al. 2002). It is also explored through its negative side: social capital can reinforce negative connections (e.g., gangs) as well as positive ones and can be employed by communities to turn criminalized individuals into scapegoats for local problems, blaming them for community unrest,

frequent police surveillance, or any happenings that are considered 'out of the ordinary' (Brody and Lovrich 2002; Burchfield and Mingus 2008; Daly and Silver 2008; Putnam 2000; Uggen et al. 2004). While its usage in criminology is often circumscribed to deviant networks and ostracism, social capital has a broader role.

Social capital can also be examined in terms of movement and mobilities. Here, the person may remain stationary, but a movement or interchange – of talk, discourse, ideas and/or tangible goods – takes place as she interacts with her network. For example, a woman may phone a friend because she feels lonely and in turn may receive compassion, support and possibly a visit. She might also be able to use her network to learn of programs or services in the community that may be useful to her. A manager at the Wabano Centre for Aboriginal Health noted the prevalence and entrenchment of this type of communication in the Aboriginal community, "If you're part of the Aboriginal community, it's basically word of mouth. They call it the moccasin telegraph." This type of network is also common among the homeless, as a manager at Ottawa Innercity Ministries indicated: "Often it's word of mouth. The street community is very much about information sharing; it's a part of their survival culture. The culture of survival." For those whose networks are based on enhancing their chances of survival, social capital provides access to important resources and information that can make life more comfortable, positive, and indeed, more *liveable*. Returning to the notion of movement, marginalized women's networks may enable movement: a marginalized woman may use her connection with a caseworker or a drop-in centre to receive bus tickets, a ride from the "Sal Van"<sup>46</sup> or, in some cases, accompaniment to an appointment. The flip side to this coin is, of course, that those who lack these networks may not gain their benefits. For many older marginalized women who are shut-in or who do not have a connection to others or to

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<sup>46</sup> The "Sal Van" is a street outreach van operated by the Salvation Army. It operates daily, offering homeless individuals free transportation to shelters and service organizations.

community services, there may be no one upon whom they can rely for assistance – who can offer information on available services, a ride to an appointment, or simply a regular visit. The benefits of social networks are not limited to service access: having social networks can provide significant benefits throughout the life course.

Research on social capital documents the positive effects of social networks for older adults – from access to assistance when needed, to maintaining one’s abilities and physical and mental health (Cattan et al. 2005; Keating et al. 2005). In short, being socially connected carries physical, mental and emotional benefits. These benefits, however, are not evenly distributed; they favour those who are more affluent and educated and also can place extra demands on network members, especially women (Bezanson 2008; Calasanti and Bowen 2006). While social networks are not uniformly positive, the effects of their absence are also marked. Many older marginalized and criminalized women have limited ties to their communities and families, creating challenges in their day-to-day lives (Maidment 2006; Richie 2001; Shantz 2008). After describing an incident at a drop-in that had upset and offended her, Jane noted the effects of social isolation on her personality and physical abilities:

As you get older, you change. And younger people just don’t understand how you can change mentally. If you have a family, no. Because you’ve got your family, you’ve got people around. But when you’re by yourself, you feel more aches, things get to you just a little bit more when you don’t have a family because of that. And that’s what they don’t stop to think about down there. Because a lot of us, quite a few actually, when we leave here, we go home alone and we don’t see anyone until we come here. ... That’s what I’m finding now as I’m getting older. Like I’m wearing out. [Staff] said, “Well, you’re not getting any younger, you’re getting old yourself.” And she’s right. You can tell the difference. ... It makes a difference that way. ... When I leave the front doors, that’s it. I don’t like talking to anybody else or anything. I just come here and that’s it.

Isolation has made Jane “wear out,” become more sensitive physically and emotionally, and generally slow down. Anna had similar experiences of isolation, both in the shelter and in her life before becoming homeless:

If you want to talk to someone, they're busy. They'll say, "Talk to you later." So I just let it be and then I don't bother no more. I don't like bothering people, but it sure helps when you can talk to somebody that – not relates, but listens and maybe gives you an answer. ... I'm too lonely [to socialize]. I don't. Well, in here I have nothing. I'm too discouraged. But living alone was the same after I couldn't do too much because of my knee and my back, it gets you into a slump where you just hit the couch and say okay, I'll do it later – do it later. And you're just sitting there, sittin' and thinking, *this is not life*. Because the other life I had was working, come home, dancing with my girlfriends, you know, play a bit of soccer. Take care of yourself more. But not now. There's too much time on my hands.

Loneliness is linked to isolation and often has negative consequences, as evidenced by Anna and Jane's experiences (Dykstra 2009; Hawkey et al. 2006). Although strong social networks can combat loneliness, these networks are far from guaranteed for older marginalized women, who often have limited networks. Their narrow social worlds do not have a single root cause, but may have their origins in personal and family troubles, the stigma of being marginalized or homeless, or physical distance from one's support networks. Family connections are the most significant ties for many people, especially the marginalized and criminalized (cf. Farrall 2004; Keating et al. 2005; Reisig et al. 2002); however, family is not always a reliable source of support for older marginalized women.

## **6.2 Family Ties**

Most of the women living in homeless shelters noted that most of their relationships with their families were strained or non-existent, similar to the findings for criminalized women (Comack 1996; Maidment 2006; Richie 2001). The women cited a variety of reasons for these strained relationships, including physical isolation, past conflicts or events, the negative effects of their lifestyles or behaviours, and in many cases, the stigma, shame, and embarrassment associated with being homeless. Erving Goffman, in his exploration and definition of stigma, writes:

...[A]n individual who might have been received easily in ordinary social intercourse possess a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated (Goffman 1963:5)

Homelessness creates such a “differentness” for older women. Homelessness, especially for those who are relatively new to this state of being, can be extremely humiliating; it was considered by many to be stigmatizing – connoting loss and failure, even though not everyone considers it to be a stigmatizing attribute (Phelan et al. 1997). Generally, as older women are not considered likely candidates for marginalization, criminalization, and homelessness (cf. Codd 1998; Kisor and Kendal-Wilson 2002; Wahidin 2004; Washington 2005), acknowledging their homelessness disrupts social expectations. These feelings create a sense of shame – as Lewis (1998:126) explains: “an intense negative emotion having to do with the self in relation to standards, responsibility, and such attributions as global self-failure.” As common discursive conceptions of “responsibility” generally refer to individuals who actively self-govern and manage their own risks with minimal state involvement (Ericson and Doyle 2003; Foucault 1988a, 1991; Garland 2001; Hunt 2003), homelessness is extremely incongruous with this conception. Indeed, homelessness is often seen as a personal failing and can be tied to feelings of failure or self-blame (Gilbert and Andrews 1998; Liu et al. 2009; Nemiroff, Aubry, and Klodawsky 2011; Phelan et al. 1997). Lewis further argues that shame “is elicited when one experiences failure relative to a standard (one’s own or other people’s), feels responsible for the failure, and believes that the failure reflects a *damaged self*” (Lewis 1998:126, emphasis added). Conceptions of the damaged or stigmatized self – or of a “spoiled identity” in Goffman’s words – can lead feelings of shame (Goffman 1963). In the women’s interactions with their families, not only are social norms broken, but so too are archetypal constructions of “mother”, “grandmother” and other normative female roles. Kristin illustrates how shame and embarrassment led her to minimize contact with her sisters and mother. For Kristin, isolation is a strategy to manage the emotions stirred up by family contact:

Right now, I’m really not in contact with a lot of my family members. There are a couple of them that I planned on, but it was a matter of – I didn’t want to put something emotional on my plate. You know, where maybe they were giving me

a hard time about why they hadn't heard from me in a while. I didn't want to put something like that on my plate....

In Kristin's case, the lack of family contact is a personal choice. She effectively divides her social world (cf. Goffman 1963; Hannem and Bruckert 2012), leaving her family in the out-group of those who are unaware of her homelessness and the stigma attached to it. This allows her to erect a barrier to shield her from negative treatment and stigma, protecting her – at least temporarily – from potential negative treatment from her family. Mary indicated that she had experienced the shame Kristin feared:

I used to have a good reputation. I was always involved in my community. President and secretary of many boards of directors, and now I don't find I – I don't fit anywhere. I don't feel comfortable going to family gatherings because of my homelessness. My children are – I think ashamed. They don't come to see me here. So it's affected my family life.

Mary explains that her embarrassment and shame are shared by her children, just as prisoners' families share the shame of the prisoner (Hannem 2012a; M. Lewis 1998; Uggen et al. 2004). Her changing familial relationships are part of a broader process of identity negotiation. She finds that her previous identities – those linked to her former community activities and family relationships – no longer reflect her reality and necessitate a reconfiguring of her identity.

Danielle did not express embarrassment or shame about her situation, yet the stigma of her mental health disorder and homelessness limited her relationship with her family. When asked how her family figures into her life, she responded:

Right now they don't. No, they don't. They told me I was no good. ... Because I have bipolar they think I'm stupid, think I'm a retard. They have nothing to do with me at all. Period. Even a dot on the wall would not change their minds. And I just found out in 2002 that I have bipolar. I'm normal. So what? I cry. Big deal. I don't harm anybody. I'm stabilized, instead of me being down all the time, and that's why I said, my family – they don't care.

Danielle's experience illustrates how a stigmatizing status – whether justified or not – can make an indelible impression on others, including those whom one would otherwise expect to be among the most supportive and positive influences in one's life (Major and O'Brien 2005).

Danielle's story demonstrates Goffman's assertions that as others learn of one's stigmatizing

attribute – such as a mental health diagnosis – they will come to treat the stigmatized person as different, deficient, or as having a “spoiled identity.”

Stigma based on an individual attribute is not the only reason for a lack of family contact. For others, including Sara and Adele, the lack of contact with family is connected to trauma and events in the past. These events, in many cases, prompted the involvement of agencies of social control; for example, Sara’s former boyfriend sexually abused her children, resulting in their removal by child welfare services. These types of interventions are certainly stigmatizing, but also have consequences beyond simply labelling an individual or reducing her social status. The interventions often ensure continued and ongoing contact with these institutional authorities, either through periodic evaluations, or through “referral” to other agencies, and therefore being drawn further into the web of social control through the involvement of additional authorities and agencies, such as the police or probation officers (cf. Cohen 1985; Comack 1996; Maidment 2006). In addition, they may also lead to the disintegration of once-strong networks and bonds as the actors involved in the situations attempt to insulate themselves from further trauma (Cyrulnik 2005, 2007). Sara’s situation fits within this framework; her connection with child welfare authorities escalated to police involvement as her addictions became apparent. She was also placed on a community treatment order,<sup>47</sup> by which she can be apprehended or involuntarily hospitalized if she does not submit to taking her psychiatric medication. This web of state involvement limited both her ties to family and her autonomy. Although she lost contact with her children many years ago, Sara desperately wished to

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<sup>47</sup> Community Treatment Orders (CTOs) are used to enforce compliance with medication for individuals with histories of psychiatric hospitalization and who often do not take the medication prescribed to them. Individuals may be placed under a CTO to secure their release from a psychiatric facility, or as part of a community treatment plan (MOHLTC Ontario 2009). Individuals who breach their CTOs may be returned to psychiatric hospitalization or face other consequences, depending on the individual case.

reconnect with her daughter and regain part of the life she feels she lost. However, contact with her daughter has not grown since a chance encounter several months before the interview:

I met my daughter at BeaverTails. So I'm hoping if I go there every day, I'm hoping to see her again. So I go to BeaverTails and hang out there for a while hoping to see her again. That's where I met her, eh? She was with my granddaughter. ... Oh, we cried. We hugged and we cried. She won't give me her address or her phone number yet. She blames me for what happened. That's a lot of burden on me. She blamed me for it, but I'm not to blame for that. I was completely taken by the answers [ex-boyfriend] used to say.

While Sara's hopes for reconnection are at best overly optimistic and likely unrealistic, the yearning to reconnect and bury past pain and guilt was a common theme for the women, and for many older marginalized and criminalized women (Maidment 2006; Richie 2001). Adele also noted that her children blame her for events in the past.

... my husband started smoking crack and I decided, well, this isn't for me and it's not for my children so I left my children with him and here I am now. Sad. So many years later and my daughter feels that I abandoned her and she feels slighted or whatever. And it's lost time between my children and I and I feel shattered, you know, 'cause I'm sixty-five years old.

Re-establishing family relationships is something that some of the women, including Sara, actively attempted. Most respondents, however, were not making attempts to reconnect, often citing past incidents or personal trauma as reasons for not reaching out. As with Kristin, who decided to limit contact with her family, many other women cite a lack of familial contact as a coping strategy and a way to escape the negative effects – including shame, anger, and ongoing emotional pain – of past traumatic events (Cyrulnik 2005; van der Kolk et al. 1996, 2006). While the participants all had very different life experiences, past trauma and abuse were common. As such, strategies such as self-isolation were cited by several women as mechanisms for coping with past abuse. Sherry, for one, was sexually abused by her father as a child. She did not remember the event until adulthood, but explained how her memories of this experience led her to cut ties with her family:

I moved, I changed my phone number and didn't give it to [father]. I gave it to my other family members, and told them – I said, you know, I didn't go into details, but I said, "I didn't expect you to have any comment, but he sexually abused me

as a child. I don't want him having any more contact with me; I don't want to have any more contact with him. ... I want contact with you, but I want nothing to do with him." And my sister ... she was the worst one to deal with over that. She kept pushing me to have contact with him when I said no. I think it was her that finally gave him my phone number, because he started phoning me. So I changed my phone number again, and told them I had moved, then had no more contact with *any* family member after that. Just cut them off.

Pain, stigma and the fear of further rejection led many of the participants to minimize their connections with their families. While some of the women wish to re-establish contact, they often face significant barriers to doing so. These barriers range from dealing with the aftereffects of trauma – including fear, shame and anger – at an individual level (van der Kolk et al. 2006), as well as practical roadblocks, such as not having the resources – financial or ability-wise – to locate family members, or to contact or meet them if they are found. Indeed, some women may find that their family members have died, eliminating the possibility of reconnection or reconciliation. Preparing oneself for a potential reconnection is also difficult due to the limited access to counselling, therapy, and other supports at the community level, especially for marginalized women who have little, if any, ability to pay for these services.

While the loss of family connections was a common thread throughout the interviews, many of the women surveyed retained bonds to one or sometimes two close family members; these were often their siblings, aging parents, or children. For many of the women, the family members who maintained contact were also marginalized, just like the women, suggesting that, as Goffman (1963) notes, individuals with the same stigmatizing attributes can receive support without judgment from their similarly-situated peers. In the absence of other family connections, these bonds become especially meaningful and central to the women's lives (Nemiroff et al. 2011). Lacey, for example, has a close bond with her daughter, who has also experienced homelessness:

My daughter is the most.... I need her, I need her – I can't live without her. It's just that she's her. She's her – she's [Daughter]. She's the best thing God ever

put on the planet. Even if she wasn't mine I'd still think that. She's just incredible – incredible. ... She's my only daughter; we can sit and do our nails together. Do our fingernails and toenails.

As for the rest of her family, however, she remarked, "They choose not to be in my life." As she and her daughter share the stigma of homelessness, they formed a close bond that provides mutual support and also insulation and protection from the negative treatment they may receive from other family members. Of note, Lacey also struggles with addictions, which often changes individual behaviour and can have negative effects on one's relationships (cf. Maté 2008), further limiting her chances of familial reconciliation. An Ottawa Inner City Health (OICH) nurse commented that connections to family wax and wane over time and are often linked to a client's current condition. Probing clients' support networks is part of the agency's intake process, and it often uncovers few connections:

In our intake, we would ask, do you have anyone you can talk to? Who would you go to? What's an emergency contact? Who would you want us to call? And there are probably less than 50% that can come up with a family number. They might say, "Well, you can call my Mom. She lives up north and this is her name" and not know her number. Over time, the family supports will come out if the person starts to stabilize, though. Like this 86 year old that I keep coming back to.... It ends up that she has a brother in Montreal; she has family coming and visiting her now; the extended family has started to hear more about her.

These family connections, while usually perceived as being extremely important and central to the lives of older and marginalized women (Farrall 2004; Health Canada 1999, 2002b; Keating et al. 2005), were not necessarily as significant to their families, as evidenced by the tenuous and limited nature of the relationships. Building strong connections with children and other family members, while a priority for many participants, can only be a realistic goal if other family members are interested in further engagement and, in many cases, if they can forgive the women for past events. While family connections may be re-established over time, this is a slow and sometimes difficult process that requires patience from all parties and often facilitation by support workers or other supports (Nemiroff et al. 2011). Anna is looking to establish a relationship with her son, but explained that he is not in her life right now. "But, um ... kids? I'm

very disappointed. My son's the only one, he's not supportive; he doesn't even take my call. He blocks my number and I brought him up by myself, so that's a disadvantage there." While she has not been able to reconnect with her son, Anna indicated that this was a priority for her, and was especially pressing due to her recent illness: "I found it tough since I lost my whole family. Because you're in the hospital, no next of kin, and you're scared if something happens, you know?" For Anna, making a connection with her son would help to fill some of the many gaps she identified in her life, including loneliness, depression, and fear about the future. In contrast to Anna's experience, Marie's relationships with her children and grandchildren are positive, but limited due to the distance involved in visiting them and also due to her children's busy lives.

Her contact with her family is infrequent despite her desire for closer connections:

I have three grandchildren and I want to speak to them; I don't see them very often. I have three children. I have a daughter; before I got married I had a daughter and after I got married I had two boys. Two of my children have children, so I only have three grandchildren. ... Yeah, so I'm proud to be a grandma. I never thought I'd be a grandma with the way things were going with my children. But now, oh my, they're all coming. Yeah, and I would like to speak to them in Cree. I do a little bit, but I don't hardly see them.

For Marie, family mobilities limit her relationships. While many of her family live within the region, a lack of both transportation options and free time limits their contact. She also alludes to past familial difficulties including addictions and substance abuse, from which her family is still healing and recovering. While Marie was very reflexive about her own situation and the challenges her family has faced, this was not the case for all the women interviewed.

In some cases, many potential reasons for a family's lack of involvement were immediately apparent to me from my perspective as a researcher and as someone who has worked with homeless women. Indeed, these reasons would also likely be apparent to any average person who engaged the women in conversation for more than a brief moment. There are various telling actions, comments, and behaviours that set women apart; for example, struggling with

severe mental health disorders, such as schizophrenia or paranoia; capacity and developmental issues, including fetal alcohol spectrum disorder or acquired brain injuries; addictions; conditions that reduce their quality of life and that of those around them, such as hoarding; or as having experienced significant periods of institutionalization (cf. Boss 2006; Cameron 2008; Steketee and Frost 2007). While my research foregrounds the women's narratives and explanations of their lives, examining their accounts as a critical researcher necessitates also examining the other signs and signals that are apparent in the interviews (cf. Berg 2009; Gluck and Patai 1991; Reinhartz 1992; Riessman 1987). For several of the women, their narratives included discussions of severed relationships, but little reflection on the multiple reasons behind these broken bonds. This was also highlighted by several of the professionals interviewed. A staff member at Hope Outreach explained that, in many cases, the lack of family connections and involvement were the result of family burnout:

There's also the flip side to that [abandonment], because you have families – to play the devil's advocate, you have families and let's say the mother is schizophrenic. ... She had a career, has two children and a husband. They did all they could for as long as they could to the point where there's no contact. Where it ends is that it ends up sucking the life out of people who are in your life. So what ends up happening is that you have to set them adrift because otherwise you're going down. And then that's the other side – which is really hard. Because you get women here – and men in the men's shelter; it's not just isolated to women – the families have been so drained and worn out that they just can't do it anymore.

The worker's insight on older women's family ties reflects the reality that in many cases, older marginalized women's current and past behaviours make maintaining relationships with family difficult, often creating stress and overload for the families (Figley 1995). In some instances, as in the case described above of Sara's relationship with her daughter, families may also be attempting to heal from the pain that the women have either directly or indirectly caused (Cyrułnik 2005, 2007). Unfortunately, this healing process is not always facilitated by the women's actions and understandings of events. Evelyn, for one, reflected on her lack of contact

with her children. She linked her children's lack of contact to her stay in the shelter, but not to her mental health, which also played a role in the breakdown of her family:

E: I'm really missing my kids. I'd like to get them. I'd like to get back to them. They're kind of important kids and all that. Yeah.

L: Is there still a connection there?

E: Well, during this stuff [gestures around herself], no. That's the way it has to be.

These types of situations make it difficult for women to maintain relationships with family or friends. They also challenge workers to properly understand and respond to client needs (Golightley 2008). A manager at The Good Companions noted that, for dealing with clients who have little insight into their own behaviour or challenges, care and support involves:

...having real conversations with people about, "Oh, my daughter never calls..." Is it because she never gets anywhere with you? Is it because she's too far away or too busy? Every situation is different. We do a lot of balancing and juggling – what's a real issue and what's you just venting?

For both the older women and the workers who support them, the women's mental health and other personal difficulties can create barriers for re-establishing contact with family. Indeed, connecting with family may be only one of several interrelated goals for the women; they may find success, but often must also make progress on other issues as well before familial reconnection can begin to take place.

Family relationships were seen by many of the women as minefields of past hurt and potential future trouble, making discussions of family difficult and painful. At the same time, older adults often long for the intimacy and comfort of familial connections (Kotter-Grünn et al. 2009).

Where family relationships were linked with different forms of hurt (emotional, physical, sexual), some of the women created "extended families" for themselves, including close contacts that filled familial roles in their lives (Prins et al. 2009). For example, Bev indicated that her adult children were no longer part of her life. She struggled with depression, isolation, and loneliness, especially since leaving the shelter and moving to a rooming house. For Bev, allowing her dog

to take on the role that her children once filled, in particular providing her with love, affection and a reason to keep physically and socially active:

I don't know. I – if it wasn't for my dog, I don't think I'd go out of my room, you know that? Yeah. I'd go long enough to get food and back again, that'd be about it. I'd be three hundred pounds again. But Leo keeps me busy. Yeah, my – he's a two-year-old. I've had him since he was nine weeks, eh? Yeah, he just turned 2 September first. Yeah, we get along pretty good, him and I.

Although Bev did not foresee a closer relationship with her daughters, she recreated a sense of family by keeping a pet, a strategy that has demonstrable positive effects on owners' health and self-esteem (McConnell et al. 2011; McNicholas et al. 2005; Richardson-Taylor and Blanchette 2001). In contrast to Bev's recent alienation from her children, Deborah's relationships with her family were severed at a young age, playing a significant role in her journey through homelessness. Despite not having her own family, she has been able to become a mother figure and mentor for many street people. Through this role, she creates a family for herself and provides familial support to others:

As long as they [street people] have someone out there who truly, really does care, and they know that, that will keep them going, okay? Me, I see, I see things in people that I don't know. There's certain things that, one of these days they're just going to snap out of it and they are going to see that they... I tell them that you're beautiful, you're a somebody, you've just got to remember that. Don't call yourself an idiot, stop calling yourself stupid. Stop saying that you're a dummy and all this. You know what? Because you're not. You're not. They need someone on their case all the time like that, or they drown in their sorrows and they just want to forget. Or they just want to get high because they don't remember the nightmares that everybody told them to shut up about.

Deborah takes pride in her role as a surrogate family member and recognizes the value of the social interaction that she provides. While older marginalized women's relationships with their family members often appear to be untenable, at least in the short-term, other relationships can come to take precedence. The women may gain strength and find support through other relationships, especially with their peers (Nyamathi et al. 2000). These relationships allow them to fulfil their needs for companionship and affection, fulfilling the same roles as similar relationships in prisons (Gillombardo 1966; Owen 1998).

### 6.3 *Finding “community”*

Although becoming homeless or marginalized can be a troubling and traumatic experience, respondents noted that it also provided an education on friendship and community. The homeless are, in many ways, separated from the rest of society: their lack of resources prohibits many forms of social participation and engagement; their homeless status may criminalize or limit their use of public spaces; their stigmatized statuses limit social interactions; and the precariousness of their situations also creates difficulties for engaging in social life (Casey et al. 2008; Harter et al. 2005; Nemiroff et al. 2011; Bellot et al. 2005). Maggie reflected on the role of social life in her journey through homelessness:

I have lots of friends, it's just – one thing I've learned, too, is who my friends are. Because you say, as soon as you tell them you're living in a shelter – some I haven't heard from again since I told them I was living in a shelter. You're different. It's pretty hurtful. But if it's how they see friendship, well they can have it. They're definitely not my friends, obviously.

This painful realization led Maggie to re-evaluate many of her relationships. While she had come to accept her status as a homeless person, the stigma of the status alienated former friends, who no longer accepted her and who now saw her as “homeless” instead of as a friend, mother, or former neighbour (cf. Goffman 1963; Hannem and Bruckert 2012). In her case, the shelter provided many tangible resources: accommodations, food, clothing, access to health care and other necessities, but also the intangible stigma of being “homeless” and “in need.” Despite negative connotations and perceptions, shelters and drop-in centres are often essential in meeting women's needs for basic necessities (Deward and Moe 2010). In addition, however, they provide a social environment. Many of the interview participants reflected on how they formed new relationships and communities, built on common bonds and understandings of these particular experiences.

Relationships within the shelters and drop-ins serve many purposes, from passing time to mitigating the stigma that older women feel about their homelessness. As homeless individuals

frequently experience loneliness and social isolation (Cameron 2010; Kisor and Kendal-Wilson 2002; Rokach 2005), these friendships take on a special significance for the women.

Friendships with fellow shelter residents or drop-in participants not only fulfill one's need for human interaction, they also provide concrete support, helping the women to learn about homelessness and the resources available. Erving Goffman writes about this latter process vis-à-vis the newly disabled, but his description fits the experiences of older marginalized women:

...fellow-sufferers more advanced than himself in dealing with the failing are likely to make him a special series of visits to welcome him to the club and to instruct him in how to manage himself physically and psychically (Goffman 1963:36)

For homeless women, instead of receiving a special series of visits, initiation takes the form of meeting others at the shelters and drop-ins or on the street, asking questions, and opening oneself to new relationships and ways of getting by. The difficult experience of shelter life and homelessness provides a common link over which many of the women – of various ages, from diverse backgrounds and with different struggles and goals – can find common ground and build relationships (Nyamathi et al. 2000). Indeed, stressful events like homelessness can lead individuals who share the experience to form close bonds (Lois 2005; van der Kolk et al. 2006).

For example, even though some Maggie's friends deserted her upon learning of her homelessness, she was able to find new friends in the shelter:

I've made a lot of friends here that I have. I've very well liked. I feel it – most of the girls, they talk to me every day. I listen to a lot of their stories; I'm a good listener apparently. And I help them if I can. ... I love a lot of the staff here. I get along with the girls. I've had many roommates; how many, I don't know. I've made a lot of friends and I know when I'm gone from here I will have some really good friends, for sure - for life.

Maggie's stigmatized status and identity as a "homeless person" altered, but did not limit, her social circle. Within shelter friendships, the women are able to create for themselves a protected and safe place to discuss their thoughts and feelings, share a cigarette, or simply hang out without having to negotiate their statuses as homeless or marginalized women. In contrast to research findings indicating that marginalized people's social bonds rarely offer

concrete assistance and work to reinforce marginalization (Field 2003; Reisig et al. 2002), the women found their networks to have significant personal benefits. Their friendships, as with other social bonds (cf. Keating et al. 2005; Novak and Campbell 2006; Putnam 2000), provided a variety of tangible and intangible returns. Mary indicated that she relied on help from other residents to keep herself safe while in the shelter. As she was unfamiliar with homelessness, street culture and what to expect at a shelter, her peers were instrumental in ensuring her safety:

I had no idea. There was one woman here – I'll tell you, it was the funniest thing. She stood up at the dining room table, and she said, "I'm from China Grove." And I was about to ask her if it was an island in the Mediterranean or something! [laughs] And this other girl who was a bit tough, she was kicking me under the table. She's going, "*Shh! Shh! Don't say anything!*" Well, apparently China Grove is some gang in prison, and this woman was announcing to the other women who had been in jail that she knew that she was from China Grove and there was some big deal. Anyways, she ended up stabbing one of the girls here with a fork and she ended up getting taken away by police, but here I was going to ask this woman if it was an island in the Mediterranean, I had no idea! [laughs] So even the language, it's not the same. Thankfully, though I've got some of the girls, I think they know, oh, the innocence kind of thing or naiveté. ... The girls all call me a virgin. It's hilarious, they think it's funny.

While Mary's naiveté was considered comical to some of the other residents, they nonetheless recognized that her lack of knowledge placed her in potential danger and helped to ensure that she remained safe. She is "welcomed to the club" of homeless women through being educated on the ins and outs of shelter life, including its connection to the mores and folkways of prison life (cf. Goffman 1963).

Homeless women can provide support and even play guardian roles for those who inadvertently encounter danger. They may also, however, take advantage of one another and prey on the naiveté of those who are unaware of the informal codes and rules of street life (Dietz and Wright 2005). Homeless individuals are much more likely to be victimized than other groups; they often are the victims of crimes such as theft and assault, as well as violence within shelters (Brassard

and Cousineau 2000; Fischer 1992). Indeed, the skills that aid survival on the street can also lead one to take advantage of others. Maggie's experiences with the other women in the shelter were mostly positive, but she had also learned a difficult lesson about doing favours for others:

I've helped some of the girls get cigarettes here, but I just got in trouble for that because a girl ripped me off. She didn't pay me the money for the cigarettes. Which, you know, fifteen dollars is fifteen dollars. I've got to chalk it up for a loss now. I learned a lesson.

For the women, many of whom only receive \$28 per week in pocket money<sup>48</sup>, the loss of fifteen dollars is significant and very upsetting, as is the loss of one's trust in others. Ottawa's two women's shelters each house more than fifty women, many of whom do not know each other. In this environment, stealing from and/or misleading others is common and easy; the chances of getting caught – or of someone reporting the incident if one is caught – are generally quite low (Brassard and Cousineau 2000). This situation makes all women vulnerable to victimization; this vulnerability, however is amplified for women who are already disadvantaged in terms of their reasoning skills. Maryann, who has a cognitive delay and requires significant supports to manage her day-to-day affairs, has found herself the victim of thieves and would-be "friends" on several occasions. She described a particularly troubling loss:

Right now, I'm on my third year of my sobriety. I have three medallions, one for the first year, second year and third year. Since I've been here, somebody took my third year medallion right out of my purse. I don't know who, but I wish whoever did would give it back to me, because it means the world to me. It means I achieved something.

Maryann's victimization shook her trust in others and also highlighted the intersecting nature of vulnerabilities: for Maryann, age, physical health, mental abilities, and homelessness all make her an easy target for others in the shelter. She is not alone in this position, however; victimization takes on many forms and does not have a single target. Other forms of

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<sup>48</sup> Homeless individuals who do not have any source of income, including Ontario Works, receive a personal needs allowance (PNA) from the city. The amount paid is \$4 per day, paid weekly. While women's basic needs – including food, shelter and toiletries – are provided by the shelters, this allowance must cover all of a woman's additional needs – such as for cigarettes, bus tickets, basic medication (e.g., stomach remedies or painkillers), or purchasing a coffee with a friend.

victimization – most notably bullying – also exist in the shelters (Brassard and Cousineau 2000; Deward and Moe 2010; Fischer 1992). As in schoolyard situations, bullies tend to pick on others who are perceived to be weak or vulnerable in some way. Anna, who suffers from a heart condition and also has mobility impairments, experienced harassment from younger women who sensed her anxiety and vulnerability.

But, and I don't, I don't speak up for my rights. Especially in here. They can just walk by and call me a douchebag or, "Do yer laundry now ya bitch," or – geez, why are they talkin' to me this, they don't even know me! And it puts me right down, like I can't... maybe it's because I'm not eating good, not eating the right food, but I can't fight back. I'm not strong enough to say, hey, watch who you're talking to. I just end up crying, or I go down, you know. I mean, some of them are very, really bad.

Anna's depression and anxiety are fuelled by her victimization, which also led her to minimize her social interactions despite her desire for social contact and emotional support. Working in shelters revealed to me the often mercurial nature of relationships among residents; friendships can quickly sour and enemies can grow close. These relationships often function on a day-to-day basis, especially for women who have mental health disorders, who are seen as rats or snitches for reporting abuse to staff, or who are vulnerable to exploitation due to their inexperience, naiveté, or inability to fight back (Deward and Moe 2010). The effect of the 'street code' – that nobody saw or heard anything, regardless of what happened – often ripples out where people conduct themselves in ways that are not tolerated in other environments, which can lead to problematic encounters and strained relationships (Anderson 1999). When women reach out to one another for support, they must be careful to balance openness with seclusion to ensure that they are not leaving themselves open to victimization.

In spite of the homeless and marginalized often being labelled as "takers" or selfish and sometimes victimizing those who are in similar positions, friendships in shelters and drop-ins demonstrate the women's ability to build reciprocal, communal environments with their peers.

Indeed, this is one of the primary goals of the drop-in centres (cf. St. Joseph's Women's Centre 2011; The Well 2012). Dina, who spent many years hitchhiking from place to place, describes how she made friends at the drop-ins when she was new to Ottawa:

I just watch people. And they ask me for a cigarette. Or they're watching me. They know I'm a new person when I first came here. And just, you know, learn their names. The first step would be to learn their names. Then after a while you see these people every day, they just become your friends. Or acquaintances, I call them. And they help you out with a cigarette here and there, or whatever. It's just someone to spend the afternoon with. Your time when you're having a coffee. Someone. We've got our little circles eh? And it's just, companionship is very much appreciated by everyone. ... And it's nice – you don't want to be alone in life, eh? So it's nice to have companionship. And even just to know that you're not the only one.

Although not an ideal setting for everyone, shelters and drop-ins offer marginalized women a sense of camaraderie. Ashley reflects on the support that she found at the shelter, indicating that the support of her peers is something that is otherwise missing in her life:

Well, the first time that Ken told me that we were done, we were through, we were finished – when I came back, two of them gave me hugs, let me cry on their shoulders. It just, it felt good. It's just – good to have people around who you can cry on their shoulders. People who care. And I mean, I've never had that anywhere else. That I won't even get from my mom. She'll just say, "Oh, it's the past. Get over it." She's very negative and it's like – that kind of support won't be there for me. So I'm going to miss that.

Ashley's statement reveals the rarity of this type of bond for women who have otherwise led marginalized lives or who receive little love and support from their families. Indeed, these bonds can allow individuals to receive support and encouragement, and to develop resilience (Cyrulnik 2007; Green 1998). Other participants also commented on the generosity – both in terms of resources and time – offered by their peers in the shelters. Kristen, who was not new to criminalization and homelessness, stood out in the shelter due to her physical appearance; her clean-cut look was incongruous with her experience of addictions, homelessness and imprisonment, leading many women to avoid or ignore her. To cope with shelter life, she formed a relationship with one of her roommates that was mutually beneficial:

One of my roommates is – she has a lot of trouble with English. But she's been very nice to me; she's been very helpful with some of the things. She's incredibly

practical and handy. And she's helped me, so what I've been doing is trying to act like – not quite a translator, between her and the staff – but they're busy and they don't have time to be able to spend. So I will figure out what she wants and go to the staff and say, "This is what she needs." And they appreciate it. She appreciates it. So it's mutual; I'm helping her but I can see – she's helping me, but I can also see that I'm helping her. Because otherwise I think she'd feel pretty lonely in this place.

Kristen's relationship demonstrates the value of social capital in the shelter environment; both women are able to meet needs, mirroring the support many community-dwelling older adults receive from their social networks (Keating et al. 2005). While Keating et al.'s study focused on relatively privileged women, Kristen demonstrates that these relationships and social capital building in general are not tied to one's socio-economic advantages. For older marginalized women, their communities – including fellow homeless and marginalized people – can and often do provide concrete support and assistance, familial bonds, an overall sense of community and commonality, or simply a way to pass the day.

## **Leisure Time**

Friendships and relationships on the street allow the women to interact while forgetting their status as "different" or other. For older marginalized women, interacting with their equals or peers can minimize power imbalances, provide a sense of camaraderie, and also limit potential moments of shame or embarrassment with respect to their marginalized statuses (Nyamathi et al. 2000). These friendships and relationships are also instrumental to passing time and filling otherwise empty hours that can make staying in a shelter unbearable or similar to "doing time" in prison (Deward and Moe 2010; Wahidin and Moss 2004). Many of the interview participants remarked on the repetitive nature of time and the loneliness and boredom that this causes.

Ekatarina explained that she struggles to fill the long days:

So I figured if I go to the Y in the morning and then walk an hour with my sister at night, then I can go to the library until it closes and that'll keep me occupied during the day. During the times that I find the most stressful. Mornings are stressful; the last few weeks *everything* has been stressful. But it's not like maximum stress, it's just – I'm wondering – should I go out or stay for a cup of coffee in the kitchen? I was doing the dishes for a while – a lot of dishes, and that

calms me down. I don't like to see people seeing me upset. So when I do I either leave or I go to my room.

Reducing and hiding her stress becomes a full-time job for Ekatarina as she attempts to keep occupied. These experiences of stress can be physically and mentally harmful to the women, especially when they occur over long periods (Raphael 2004, 2006; Rosch 1997). While many programs and activities are available in the community (Community Information Centre of Ottawa 2012), not all women feel comfortable, or are physically, mentally and emotionally capable of, reaching out to access assistance or find ways to fill their days. In addition, some older women sought social opportunities that allowed them to avoid or abandon, at least temporarily, their stigmatized statuses. While Joan did not express the same level of concern over others' opinions, she also struggled to fill her days. She kept herself occupied thanks to a laptop computer she obtained through a non-profit organization:

What do I do? I go to Starbucks or Bridgeport and surf the web. I got to [school], I still have access there, but I don't go to the library because I don't want to rub shoulders with the people from here. Here is enough. I go to [school] to surf their hours. I could spend the whole day there. I'm wasting time there. I just can't sit. This is crazy. Not enough human contact. I'm not accomplishing anything. What I do? I don't do anything.

Joan uses her laptop to negotiate private space; this small advantage allows her to "pass" in public spaces without drawing attention to herself and resist her status as an "outsider" (Casey et al. 2008; Goffman 1963). Despite her tactics for navigating the social world and fitting in, Joan notes that she remains isolated. Like Joan, Louise notes that she has few social interactions to fill her days. Reflecting on who she talks to, she highlighted the importance of small contacts that are considered mundane to most people, "[I talk to] store clerks. Usually they seem to be full of actual talking like, "Three dollars, please," "thank you," stuff like that for actual talking. That's about it." Similarly, Tracy indicated that her days are often empty: "What I do in a normal day? I watch TV, that's about it." While the women's comments at first show the mundane nature of daily life, including small interactions and ways to fill long days, the cumulative nature of their experiences – where many women have few interactions with others,

limited social contacts and few events or routines in which to participate – highlight the importance of developing friendships and finding ways to fill spare time. Past research has shown the value of various leisure pursuits for positive and healthy aging; however, social networks – which are significant components of many leisure activities – are far more important and wide-reaching in this regard (Green 1998; Prins et al. 2009; Putnam 2000).

As Goffman (1963) notes, stigmatized individuals can collectively create barrier and stigma-free environments to allow them to socialize without hiding their stigmatized status. These settings are generally set apart from the “rest of society,” demarcating the participants as different, yet also collectively similar, as in the case with spaces for older adults (cf. Shilling 1993; Tulle and Mooney 2002). While the separation of groups based on attributes such as age, gender, and marginalization can be seen as both a potentially positive or negative occurrence, this separation can provide welcoming environments in a sometimes-inhospitable world. Separate settings facilitate social movements as the women establish connections across similarities, and also physical movements as the women are provided with *a place to go* and *a reason to move*. Maggie’s shelter stay followed a string of challenges, including her mother’s illness, an eviction, and a falling-out with one of her children. Despite these difficulties and her isolation from her former friends, Maggie finds entertainment when spending time with the other women:

I’ve got no money to have fun really. But – this is going to sound funny – we sit in the parking lot and we sing, we tell jokes. We talk about anything that is not related to this house. We have permission from [the owners] to sit in the parking lot. They call us the ‘Parking Lot Girls’ – we have a name now, a title. ... We sing and we talk, we make tents. I have pictures; I take pictures of everything. ... We used to sing at the side, but they told us we had to be quiet, so we took our voices over there. We can do pretty good; we just choose random songs that we think everyone would know and then we go for it. Oh yeah, we belt it out. [laughs] We do have fun. We dance; we dance in the parking lot.

Outside of the shelter, community residents can be very supportive of the women; not all of her interactions are coloured by negative stigma or marginalization. While her poverty and

homelessness constrain her mobility and limit her access to leisure activities, they do not preclude her having fun and finding positive ways to pass her time. Similarly, Dina, who had been struggling with an addiction to crack that led to her homelessness, found that her social network keeps her engaged and occupied:

Most of these days, especially when I'm staying here, I have lots of time to think. I think my life is – I don't get bored too often. I don't have to sit there idly bored. I live a pretty exciting life. [laughs] With my friends, thanks to my friends.

As she is disabled and uses a wheelchair, Dina's only option for emergency shelter was to stay at Hope Outreach, where drugs are easily accessible. This access to drugs was a significant challenge to her recovery, but she found that her networks were ideal for both filling her days and stopping her from using drugs. She continues:

I like going to parks - beside the river for walks, sitting on top of the Rideau Centre in the gardens up there. I like to be around plants and trees and nature. And that's where I spend most of my time. I don't spend my days here. Because I found when I was here I almost needed to smoke dope, pot, marijuana just to stay here. But then my ex-boyfriend used to take me ... we'd go to beaches and parks. So I was never here and I felt a lot better eh? And now my new boyfriend and I, we tend to go and sit in the park rather than stay here. Because there's a lot of drugs here and it's a negative influence.

Brenda, who had spent several years travelling across Canada, also chose not to spend a great deal of time at Hope Outreach, preferring to tour the community on foot to become acquainted with the city and its resources and also to meet its residents. She noted the importance of the homeless community in her life:

My day-to-day life here in Ottawa has a lot to do with just getting out and connecting with other homeless people. And I do most of that over at Centre 454. And I also love the Byward Market. I spend a lot of time walking in the Byward Market, being in that area - Lowertown, Byward Market. I haven't really gotten to know the city, although I thought I'd try.

For many interview participants, the networks they establish through homelessness and marginalization become central to their lives. Sherry's social network, for example, revolves around the city's drop-in centres. As she considers her neighbourhood to be dangerous and

*risky* in terms of victimization, the drop-ins provide an opportunity for *safe* socialization. She describes the composition of her network.

Oh, well, a lot of the women here. Not all of them, but a large number of them are my social network. And, um.... they're the closest ones right now to me at the moment. Yeah. Because I end up spending so much of my time here. And I live [near downtown], so I don't, I don't.... like, I've always made it a policy not to get to know my immediate neighbours. [laughs] It's just, "Hi!" and "Bye!" and "Have a nice day!" Don't get any more involved than that, because there's a lot of highly illegal activity going on and I don't want to be involved in it! [laughs]

The drop-in centre provides a mediated environment; staff actively monitor participants, are physically present to observe the women's interactions, and are quick to enforce rules<sup>49</sup> to ensure the environment remains safe for everyone. This safety allows Sherry to build relationships without the fear that she experiences in her neighbourhood.

At the drop-ins, friendships may form based on women's past or current experiences, or simply their desire to socialize. As the programs and services are free, the drop-ins also serve as meeting places for diverse groups of marginalized women. Amanda, an Inuk woman explains:

That's why I come here. My friend, not too many people around outside you can talk to an Inuk person. We always talk Inuk, in the way? Yeah, and the [Inuk] people always come here. Maybe that's why too, I miss the Inuktitut talk, I always come here. Yeah, I love that. Maybe I miss that. I grew up where all the people speak Inuktitut, that's why I guess I come here. Yeah.

The drop-in centre allows members of diasporic communities to reconnect with their friends and culture, reinforcing their sense of community and family. While Amanda's network offers a sense of 'family' based on culture, marginalized women may form new "families" through their contacts, locations and past experiences.

### **"Family" on the Street**

For those who have experienced life-long marginalization, the nature of their personal relationships often changes. Although some marginalized women's natural families no longer

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<sup>49</sup> The codes of conduct of the drop-ins and shelters are further discussed in Chapter 8, particularly in sections 8.2 and 8.3 and their subsections.

play significant roles in their lives, their desire for family-like contact – including unconditional love and support and life-long bonds – does not wane. As family types and arrangements become more diverse, there is a growing recognition of alternative family forms; blended families, same-sex families, and extended families, for example, all provide the same caring, nurturing, and close connections of “traditional” families (Mandell 2004a). With this in mind, it follows quite naturally that alternative family forms would also appear in the lives of individuals with few ties to family, such as many homeless and marginalized persons. For older marginalized women, especially those with significant histories of homelessness and a deep entrenchment in street life, the street becomes a natural setting in which to make families. The women’s age and social positions lead them to be perceived maternally by some – including both their peers and the staff working at the various helping agencies in the community – thus allowing them to become “mothers” in new families of their own making.

In many families and cultures, older women’s age and experience affords them deference and privileges from their peers and from younger people (Abu-Laban and McDaniel 2004; Mandell 2004a). In practice, this may manifest in the women receiving special attention and treatment or in value being placed on their wisdom and experience. Their age may also bring new responsibilities for mentoring others, educating younger generations, or taking on ceremonial roles as elders. While older marginalized women often do not experience this respect and deference, they may still face additional responsibilities and expectations related to their age. In the shelter, this can result in their responsabilization, just as other studies have noted vis-à-vis older female prisoners (cf. Aday 2003; Aday and Krabill 2011; Kratcoski and Babb 1990; Wahidin 2004). In these environments, older women are sometimes seen as calming influences, or as mentors who can help younger residents to sort out their problems. Some older women feel obliged – by both residents and staff – to take on these mentorship and caring

roles, whether or not the roles are ones that the women desire, reflecting the disproportionate caregiving burdens often placed on women (Bezanson 2008). Despite some women's ambivalence about making connections on the street, these bonds can be valuable, as a worker at Hope Outreach noted:

The women who are younger, they tend to have a bit more of a support group. Because they're out on the streets, they are in the 'hood ... And they have a street mother or a street father – like “he's my dad or my mom” and they have this whole little clique that's going on. For the women who are here who aren't part of that, they're just adrift. So no one's going to come and say, “You know what? You should come with us...” to [resident] because she doesn't talk.

Here, “being adrift” denotes being *on* the street, but not *of* the street. Indeed, as with any social group – whether membership is by chance or choice – social rules and mores prevail, as do in-groups and out-groups (Becker 1963). Taking on family roles within homeless communities involves engaging with the subculture of marginalization and homelessness at a level beyond simply using a shelter or drop-in. It involves accepting one's role as a homeless person and developing close ties with others in the shelter. Danielle, for example, was approached by a number of the younger women who were looking for this type of care and guidance:

They [the younger residents] try to call me “Mom” but I don't like that. [laughs] I said, no, [I'll] just be a friend. Mother? No. No thank you. Other people like to be called mother but not me. I say, just call me friend.

Danielle resists the major implications of the label “Mom” which include providing support, care, and a lasting relationship (Clarke and Griffin 2007; Mandell 2004a). These signifiers may also be difficult and problematic for her and other women who have children of their own but who have experienced family breakdown. In these cases, being called “Mom” by new acquaintances may bring up painful past emotions or yearnings for one's own family, sparking loneliness and sadness (Dykstra 2009; Rokach 2005). As she was new to homelessness, Danielle may have also been leery of becoming deeply engaged in the culture and lives of her new peers. While this prospect of being called “Mom” is burdensome for Danielle, others, including Deborah, appreciate these roles and work to fill them. Deborah explains:

I help a lot of people on the street. I go around, I know a lot of street people. Everybody calls me Mom, like maybe a hundred people call me Mom. And every time they need me, like they have a problem with their boyfriends or they have a problem with people, the way they treat them, they all come to me and I have to go solve their situations, or I just tell them something positive, or the pros and cons are this, and let them decide. They have to make their own decisions, eh? And hopefully it's the right ones.

Deborah takes pride in her position as “Mom” to a wide variety of street people; the role indicates both her entrenchment in street life and the respect that she is given by others. Mary unintentionally found herself in a mothering role, but without the respect afforded to Deborah. She noted the needs of the younger women and how their needs usually supersede her own, just as in many women’s relationships (cf. Bezanson 2008). Mary elaborates:

The social network here is you just sit outside and smoke and listen to other people’s problems. That’s often what I’m greeted with when I come down the stairs. I’ve usually got three or four women that need cigarettes or an ear to listen to. And I try to be as compassionate as I can, but often I’ll try to go off by myself and just collect my thoughts. ... [Younger women]; I don’t really talk to them, I more or less listen. ... I find that people are so stuck in their own stuff, especially the younger people, that they don’t really listen anyway. You know, you start to offer something to a conversation and they just yell over you, so I back off. They need to be heard, obviously, more, so I take a back seat a lot.

Mary’s experiences illustrate how “mothering” roles, while potentially fulfilling, also come with strings and burdens (Eibach and Mock 2011; Pillemer and McCartney 1991; Smith 1987). For women who did not willingly become homeless and who lack significant ties to street life, the imposed roles and responsibilities of street families and being the “calming influence” in the shelter can be overwhelming and difficult.

Within street life, the role of “mother” comes with significant responsibilities to those in one’s network. Just as in other mothering work (Devault 1999; DeVault 1994), it involves providing support in good times and in bad. Deborah, who embraced her role as a street mom, also had to struggle with losses within her social network. As she ages, so too do her peers who also have long-term involvement in street life that, along with addictions and health issues, can

dramatically shorten their lifespans (cf. Cheung and Hwang 2004; Cohen 1999; Washington 2005). This loss of friends was painful for Deborah, but it also led to a personal transformation:

An event that's shaped who I am today? Probably everyone's dying, OD'ing, giving up on life. ... It just, losing so many people in the past few years. You know. Watching their expressions, watching their faces, watching them give up on themselves. And me, I've been talking to them, trying to keep them from getting down. But then you can see the depression set in so badly that you knew something was going to happen. And I'm a survivor. I've always been a survivor. And I think not everybody's the same so you have to give life a chance. And you have to give people a chance. That's what's shaped me.

As loss prompted Deborah to seek treatment, support and stability from the community, her social network may have, in an unusual way, provided her with health and life benefits far greater than the networks of more privileged older women (Keating et al. 2005; Penninx et al. 1997). In addition to explaining the supportive functions of her network, Deborah also described how she came to be such a significant part of so many people's lives:

It's just that I've always been there for them, you know what I mean? And I am one person they know and trust and can talk to. Like a lot of – everybody who's on that street has either a mental or physical problem, all right? And it's one disaster that's put them all there. And it's just that we have bonded, like we can communicate. And some of us, like me, up until last year until I started opening up about my rapes and my stations and everything else, I don't know how I survived all of those years if it wasn't for my willpower and my surviving instincts, I would not be here. So I try to let them know that, you know, that we're all survivors. We have to live on. We have to go on.

Deborah frequently gives advice and support, but these are not always forthcoming in return (Bezanson 2008; Mandell 2004a); however, the instances in which she receives support, while infrequent, leave a lasting impression. She explains:

It's supposed to be a two-way street, but it don't actually happen that way a lot of times. But sometimes. ... Well, sometimes people have come through, and you know, when I'm depressed and seen that my self esteem has gone low and something. And they have, you know, just opened my eyes to a few things and brought me back up. ... You know, a hug a day, all right? It's awesome when you walk up to someone, a total stranger, and say, "Have you hugged a friend today?" you know, and they hug you. Or when you're walking down the street and you smile and say good morning, and they actually say good morning back. You know, that's a memory. That's something you can take with ya. So memories are what means a lot to me. So I like to make as many good ones as I can now. And I think I've had enough of the bad ones. Like, my half a century is loaded with it. Okay, it's time to move on.

As Deborah's story illustrates, she is instrumental in providing support to others on the street. For many, especially those who are afraid to reach out to formal support networks and community agencies, she takes on the role not just of a mother, but also a counsellor, addictions worker, and therapist. Deborah freely supports her street friends, but for those who do not know her, community organizations can provide some of these same supports.

#### **6.4 Community Organizations**

In addition to their friends and families (of both chance and choice), many older marginalized women rely heavily on the supports and services in the community. For women who are isolated, the services of shelters and drop-ins provide environments in which they can socialize and find friends. All of the drop-in centres and organizations providing drop-in services that took part in the research aimed to provide open, welcoming, and constructive environments for their clients, so as to foster positive senses of place (Manzo 2003). While community organizations occupy physical locations, they also – through their staff and users – are able to create meaning and a sense of place that surpasses a physical location: these spaces and places can take on new meanings as gathering sites, providers of food and other necessities, points of stability for those who may not have a consistent place to stay, or simply as a destination for those who need somewhere to go (Casey et al. 2008; Low 2000; Manzo 2003, 2005). This role can help to fill older women's needs for social interaction and familiar and welcoming spaces (Rowles and Ravidal 2002). As loneliness is a major concern for older women (Dykstra 2009; Penninx et al. 1997), these centres' key offerings include social interaction. A worker at The Well indicated that social needs often draw women into the centre, even if they have few service needs:

I think many things [bring women to The Well]. I think loneliness is a top one, especially for our aging population. Loneliness - addictions, poverty - addictions, personal needs, they all tie in together, right? Cultural needs. I think loneliness is the top one. ... We have a few elderly women here who are not suffering with poverty issues or homelessness or anything like that, and they come regularly and they all hang out together. They have no needs from any of the staff.

Sometimes they'll just volunteer. I think it's loneliness; it's a place to gather and be safe and be with other women.

For older women, drop-in centres can be places to find community, receive friendship and give back through volunteer work. Indeed, these connections and their imbued reciprocity are often cited as important and significant for individual and community well-being (Field 2003; Keating et al. 2005; Kim and Kawachi 2006; Putnam 2000). A desire to "give back," however, often signifies a latent need, as indicated by a manager at The Good Companions:

The loneliness brings them out, but then again, they have to have that wherewithal to step out. ... It may be an activity or it may be a doctor's referral, saying you need to get some people in your life; you need to get out and have some fun. "Go volunteer, it may be good for you" – which is a problem, because we don't want volunteers who are here to help themselves, we want volunteers who are here to help our clients, so we've got to be careful there, too. We've got to be careful that we're not spending more time with the volunteer than the client.

Indeed, many older adults desire social interaction (Novak and Campbell 2006), yet may feel that accessing community services comes with the stigma of being "in need" or "poor" or otherwise requiring help. As they may consider asking for help to be shameful, *offering* help can be a foot in the door to receiving help without assuming the stigma of a "client" or service user (cf. Freedman and Fraser 1966). Balancing women's desires to help with their needs can be challenging for organizations that, with increasing demands for services and limited means to deliver them, often rely heavily on volunteers to *provide* services, not *receive* them (Lacey and Ilcan 2006; Rosol 2012). Several of the interview participants indicated that they were both service *users* as well as *volunteers* at a drop-in facility. For example, Catherine was recently diagnosed with bipolar disorder. She indicated that she was a registered volunteer at The Well, but at times required more support than she was able to give to others:

[There] was a volunteer appreciation dinner and it was just for the registered volunteers. I became a registered volunteer at The Well a few months ago. I'm not volunteering now, but I'm still a registered volunteer and I always will be. When I decide to go back and feel mentally that I'm stable to deal with some of the characters in the place. ... I couldn't [continue to] volunteer at The Well – I'd be crying and then I'd be aggressive. I couldn't live my life going chasing my tail.

Catherine's volunteer position offered her a sense of pride and accomplishment; however, her mental health limited her effectiveness as a volunteer, at times making her presence disruptive instead of supportive. While client volunteers such as Catherine can prove difficult in terms of volunteer management, these volunteer roles can also represent an opportunity to reach out to individuals who might otherwise not access services.

Loneliness may lead some women to seek out ways to get involved, such as in volunteer roles. For those who are more marginalized, however, simply getting out of one's apartment or shelter is a significant accomplishment (cf. Flynn 2002; Maidment 2006; Shantz 2008, 2010). The drop-in centres offer the women a chance to build a social network in what can otherwise be an inhospitable environment due to their age, personal attributes and marginalized statuses (Abu-Laban and McDaniel 2004; Chunn and Gavigan 2004; Shilling 1993). Tracy, who lives in supportive housing run by the Shepherds of Good Hope, was reluctant to talk about her social world, or the world around her in general. However, she noted the particular importance of Centre 454 for her, noting that it offered a safe space in an unsafe environment:

L: So besides here [supportive housing unit], do you go anywhere else, like outside the building?

N: No. Outside's too fucked up with the drugs. ... You walk down the street and people offer you pills and drugs and shit. I don't know; I just don't like it. ... Sometimes I go over to the 454 and hang out. It's alright. The food's really good. Soups, sandwiches, stuff like that. It's really good.

Despite the perceived danger in her environment, Tracy finds Centre 454 to offer a haven where she can socialize without being exposed to drugs, making it a valuable part of her community. A counsellor at Centre 454 reflected further on the role of a drop-in as a social meeting place. The centre's location<sup>50</sup> near the Byward Market and other homelessness services makes it easily accessible for many marginalized women and men.

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<sup>50</sup> At the time of the interview, Centre 454 was located on Murray St., directly beside the Shepherds of Good Hope shelter.

[W]e have two parts of our work. ... A half day I spend in counselling and half a day in the social recreation area. One of the major, very important things that we provide is a space here in the drop-in centre. We not only provide them a space but build a small community because people can socialize here with each other and with counsellors, and get some support. Being here is almost like a home for many people who are staying in the shelter. We go around and approach people and talk to them. Sometimes if the person wants to talk in depth or asks for help, we meet them in the counselling section here. Or sometimes, they come in for counselling in particular, or to get help.

As the staff attempt to engage with all of the clients, even the most marginalized and withdrawn, the centre becomes a place where their needs – especially those for basic human contact – can be identified and met (Fawcett et al. 1995; Freedman and Fraser 1966; Kingfisher 1996). For those with few other options for socialization, meeting this need is often difficult. Sherry craves social contact and finds that the drop-in centres are ideal for meeting her needs. She describes the positive experience offered by St. Joe's Women's Centre:

I'm social, I like to be around people, but I also like quiet time. ... So I would come to places like here, or to The Well or even Centre 454 or Centre 507, Capital City Mission – the free drop-in centres, basically is what it comes down to, and socialize with people, I enjoy doing that. Men and women. When I come here, I like it here because it's a smaller group compared to The Well. I get to cook here and I love to cook in the kitchen. ... And I do other things around here, too. The clothing programs or the incentives or the toiletries, or sometimes they ask you to do other things which I enjoy, too.

A worker at Ottawa Innerscity Ministries (OIM) indicated that the organization's weekly drop-in days provide a venue for women to gather and build their social networks. The OIM drop-in is less structured than the city's other drop-in services and is largely run by volunteers, with whom some participants form close relationships. Often, these relationships can provide warmth and comfort that the older women do not receive from their other social contacts:

A lot of our ladies, there's a lot of disconnect in family relationships, come and go. Their connections with their families are often intermittent, sometimes non-existent. Whether it's with a parent, an older parent, or with a child. Their social net is very fragmented. ... a lot of our ladies, the ones that come to the drop-in, are usually single. They may have boyfriends that come and go, and may have some children, but their relationship with their children is strained, often. Their relationship with their elderly parent is strained, often. ... There's often a volunteer that one or two of the ladies have a real strong connection to, or a staff member. For them, [OIM]'s another place where they can seek that which they don't have, or have in a very shaky relationship or social net. ... It seems that it's

really a way to recreate family when family is either non-existent or fragmented.  
... They do find one another and are a good support for one another.

As with other drop-ins, OIM provides programs and services, but also contributes significantly to the women's worlds by offering an opportunity to build networks – with each other, with staff, and with volunteers. Many of the older women who regularly attended drop-in centres indicated that they formed close bonds with some of the staff. Sometimes, these bonds simply reflected their appreciation for the services provided. In many cases, however, these connections were much more significant for the women, representing a friendship or familial bond.

### **Filling the Void: Frontline Workers as significant social contacts**

Staffing at many shelters and drop-in centres involves significant turnover and a seemingly constant stream of new faces and personalities (Akingbola 2004; Kim and Stoner 2008). This high turnover is often attributed to the stressful nature of the environment, as well as the challenges posed by the lower pay offered compared to similar jobs in the public sector (Kim and Stoner 2008; Mor Barak, Nissly, and Levin 2001). This turnover means that the women may have few chances to develop close and long-lasting connections with workers. Staff that do remain in an organization, however, can build close bonds with regular clients and those who stand out or become significant to the workers. For many older marginalized women, these ties – and the help and assistance that they provide – take the place of the familial bonds often cited as key to supporting older adults (cf. Keating et al. 2005; Penninx et al. 1997; Plouffe 2003). An Ottawa Inner City Health nurse explains the value of these connections:

Most of my older women are not connected to family at all. They form relatively strong bonds with workers or with other residents. The difficulty at Shepherd's is that huge diversity between them and the other residents. But when we take them from there and move them to The Oaks, the older clients then can form better relationships. So at Special Care for Women, I'd say the relationship is with staff and at The Oaks, I would say then it can become more with other residents. Some of them have workers; not very many. Or their doctors. I have one; her best link is with Queensway-Carleton Hospital. ... That's where she goes when she's stressed.

The consistent support available from staff and community institutions can provide women with stability and continuity, states that resonate with older marginalized women, especially those who are dislodged or dislocated from significant places – such as homes, workplaces, or favourite haunts. Separations from significant places can cause feelings of loss, longing, and sadness and may be experienced as traumatic, especially for those who frequented a place for many years (Low 2000; Manzo 2003, 2005; Rowles and Ravdal 2002). Older marginalized women may meet these needs at drop-ins, where they may find the continuity, routine, and predictability that is missing in their lives (Bruckner 2001; Cameron 2010; Kisor and Kendal-Wilson 2002; McNaughton 2008; Rowles and Ravdal 2002). An Aging at Home nurse indicates that stability is essential to developing relationships with her clients:

[M]ost of the women that I work with – all the women I see every week – I have 9 senior women I see every week; I've worked with them for a year and half now, and I'm just at the point where I have a good relationship with all of them. They will all talk to me; that doesn't mean every week they will talk to me.... A lot of it has been establishing that relationship. ... it's about having that routine, knowing that on this day at this time, someone's going to check in on you. It's about stability. If I'm off on vacation or at Christmastime, when at the shelters it's not the regular staff, you'll really see that some of the women, most of them, it really changes them. They get – you can see they're not in the same headspace. I tell you that because part of my role – it definitely is as a professional, but as a support person, having that presence and that engagement.

Consistency and support were underlined as key aspects of the work conducted by many of the professionals. Indeed, these are foundational to the concepts of social work and community development (Parton and O'Byrne 2000). A worker at St. Joe's Women's Centre reflected on how she establishes and manages relationships with the centre's participants:

I think that every worker within the field of social work in particular has a different way of building, keeping, and being consistent within the client-worker relationship. I think that being such a small centre, and working with a regular population, those that access the centre regularly truly build a bond with me and notice when I'm not here.... [M]any women who walk into this centre, as I'm sure your research has shown, are very marginalized and have dealt with so much within their lives and will continue to deal with many boundaries and barriers within their lives, that it's important for me to have consistent boundaries with them because there might be a day when I move on from working here, and they need to know that there will be someone to replace me and to be okay with that.

... That often does happen in this field, and especially within this particular working environment; within a drop-in centre, you'll find that the worker transition is quite high. ... We have students who will do placements five days a week and then not return. So I think it's important to have boundaries and have that professional working relationship with all clients, to be consistent.

Developing connections with regular clients comes with the challenge of ensuring that the bonds remain professional and supportive, despite the often deep personal significance of these ties to participants and sometimes to staff. This is especially true at drop-ins and organizations where participant attendance is often intermittent. Supportive housing and shelters, as dwelling places, differ: the women *live* in these spaces, increasing the significance of personal connections within them (Heidegger 1993; Urry 2000). Long-term residents of these facilities may form significant bonds with staff, as a manager of a second-stage housing facility explains:

I would say their support network is the front-line staff. Staff do a lot of mediation, de-escalation, let's talk through this. The philosophy of the house is that every opportunity is a learning opportunity. Rather than just saying, "Enough! No yelling," nobody learns from that. So, let's look at it. If there's a behavioural issue, what if that was you? ... We all live together; 20 women plus the staff. ... So everything here is about how we can move someone along on all levels. Life skills, mental health, whatever the level is, move somebody forward so that when they move into independent housing next door where then the neighbour's going to frustrate them, they're going to maintain that housing.

In this facility, the goal is to build a community that includes residents and staff instead of distancing the two groups. It should be noted, however, that this also requires careful balancing to ensure that social work codes of conduct are respected (Canadian Association of Social Workers 2005). These two sets of needs – the residents' needs for close personal contact and the workers' needs for privacy – are difficult to balance; the messy actualities of real life situations often blur boundaries, creating difficulties for residents when workers leave, or for workers if residents become too attached (O'Malley, Weir, and Shearing 1997). The housing manager also noted, however, that working through the messy actualities of the work is critical to the environment and goals of the house. She explains:

Sometimes people ask me why women live here so long? Or what do you do every day? For us, success is in the small things. Somebody once said that a great river starts with a small trickle, and that's absolutely true here. ... Maybe

somebody's never had any social skills, never had any love in their life whatsoever, never had any attachment, never had any trust... for us, it's building that person all the way back up to where they should have been from the get-go, but they didn't get that. That's a lot of conversations and time. ...it's a lot of conversational, therapeutic relationship stuff that takes a long time to build real, authentic relationships. We definitely have looser boundaries than maybe at the shelter or other areas, because my philosophy is we are in a relationship. While I wouldn't tell them the nitty-gritty of certain things, I wouldn't hold back as well because how is somebody going to learn if I'm not going to role model? Yes, you can go through something awful and cry and still come to work and still cope. How are you going to role model this if you never disclose anything?

Through creating a home-like physical and social environment for the women, living in second-stage housing can represent an opportunity for individual growth and social development. While the setting holds great potential for residents, the manager's quote also highlights the emotional toll that the caring work entailed in rebuilding women's lives takes on facility staff; for a worker, becoming emotionally invested in a woman's life, especially when one's professional standards encourage an emotional distance from clients (cf. Canadian Association of Social Workers 2005), involves connecting one's personal and private lives, something that may be uncomfortable for many workers and also hasten compassion fatigue or burnout (Figley 1995; Kim and Stoner 2008).

Community organizations are catalysts for marginalized women's social networks. They offer physical and social spaces in which interaction and connections can occur (cf. Manzo 2003). The facilities' staff and volunteers engage with the women and help them to build social networks in safe spaces. Community organizations' impacts are not limited to facilitating social interaction; Ottawa's service network also provides a wide range of programs and services for marginalized women, ranging from hot meals and a place to stay to computer training and art workshops. The women's experiences of this network in particular, and of community life in general, are explored in the next chapter.

## Chapter VII – Finding Help: Women’s Experiences of Service Access

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## 7 Finding Help: Women's Experiences of Service Access

[T]here isn't a booklet on homelessness. I'm thinking of writing one, because I didn't know where to go. I didn't know what the rules were, how to get into a shelter, where – what parts of town were good and bad. ... So just learning all of that. – Mary

But like I'm saying, handouts, shit, you know – we were dealt a hand, we should have made different choices. We didn't. But those places are there, thank God, because down home, there's no such place as a shelter. – Savannah

All of the older marginalized women who participated in the study were connected with at least one community service.<sup>51</sup> These connections ranged from women who were new to

homelessness, to regular participants at drop-in centres and women entrenched in street life.

The act of reaching out to these organizations, through which the women also found out about and participated in this study, signify that while they are indeed marginalized and may be vulnerable to isolation (Castel 1994, 1995a), their marginalization is partial; even if they are tenuous, the women do have some community connections. This chapter explores these connections, beginning with a discussion of the value of the spaces and places the women frequent, followed by their experiences of drop-in centres and homeless shelters. I also discuss the treatment older marginalized women receive within the service environment. This chapter uses interview data exploring the women's impressions of the services, focusing on *what* services they use and *how* they perceive them, as well as excerpts from my field notes and from the interviews with professionals to offer a richer description of the services and environments.

### 7.1 **Recognizing the Value of “Places to go” and “Things to do”**

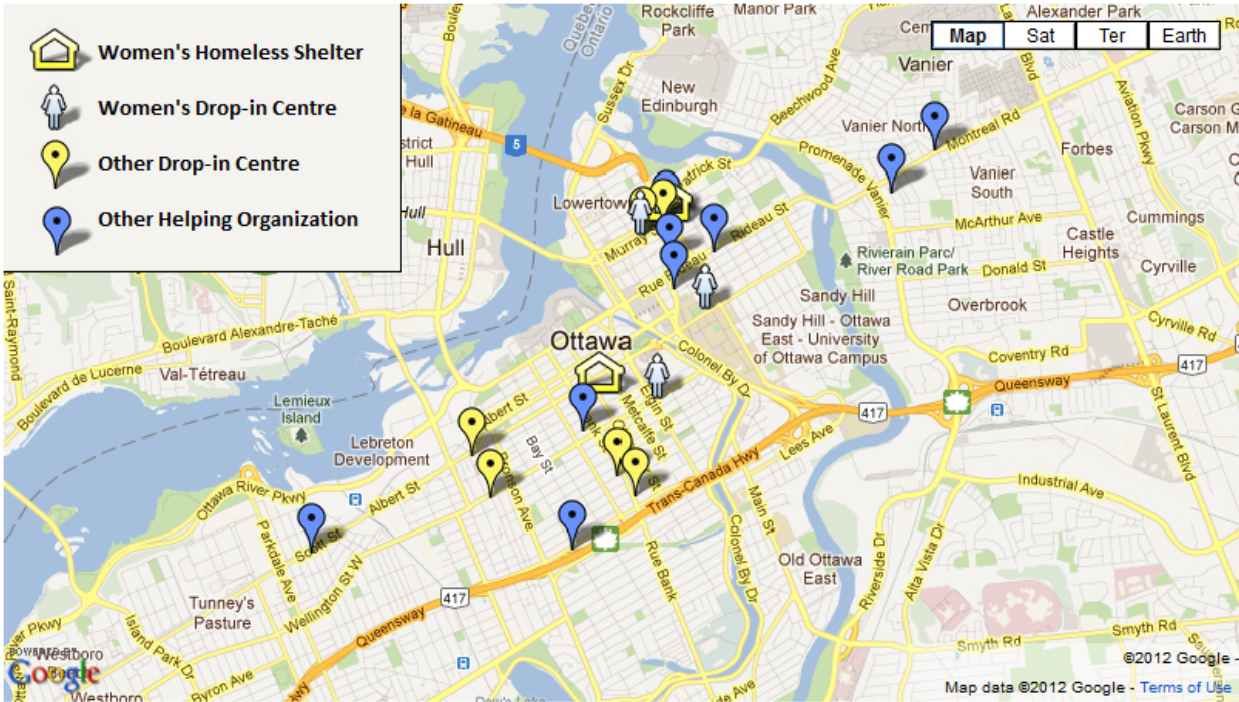
The women's engagements with community services form a key part of their social and community experiences; shelters and drop-in centres are important as they offer a way to connect with others and receive assistance. These places and spaces – drop-ins, shelters, favourite locations and haunts – are not just places to go; the spaces have emotional significance for the women (Manzo 2003; Munn 2009; Seamon 1982). They may offer safety,

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<sup>51</sup> The women often met me at these service locations and/or heard about the study at these places.

entertainment, friendship, or several of these. These community spaces form part of the women’s social worlds and can be deeply significant to them, just like the people that congregate within them or the activities carried out inside (Hester 1993; Low 2000; Manzo 2003; Urry 2000). Places that have an important resonance with community members can be considered “sacred structures”: while the places may be commonplace, memories of past events, daily routines, and the utility of a given place increase its significance to individuals and to the community as a whole (Hester 1993). While community fixtures such as schools, libraries, city hall, or other local infrastructure may be important to the community’s functioning, the informal places – drop-in centres, coffee shops, pubs, or other meeting places – resonate with community members’ needs for shared spaces (Munn 2009). They provide a destination, a way to spend time, and a chance to socialize. The following map highlights the services most frequently used by and found to be the most helpful to the women I interviewed.

**Figure 7.1 – Map of Community Services in Ottawa**



For homeless and marginalized people who have limited access to private spaces and who may struggle to find ‘acceptable’ ways and places to spend time (Bellot et al. 2005; Casey et al.

2008; Harter et al. 2005), these places are significant due to their open doors, not simply the services offered or the people present. Indeed, they may offer a ‘home’ of sorts to the women; they are not dwelling places, but do offer many similar comforts, such as meals, clothing, showers, or simply a place to relax (Moore 2000; Urry 2000).

The limited access to private spaces highlights the importance of community settings, including those provided by community organizations, as hubs for interaction. While some people may congregate, and indeed pass many hours at coffee shops, pubs, shopping malls, or recreation facilities such as bingo halls, bowling alleys, or arenas, all of these places generally require a financial transaction to gain and maintain access. For women who lack the disposable income to purchase a cup of coffee or a bingo ticket, these traditional social venues become off-limits (Casey et al. 2008). As such, the women’s movements in and through these spaces are blocked, or become hurried, fleeting, and exceptional instead of leisurely and routine (Casey et al. 2008; Urry 2000). Indeed, their presence is often the target of social control interventions (Bellot et al. 2005; Bernier et al. 2011). This deprivation of place is exacerbated for women with few, if any, other safe places in which to spend time. Although “home” is often touted as a safe space that is important and significant to both one’s physical and emotional life (Urry 2000), and is also often considered a female sphere vis-à-vis women, femininity, and traditional gender roles (Mandell 2004b), women’s home experiences are not uniformly positive (Manzo 2003).

Indeed, despite homes being considered havens and places of safety that are integral to one’s sense of self (Moore 2000), the home, in many ways, is a *risky* place, especially for older marginalized women. For women who call a shared room in a homeless shelter, a car, a small bachelor apartment, or a single room in a rooming house “home” – returning “home” may evoke feelings of loss and sadness; uncertainty and upheaval; or fear and worry for those who

consider their accommodations unsafe or who have experienced theft, assault or other victimizations (Brassard and Cousineau 2000; Fischer 1992). Similarly, for women who have experienced intimate partner violence, their homes may remain integral to their day-to-day lives, but lack significations of safety or comfort and instead may be seen as dangerous places (Beck 1997; Garland 2001). For older women who live alone, home may be a site of loneliness, isolation, and marginalization, especially for those with few family members or friends. These significations can also hold true for women who are shut-ins and whose movements are primarily constrained to the home. If they also face declining abilities, home can also be a space of constraint or confinement, negotiation, uncertainty, and possibly of fear due to the potential for slips, falls, or health emergencies (Rowles and Ravdal 2002; Weiss and Bass 2002). When one's home is transitory, conditional<sup>52</sup> or non-existent, one's movements and mobilities are altered; in these cases, the individual is not rooted in the community and thus becomes a transitory occupier of space instead of a resident (Urry 2000). With few available spaces for movement and interaction, older marginalized women's movements and mobilities become matters of necessity and urgency: they may be looking for safe spaces, welcoming spaces, spaces to slow down and unwind, or simply spaces where their presence is welcomed instead of discouraged. As such, women's ability to access community services and public spaces can provide a chance to rest, temporarily remain in place instead of being asked to "move along", or provide a reason to move and simply "get out of the house" for those who are otherwise isolated or immobile.

While many community places and spaces provide comfort and camaraderie, accessing community services can be frightening for those who have no idea what to expect or who are

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<sup>52</sup> A woman's home could be considered 'conditional' if her sleeping spot is intermittently available (e.g., a park or a building entryway); if she is temporarily staying with a friend or family member; or if she is an undeclared 'spouse in the house' whose presence jeopardizes the housing of her cohabitant.

distrustful of strangers and authorities. To better understand the lived experience of older women in the community, this chapter borrows an analytic page from the symbolic interactionist field book<sup>53</sup> and takes a phenomenological look at the women's experiences of service access; that is, it seeks to describe their lived experiences of the phenomenon (cf. Williams 1998).

These accounts of their physical, emotional and sensory experiences, provide a different and distinct perspective on the phenomena of community life and community institutions (Manzo 2003; Seamon 1982). With phenomenology, as Edmund Husserl (1970:223) explains:

... one must not operate with empty word-concepts, must not move in the sphere of vagueness, but must derive everything from clarity, from actually self-giving intuition, or, what is the same thing, from self-evidence — in this case from the original life-world experience of, or from what is essentially proper to, the psychic and nothing else. This results, as it does everywhere, in an applicable and indispensable sense of description and of descriptive science and also, at a higher level, of “explanation” and explanatory science. Explanation, as a higher-level accomplishment, signifies in this case nothing but a method which surpasses the descriptive realm, a realm which is realisable through actually experiencing intuition.

This section uses older marginalized women's “life-world experiences,” descriptions, and explanations to examine services from the women's perspectives. Here, I highlight the *what*, *where*, *how* and *why* of service access, focusing primarily on the women's experiences in drop-ins and shelters, the two most common types of services used by the women.<sup>54</sup>

## **7.2 Food, Friends and Fun: Drop-in Centres**

For all individuals, but especially for those who are marginalized, the social world is bifurcated into accessible and inaccessible spaces (Lianos and Douglas 2000). A woman's status and attributes mark her as “belonging” – or not – to a given space or place. This segmentation of

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<sup>53</sup> Symbolic interactionist and phenomenological studies have long been used to examine sociological and criminological issues and subjects from new perspectives. The work of George Herbert Mead (1913, 1932, 1934), William Foote Whyte (1943), Erving Goffman (1959, 1961, 1963) and Howard Becker (1963), among others, illustrate the power of this perspective and the nuance and depth that it can provide to research.

<sup>54</sup> As the women were recruited primarily from shelters and drop-in centres, these two service settings are explored in detail due to the wealth of information offered by the women about the settings. Where applicable, insights from other service settings are also included.

space constrains older marginalized women's movements, circumscribing their worlds. While spaces such as shopping malls, bus terminals, underpasses, community centres and parkland may appear "public" at first glance, they may still be policed and controlled to mediate *when*, *how* and *under what circumstances* individuals can use these spaces (Casey et al. 2008; Ellickson 1996; Mitchell 2012). Security technologies and tactics are at play in these environments; policies, codes of conduct, and noise and nuisance bylaws may be enacted to define and enforce when the space is "open" or "closed" and what occurs therein; video surveillance and key card access may monitor and control individuals' presence or absence from the space; and police and private security guards may be employed to actively maintain order and enforce these rules (Button 2003; Cohen 1985; Garland 2001; Lianos and Douglas 2000). These technologies mediate individuals' access to and interactions in public and quasi-public spaces (Casey et al. 2008). In particular, the increasingly privatized and controlled nature of these spaces limits older marginalized women's access to them due to their general disaffiliation to spaces of work (cf. Castel 1995a), and their lack of various privileges – including financial, social, and status-related (Boyne 2000). While this process is used by the state and private organizations to manage risk and control space, it also serves to shut out the vulnerable and marginalized, regardless of whether or not they pose a "risk" to this space or those within it.

In contrast to these heavily-controlled and mediated environments, drop-in centres offer open doors. For marginalized women, drop-ins are often the first line of assistance: they can be accessed quickly and easily without needing to call in advance or waiting for an available bed. Drop-ins address a range of needs, including meals and emergency groceries; toiletries and clothing; counselling and health services; and also helping users access work, education, and

training programs. In Ottawa, three drop-ins exclusively serve women: Centre espoir Sophie,<sup>55</sup> St. Joe's Women's Centre and The Well/La Source. Many other drop-in centres exist; some, including Centre 454, Centre 507, Ottawa Innercity Ministries, Shepherds of Good Hope and St. Luke's Lunch Club, serve homeless and marginalized individuals, while others offer services for specific populations, such as Aboriginal persons, youth, francophones, seniors, or those residing in specific areas of the City (Community Information Centre of Ottawa 2012). This range of environments and services provides older marginalized women with *choice*, something that is otherwise limited in the lives of marginalized individuals (Sen 1995).

The drop-ins and day programs offer varying services and qualitatively different environments. Not only does each centre have a different physical location and slightly different mandate and programs, they each have a different *feel* and atmosphere – qualities that imbue places with meaning and set them apart from one another (Manzo 2003, 2005; Sheppard 2002). This was evident during my fieldwork and from the women's accounts of their experiences. The *feel* of the centres is linked to characteristics of the physical spaces they occupy as well as to the women and workers who populate them. St. Joe's, for example, is a small facility in the basement of St. Joseph's church, located on Laurier and Cumberland streets, conveniently close to transit (for the women) and to the University of Ottawa (for me). After descending a flight of stairs, women enter the common room, an area which, for me, was reminiscent of sitting in the large kitchens and sitting rooms common in older farm houses and large homes:

I go in the side entrance and down a steep flight of stairs. The air is humid and warm in here and smells like coffee. I open a door at the bottom of the stairs to find a common room that looks a lot like a Mennonite kitchen: bright, large, open and dotted with plain wooden tables and chairs. There are maybe 30-35 women here right now, grabbing coffee and cereal from a shelf and cupboard by the

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<sup>55</sup> Centre espoir Sophie was not included in the research as a recruitment site as the services are offered exclusively in French and all interviews for this project were conducted in English. Several of the interview participants, however, indicated that they currently used or had previously used the services of Centre espoir Sophie.

kitchen, playing cards, reading newspapers, checking out what's going on in the kitchen and hanging out near a small staff office, where [contact] and some other young women are hanging out. It's bustling and a bit noisy; I take a minute to change my glasses before realizing that everybody's looking at me; I guess I stand out a bit with the ink. [Contact] remembers me and greets me warmly. She warned me by e-mail that today would be a hectic day because 3 students were starting placements; it turns out that the hectic-ness is compounded by the fact that it's food bank day (Field Notes, September 24).

In addition to this main area, St. Joe's also has a daycare room, computer lab, laundry and shower facilities, food pantry, a small kitchen and staff offices. Despite the small space, the setting feels cosy and comfortable. The Well is also located in a church basement, that of St. John the Evangelist, at the corner of Elgin and Somerset. In contrast to St. Joe's, The Well is a larger facility with a particularly big and open common room that is similar in size to a small gymnasium. On my first visit, I entered by the wrong door, leaving me lost in the large centre:

This place is oddly set up... it's kind of a maze, really. I haven't been able to get hold of [contact], so I'm kind of 'cold calling.' I wander in and start popping my head in different rooms (choir, laundry, quiet room, boutique...). I have no clue where I am. One of the women sees me wandering around. I ask if she knows if [contact] is around (thanking myself for not blanking on the name!)... She directs me to go see if she's in her office. I start off in what is apparently the wrong direction. The woman tells me that it's faster to go down the ramp, turn left into the boutique, left again past the kitchen and through the dining room. I eventually find [contact] (right where she's supposed to be). This is a crazy day at the centre – all of the dining tables (maybe seating for 100-150??) are full, and it's also the first day for a new placement student. I see lots of faces I recognize [names] and lots more that look really familiar (Field Notes, September 15).

After entering The Well via the main entrance (using a staircase or a lift), one arrives in a corridor that leads to program rooms, a second-hand boutique, showers and washrooms, a kitchen and the common room and staff offices. Further down the hall, one finds a computer area, cots and laundry facilities. While the amenities are similar, The Well and St. Joe's provide the women with *choice*. Sherry illustrates how the small and close-knit nature of St. Joe's and its programs (including an incentive program for those who help with chores) create an engaging environment:

The women here get to actually do stuff, not just sit around. If you want to get involved and do stuff you can do that. I personally think it's good for people. ... But I think it's beneficial for your own self-esteem, to get your body moving, to

realize that you've made a contribution – for yourself and others. Yeah. And to have camaraderie and friendship and laughter. It's good for people. Personally, I think they should have places like this for the men. Because I think that's part of [husband]'s problem. He's been isolated. When you go to 507, it's not this kind of atmosphere. 454 is not this kind of atmosphere. Even OIM, which is nice, is not this kind of atmosphere....

Brenda, who has lived and accessed services in many cities and considers herself to be a social worker to her friends and acquaintances on the street, also found an environment she considered to be special and unique in terms of service delivery at Centre 454:

[There's] a lot of relationship-building with the people next door at 454. Because they're very like-minded to me, like, they do believe in freestyle social work over there. And I think it's marvelous, marvelous. It's probably the best facility I have ever come across. ... Part of that is because they're so small, they can't do it all themselves. But that creates a community which is something that I'm not seeing anywhere else.

The small physical spaces of Centre 454 and St. Joe's create a sense of closeness between staff and participants that are unusual and special in the community, especially for marginalized individuals (Casey et al. 2008). Dina explained, "I go to St. Joe's church on Cumberland and Laurier, I'm not a volunteer there anymore, but I still find a lot of support and have felt love there, so I go there." For her, the sense of love in the centre draws her back, even though the facility is difficult for her to access due to her physical disability, highlighting the significance of a place's *feel* beyond its convenience or accessibility (Manzo 2005). Similarly, France noted of St. Joe's, "This is like a second home to me. [Manager]'s been good to me, all the staff have been good to me, I've never had any problem." For women who have few spaces of belonging (Casey et al. 2008), the drop-in centres can *feel* like a home and provide a sense of belongingness (hooks 1990; Urry 2000). While the welcoming-ness of the environment is somewhat intangible, the drop-in centres also provide many concrete services.

Aside from the atmosphere, the women cited different reasons for attending a given drop-in. As the programs are funded by the city and mandated to provide women with certain basic services, these needs are often the drivers behind women's initial visits to the drop-ins.

Catherine, who is a regular at several drop-ins, indicated that she enjoyed going to The Well as the facility was best able to meet her material needs. She explained:

The wonderful thing about The Well is that they've got good donations. And since it's for women, a lot of women are abused by men, and I think people have more sympathy. I've been to the men's places and they hardly have anything – no toothbrushes, no nothing. Whereas they've had. So people are more willing to donate to The Well, it's a nicer place when you go in, they have more food. If I need a loaf of bread, they'll go in the freezer and give me a loaf of bread, or some milk or something. They don't let you go if you don't have nothing. They don't let you. And they've got a little bit of a food bank inside of the boutique.

Food is of particular importance to older marginalized women; due to their low incomes, many struggle to afford a nutritious diet (Green et al. 2010; Health Canada 2002a). Day programs that offer daily hot meals and emergency food services can be essential to meeting this basic need. As Marie remarked, “You can never go hungry in Canada, I say.” As individuals age, however, malnutrition becomes an increasing concern (Green et al. 2010). A manager at The Good Companions<sup>56</sup> reflected on this issue:

The dining room – a hot meal – that's part of our program. We're funded to provide that. There's a notion – the 'tea and toast syndrome.' The dining room – we're funded for that because you're more likely to eat more and better and well if you're with other people and you have a hot meal accessible. So that's a nutrition program that goes on regularly.

The “tea and toast syndrome” denotes the situation in which many seniors lose their appetites as well as their ability and motivation to cook; therefore, they will frequently eat toast and drink a cup of tea instead of having a proper meal. This can cause a host of problems, including malnutrition and water retention (Yeates, Singer, and Morton 2004). Having a routine that includes eating well-balanced meals, and eating at least some of one's meals in the company of others, is extremely helpful in ensuring proper nutrition and adequate food intake for older marginalized individuals (Campbell and Leidy 2007; Green et al. 2010). Like The Good Companions and The Well, St. Joe's also provides food services, including two daily meals and

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<sup>56</sup> The Good Companions is not a drop-in centre per se; it charges membership fees, which can be reduced for those who cannot pay. The centre offers a range of paid and free programs and activities, a day program and hot meals. A large common dining room serves as a drop-in for individuals who attend the centre. Organized games of cribbage, euchre, and bridge are also offered weekly on a drop-in basis.

an emergency food cupboard. A worker reflected that food is the primary reason for many women's first visits to St. Joe's:

More often than not, what's bringing people to St. Joe's for the first time is a direct need. ... So more often than not it's our food cupboard – we're technically a food cupboard – that will bring women in to our organization. They've gotten their food bank for the month at their local food bank, but they still are lacking in groceries and nutritious foods at home, so they find out about St. Joe's Women's Centre to access our food bank directly, and then find out about the other services that are going on.... I would say another good percentage of what brings women here is just the need to get out of isolation. Isolation, so many of our women are isolated within their homes and use St. Joe's to socialize and meet that need directly. It's usually a direct need that they are looking for when they come here, and then through an orientation or a tour or talking with staff, they find out there are more services that they really could need and they didn't even know that they needed.

This worker indicates that while women may come to the centre to meet their basic needs, they often end up finding additional programs and services that can improve the quality of their lives. This "foot-in-the-door" approach to delivering services helps women who are either reluctant to ask for help or who do not know where to go to receive the services they need. The technique works by first allowing them to become comfortable with a small intervention or service before offering additional assistance or intervening in a more significant way (Freedman & Fraser, 1966). Inviting women into the facility for tours also reinforced the range of services available, the women's options for service access, and the welcoming nature of the drop-in centre.

In addition to meals and food bank services, most centres offer activities and a range of other supports, often in collaboration with other community organizations. Although many centres offer similar programs, each centre's services are slightly different. At the women's centres, popular activities included bingo and card games; arts and crafts; and singing or karaoke. At the other drop-ins, movies, games and creative pursuits were also popular. Louise had lived in Ottawa for less than a year at the time of her interview and was a regular at The Well. She remarked on the range of services available to her:

Um, they hooked me up to the ODSP.<sup>57</sup> They've helped me find housing. I look in the clothing, eat lunch, they did my taxes. ... What else? I've used the phone. They cut my hair. I've talked to some girls in here about whatever. I talked to a whole bunch of women, met a whole bunch of women here. I just about know everybody who comes in here all the time. I didn't know *anybody* coming in here ten months ago...

Louise's experience highlights the wide range of services that are available to women at The Well. In practice, these services are offered directly through the centre, as well as through partnerships with other community organizations. The professionals highlighted that, by using a collaborative service model, the centres are able to offer more services, and partnering organizations can engage with clients who otherwise may not seek out their services (Yamatani and Spjeldnes 2011). Similarly, France recounts her amazement at the number of services available at St. Joe's and at the generosity she has experienced there:

The services? Oh my God, I couldn't believe my eyes! The first year I came here, I was like, okay, it's a women's centre, we have breakfast, lunch, um, like for toiletries, I couldn't believe my eyes. And then the first Christmas, the gift we had – it's stuff that I don't even need to bother and get half the time! Or I get to do incentive – like setting tables and, passing the broom, what else is there? ... And when you go for incentive, I can't believe my eyes sometimes as the stuff people can give. Oh my God, a brand new watch from – I can't remember the name. I got some brand new stuff in there and the same thing as the clothing. ... Sometimes the food bank sends us stuff. Cleaning stuff, sometimes dish soap. I'm just naming anything. So there's no way in the whole world a woman cannot have what she needs when she comes here. ... Here if you, if you come and they see you crying, they're going to ask you to go to the office and talk about it. So they're never leaving anyone down, whatever, you can talk about what happened and they can give you suggestions. They're there to listen to you.

As the quotes above reveal, women who visited the drop-ins tended to have very positive views of the centres and the services that they offer. Indeed, on my many visits to The Well and St. Joe's, the environments were overwhelmingly positive; women engaged in programs and activities, chatted with one another, read newspapers, played cards and ate meals. While disagreements and conflicts occurred from time to time, the majority of participants at the centres remained calm and avoided conflict. Indeed, program participants more often *mediated*

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<sup>57</sup> Louise refers to the Ontario Disability Support Program, which provides income to Ontarians with disabilities.

potential conflicts for one another than encouraged them, and those who were upset or unruly generally deferred to staff if asked to calm down. This sense of calm and decorum may, in part, reflect the nature of the services and their delivery. Women are free to come and go as they please; if they dislike the environment, other participants or the programs, they can leave and meet their needs by accessing other drop-ins. The variety of service options is important for allowing women to find environments that suit them. Sherry, for instance, attends many drop-in centres depending on her needs and the services available on a given day. She explains some of the reasons why she prefers certain drop-in centres over others:

Oh yeah, here's a good place to go [St. Joe's]. Here. Sometimes it's good at OIM, Ottawa Innercity Ministries. And they only meet on Wednesdays. ... I do like going there. Sometimes to 507, but it's hard for me because it's a huge flight of stairs to get up to 507 and it's hard on my knees, oh, it's hard! Centre 454 is good. Like I said, CCM is good. I used to go to The Well. I worked there for a year. I left because I didn't like the way the women were treating each other. It was getting really nasty, back-biting, fighting. I just didn't want to be in that kind of environment, so I've never gone back. I like it here a lot better.

For Sherry, the people, physical spaces, and available services dictate where she goes.

Savannah indicated that she is also aware of the many services available to her. Like Sherry, she tried many different drop-ins before finding one where she felt comfortable:

[Boyfriend] showed me everywhere to eat in Ottawa. Where to get clothes and stuff. Yeah, I usually do the fall fashion shows at the end of the month at The Well. Spring Fling I didn't do because I couldn't find something I liked to wear. St. Joe's – I don't hang there. I find it too small, too claustrophobic with too many people in there. I can't be around too many people.

Sherry further explained that, depending on the type of service or assistance that a person requires, different centres may be better able to meet a person's needs. She notes that the clientele varies between the centres, as do the services provided:

Centre 454 is great too; the workers there are really good. They have knowledge and skills that the people here [St. Joe's] don't. So if they can't help you here, I would send people down there and have them hook up with the counsellors down there. The problem there is that there's even less privacy than there is here, it's – it can at times be a very rough area because it's in the hood. The staff are really overworked. So you could go down there hoping to see a counsellor, because you never know which one's on duty, and you might get in and you might not, that type of thing. And they know a lot about everything, and in some

ways they don't know the stuff that the people here know, so switch back and forth type thing I'd say.

Sherry's final remark, encouraging women to switch back and forth between centres, exemplifies the manner in which many individuals, including the older marginalized women who participated in the study, access services. Many of the women indicated that, while they may have a preferred drop-in, they often go to more than one centre depending on their needs, the programs, activities, or meals available on a given day, or their ability to physically go to the various centres at different times. This method of service utilization reinforces the need for a strong community service network and multiple options to assist women.

The drop-in centres and helping services go beyond meeting individuals' day-to-day needs, providing everything from friendship to dental floss. One of the few things not provided in the centres, however, is a place to spend the night. Most drop-in participants do have housing, although their housing situations may often be considered precarious or tenuous for various reasons, such as low incomes, problems with physical accessibility, difficulties with roommates, or mental health disorders, among other reasons. For women who have nowhere else to go, the city's homeless shelters can provide a place to stay.

### **7.3 On Becoming "Unsheltered" in the Shelter<sup>58</sup>**

Many of the women interviewed described living lives that were at least somewhat "sheltered" before their encounters with homelessness and marginalization. Most participants had not led privileged lives; while they had often lived in modest or somewhat precarious circumstances, most were accustomed to having a place to live and a steady, if low, income either from work, social assistance, or disability benefits. Researchers have long noted that the majority of older female prisoners serving time are new to the criminal justice system and experiencing prison for the first time (Aday and Krabill 2011; Kratcoski and Babb 1990; Uzoaba 1998; Wahidin 2004).

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<sup>58</sup> The title borrows from D. L. Rosenhan's well-known article, "On being Sane in Insane Places" (1974).

While comparable statistics on shelter residents are not available, this study uncovered similar findings; many of the women interviewed were staying in a shelter for the first time as older adults. Some of the women, for example, indicated that they had been married, raised children, had careers, had owned cars and/or houses, and were unaware of many aspects of homelessness, including its prevalence and the services available within the community. Coming from this background, the shelter experience was new and unexpected.

It must be noted that shelters and prisons are quite different; women are not sent to shelters to be punished for infractions and are not “doing time” while staying at a shelter, although comparisons of this nature have been made (Deward and Moe 2010). The experiential reality of the shelter is, however, especially challenging as most of the women did not anticipate becoming homeless and had few ideas about what to expect. Howard Garfinkel (1956) described how the experience of arriving in prison is filled with “degradation ceremonies,” which he defines as “Any communicative work between persons, whereby the public identity of the actor is transformed into something looked on as lower in the local scheme of social types...” (1956:420). These can include the ritual of arriving at the prison, as well as practices such as fingerprinting, photographing, strip searches, and receiving a prison uniform, all of which serve to strip an individual of their identity and instead re-make her as a “prisoner.” The degradation ceremony of homelessness is less formalized and consistent, but can result in the same negative stigma and degradation associated with coming into conflict with the law and imprisonment (Phelan et al. 1997). The process generally involves arriving at a shelter through any one of many pathways (e.g., self-referral, referrals from the city, police, other shelters or other marginalized individuals); completing an intake interview with a shelter worker; handing over medication, weapons, and drug paraphernalia; receiving a bed kit and being assigned to a room; learning the basic rules of the shelter (curfew, meal times, acceptable behaviour, etc.)

and then being immersed in the shelter environment. This is a jarring and emotional experience for many that can give rise to fear, anxiety, and an overwhelming desire to be anywhere else. The experience is magnified for older women, who, as discussed, often have more difficulty adjusting to and coping in the shelter environment. Danielle, who had arrived at Hope Outreach a few days before her interview, reflected on her experience of coming to the shelter:

Scary. Ohh! *Point. Blank. Scary.* I've never been into a situation like this – never. This here is – wooooah! Like, okay?!? I wasn't sure, at all, I didn't know. But I'm trying to accept it. ... It's the whole situation. The whole situation is kinda scary. You never know what's going to come next. Like, I see a lot of people with a lot of anger and a lot of sorrow and pain. You can see it in their faces and in the way they try to – they try to run, but they fall back. They try to run. I wish them all the best, to be able to keep and take that big step out. But that's my hope for them. But here is scary.

At Hope Outreach, where the service philosophy focuses on harm reduction, clients' behaviours are often disruptive and challenging for staff to address. This atmosphere can intensify the experience of othering and amplify the significance of the degradation ceremony for first-time shelter residents (Deward and Moe 2010). A worker from Hope Outreach describes how older isolated and marginalized women may arrive with little warning or preparation:

The problem is when the police go and take somebody out of their home like that [during an eviction], and my point is – when they're so isolated – they bring them here. Where are they going to take them? That's where you're talking about being marginalized in many ways, because now you're on your own, you can't advocate for yourself, you're a hoarder, you smell bad, you're all these things, no one knows anything about you, so what are we going to do with you? We're going to bring you to a homeless shelter – you've probably never stepped in and have no idea. You step in and it's "Oh my – look!" You've got nothing but a pair of slippers on your feet and that's it. Then we have to go and take your life and unravel it and work backwards.

Coming to a shelter is often the only option for those with few social contacts who face eviction. Women with broader social networks or more financial resources may be able to avoid shelters in these situations by living with family or friends or paying for other accommodations. When there are no other options, or when the resources and/or patience of one's networks are exhausted, going to a shelter may be the only remaining option, as was the case for Mary. After losing housing and staying with a friend, she found herself homeless:

Homelessness has shown me things in this society I didn't know was here. When I first was brought to Hope Outreach down on King Edward I was horrified. Try traumatized. ... I was there for five hours. Oh my God – they should condemn that place. Oh my God, that is like a visit to hell. Scared the shit out of me, I don't mind saying. All of the drug addicts and alcoholics. The staff there is really nice, but just going into this place – it's people using all over and it's just – it's frightening, it's scary. And I know they're doing what they can, but the co-ed bathroom with just a shower curtain across in front of the toilet which is filthy?! I was just like – I was horrified. People call it "The Jungle" for good reason. It's frightening. ... I didn't even know that even existed in Ottawa to that level. Wow.

After her five-hour stay at Hope Outreach, Mary transferred to a bed at Cornerstone. At Cornerstone, however, the shock of homelessness continued to affect her life. While she once again completed an intake, handed over medication, received a bed kit and learned the house rules, the stress of her circumstances wiped these experiences from her memory:

The psychiatrist said extreme stress can cause short-term memory loss, and quite remarkably. And still to this day, the first week that I was here, I have absolutely no memory. I actually signed documents when I got here, and two weeks later, I found this sheet and saw my signature, and I'm reading it for the first time. I was in shock then, but yeah, that's one of the big concerns. And I find a lot of the women mention that, short-term memory loss, big time! It's very scary. Especially at this age, it's like "Oh my God! Do I have Alzheimer's?" That's the first thing that everybody thinks. But honestly, sometimes, well maybe this is something. But I've got so many other health concerns, I don't need one more. I don't want to know if it is!

The effects of stress can be far-reaching, affecting physiological functioning, mental health, and memory (Rosch 1997; Williams et al. 2006). While Mary indicates that the memory loss she experienced is not unique to older women in the shelter, she notes that it takes on a new significance due to her age and health conditions. These concerns are well-founded; older women experiencing homelessness, severe poverty, or imprisonment are found to have higher rates of health problems, including dementia (Aday 2003; Aday and Krabill 2011; Baggett et al. 2010; Shantz and Frigon 2009; Washington 2005). Indeed, long term stress and living in inhospitable conditions are linked to the accelerated aging that leads homeless, marginalized, and criminalized women to frequently be defined as "old" at age fifty (Wahidin 2004, 2006; Washington 2005). New experiences and exposures, fear for one's safety, as well as health

conditions and concerns can all make shelter stays challenging for older women, especially when they feel like they do not belong in the shelter environment.

David L. Rosenhan's now-famous article, "On being sane in insane places" (1974), describes an experiment in which people without psychiatric disturbances – the "sane" – faked symptoms of mental illness by pretending to hear voices, and were subsequently admitted into psychiatric facilities – the titular "insane places." Once admitted, the participants stopped faking symptoms and waited to see how staff reacted to them. One of the most interesting findings of Rosenhan's study was that the institutions' other residents realized quickly – indeed, almost immediately – that the study participants *did not belong* and were not truly mentally ill. The staff, on the other hand, was not so quick to pick up on this. Rosenhan's article provides a telling parallel to many older women's experiences of shelter life. For those who come to the shelter for the first time, there is often a sense expressed by others, and by the women themselves, that they do not fit in. This feeling includes the fear and anxiety expressed by the women about the shelter environment, but is also a reflection that their lives and experiences are incongruous with their surroundings. Joy, for example, explains how she did not fit in in the shelter:

It's not easy living here these days. I had a time where I was at the other shelter on King Edward before I was here [at Cornerstone] and it wasn't easy because there people are – um, on drugs or whatever. Recovery, people from alcohol or something to that effect. Me, I never drink, so I've never had that problem. I don't smoke, so I've never had that problem. So like, it was new to me. [laughs] ... For two weeks I didn't sleep, I mean right through. So it wasn't easy. So I talked to one of the women [staff] and I said look, "I don't think I'm no better than nobody, but I'm not accustomed to this kind of life." I never subjected myself to – well I was going to say no kinds of abuse – because there was abuse and there was abuse, but no, no... putting something in my body? No, I never subjected myself to that.

Many older marginalized and criminalized women experience a sense of being *different* from other groups (Kratcoski and Babb 1990; Washington 2005). This feeling encompasses both the physical environment and the interpersonal relations within it, as Mary illustrates:

And getting used to becoming – or being a statistic or a number – takes some getting used to. I'm not used to being treated or spoken to – you know, in that way. So I'm insulted, I'm hurt, I'm offended so many times. The other girls are sort of coaching me, like "Oh well, meh! That's nothing."

For Mary, "being a statistic" is a new and unwelcome reality. Her experience mirrors those of new prisoners and of ex-prisoners, who note that losing one's identity in the eyes of others is an integral part of one's degradation ceremony and of bearing one's new labels (Becker 1963; Garfinkel 1956; Goffman 1963; Hannem and Bruckert 2012; Strimelle and Frigon 2007). For Mary, this treatment was a small, recurring reminder that she now holds the master status of a "homeless person" – at least within the shelter (Becker 1963). While staff and other residents can help older women to adjust to their surroundings, acclimatizing to the shelter experience often takes time for adjustment and reflection. After having time to reflect on their experiences, the sense of being different or "other" brings new revelations.

Instead of focusing on the negative elements present in the shelter environment, some of the participants highlighted how the shelters reinforced their resilience. Surviving in a tough environment can be a source of pride and is significant accomplishment, especially when one considers the alternatives to this resilience (Cyrulnik 2005). Maggie's first shelter experience was coming to Cornerstone, where she had lived for several months at the time of her interview. Her initial experience was less traumatic than Danielle's or Mary's, but was nonetheless eye-opening. When asked about an event that had shaped her, Maggie responded:

You know what? Coming to this place [Cornerstone]. I've never had a lot of major problems in my life because I'm a very organized person and I keep dates usually... appointments and stuff like that. Coming here has shaped me a little more; opened my eyes a little more, to the world around me because I'm not used to being around mental people. I probably could now work in a hospital, you know. Elderly people, schizophrenic; there's so many characters in the house that really opened my eyes and changed me in a lot of ways here.

After several months at the shelter, Maggie came to see homelessness as a formative experience, with both positive and negative attributes; she still struggled with her situation, but

showed resilience, accepting the challenges she faced and developing ways of coping and surviving (Bonanno 2004; Cyrulnik 2005). Kristin also indicated that, while the shelter is not an ideal place to be, it serves a useful purpose for her and many others:

Well, my own experience is that [homelessness] had nothing to do with being lazy. It had to do with a couple of situations that all came together at once and maybe I wasn't paying attention to everything. It wasn't that I was lazy or that I was trying to be a jerk, or trying to be a fuckup, things just happened. I was and am really grateful that the shelter system exists so I could park myself somewhere safe until I can get myself together. Yeah, there are people in the shelters that aren't getting their stuff together or for some it's their long-term way of life, and for those I genuinely feel for them. Because it's not any kind of life.

For women like Kristin, shelters can provide a wake-up call and warning of the dangers of their lifestyles; Kristin's stay is a potent reminder of the importance of managing her addiction, relationships, and her financial affairs (Sutherland et al. 2009). Dina also struggled with addictions. Like Maggie and Kristin, she found her shelter stay difficult, but also a testament to her resilience as she got clean and maintained her sobriety during her stay at Hope Outreach:

I never really drank. I smoke pot. I tried a crack habit. My best friend turned me on to crack and I got addicted to crack. I was addicted for four years. And I just got off of that. I've been clean for about eighteen months now. This is the crack central of Ottawa. They call it "Shepherds of Good Dope." [laughs] It's a tough place for getting clean. But I did it. I wanted to do it.

For Dina and the other women interviewed, the shelter provides more than simply a roof over their heads. Shelters also provide lessons on life, patience, and resilience, which help to instill a sense of thankfulness for one's own abilities and perseverance (Sutherland et al. 2009).

Older women's first experiences of shelter life are oftentimes eye-opening, shifting their understandings of their communities, of homeless shelters, and in some cases, of themselves. While these experiences and the women's interpretations of them vary, one theme that the women – both those new to the shelters and those with significant past street involvement – consistently highlighted was safety within the shelters.

## Safety

For women with long histories of homelessness, the shelter environment is not usually perceived as being exceptionally scary or frightening. Their past experiences often include significant traumatic events and exposure to a range of dangers; in contrast, shelters, like prisons, can offer a measure of safety and security that some women have not frequently experienced (Robert et al. 2007; Shantz and Frigon 2009). Older women with histories of homelessness offered insights and critiques of the services available based on their knowledge of the services in Ottawa and other areas and also based on years of experiencing shelters and drop-ins from the client's perspective. Despite their familiarity with shelters and drop-ins, many of the women's views mirrored those of women new to homelessness, citing safety within the service setting as an important issue. Savannah noted that the harm reduction policies in place at Hope Outreach were helpful for some at the expense of others:

But with the shelters – it's great. It's good, but the Shepherds, they have to change their way of stuff in there because they hand out needles and they know the girls are going in the bathrooms and doing their shit, and the girls leave their needles and bloody Kleenex. I know it's a safe environment for them, but there's women that don't do that shit, and they've got to walk in there. And ladies step on a syringe – they've got to change that whole thing over there at the Shepherds.

Harm reduction policies aim to mitigate the negative effects of drug use: providing clean needles and other drug supplies can help to reduce the transmission of diseases including Hepatitis C and HIV (Marlatt and Witkiewitz 2010; Van Den Berg et al. 2007). Problems can arise, however, when the materials provided are not properly managed and disposed of, creating problems for other women in the shelter such as Anna, a resident of Hope Outreach, who noted:

I was, I just missed walking on two needles, like for crack. I don't know about that stuff because I don't take that stuff. You know, I was just told to try to put your shoes on. I got no slippers.

The danger of discarded needles is greater for Anna than for more seasoned residents; Anna had no previous exposure to street drugs, no expectation of finding drug paraphernalia in the shelter, and was unaware of the potential danger in her environment. This reality of the

environment highlights the difficulties associated with implementing harm reduction policies. While the benefits of harm reduction are well-established (Marlatt and Witkiewitz 2010; Van Den Berg et al. 2007), there are pitfalls and messy actualities in implementing and living with the policy, including dealing with those who do not follow safe disposal protocols for paraphernalia; mediating conflicts tied to intoxication and drug impairment; and in attempting to ensure that the environment remains safe. While their knowledge of potential dangers minimizes some of these concerns, the violence present in the shelters remains troubling for the more street-entrenched women. Savannah indicated that violence was an increasing problem at Hope Outreach:

... But I really think the Shepherd's gotta rethink what they're doing down there. It's not a good place – it's not safe down there anymore. People are hitting people over the head with bottles. You know [client]? She got beat up because of not giving a girl a drink. She got hit over the head with a wine bottle and she died. They had to pull the plug. The woman was dying from cancer. It's really dangerous down there; it's really dangerous, in that respect.

While Savannah cited the negative side-effects of harm reduction policies as one reason why Hope Outreach is considered by the women to be dangerous, Brenda linked the lack of safety to protocols limiting staff-client interactions. She noted how the facility's no-touch policy limits staff's ability to intervene in conflicts:

The clients know there's a no-touch policy so they can be ripping each other's hair out and staff won't touch them. They'll call the police and wait for them to get there. And then the police don't keep them. The police brought a woman here – last week, three officers brought a woman here in cuffs. Just a heads-up: *if you have to cuff a woman to get her in the car, she has no freakin' business in a building where no one can touch her!!* You know, like, *THINK!* Of course, a minute and a half later she had assaulted a staff and two clients, and the police were called .... Like, what the hell! We had two old ladies assaulted and a staff member pushed or something. But the staff can't push back! ... I do not blame the staff, okay? The staff is doing the best they can....

While Hope Outreach is widely recognized for being the last avenue of support for many of Ottawa's most marginalized women, maintaining order in this environment can be very challenging (O'Malley et al. 1997). In this case, the women with the highest level of *need* do indeed pose the highest level of *risk*; their behaviours jeopardize the safety of other residents and staff. In this environment staff must attempt to balance all residents' rights to safety with

accommodating individuals with challenging behaviour that is often linked to addictions, past trauma, and/or severe and persistent mental health disorders. It should be noted as well that while the women primarily expressed personal safety concerns regarding their time at Hope Outreach, violence and danger are also a regular occurrence at Cornerstone. While these events are less common and generally less severe at Cornerstone, they nonetheless occur regularly and also require intervention by staff and sometimes police.

While staff struggles to accommodate all of the city's marginalized women and their competing needs within the existing service framework, abuse and victimization do occur (Fischer 1992). Many professionals noted that older women are vulnerable to victimization within shelters, domiciliary hostels, and drop-ins, particularly at Hope Outreach; the wide range of clients and the focus on harm reduction means that safety cannot be guaranteed, despite ongoing attempts to make these spaces as safe as possible. A manager noted that, while Cornerstone shelter is considered to be a safer option than Hope Outreach, it is also problematic in some ways:

Because of our facility and the way it's laid out, there's so many stairs, it's very difficult as well to keep a lot of senior women here. If people have a lot of special needs and are on the main floor, that's about as far as it can go. We have an elevator on the main floor that has never worked. This is long before I got here: somebody decided to put the elevator in but never measured the hallways, so it's not possible to use a wheelchair in those halls. I think at one point they did have some sort of accessible bathroom downstairs but I don't know when that got changed into a bedroom.

With the available shelter options, older women are placed in a catch-22 situation: the services that are physically accessible lack safety, and those that are relatively safer are not physically accessible. This results in weak and frail women being placed in situations in which they are vulnerable to victimization and often unaware of the potential danger surrounding them (Bruckner 2001; Dietz and Wright 2005). The manager also noted that dangers and safety concerns are not limited to shelters; they also exist in other housing situations:

The increases, in terms of domiciliary hostels, the secondary victimization - In a place where you're not normal, and there's so much instability with mental health and addictions; people get taken advantage of financially and it's just that secondary trauma that just brings them down emotionally and physically and it's hard for them to get out again. It exacerbates the whole reason why they're there in the first place, really.

The danger posed by other residents is especially acute for older women with mental health issues (Dietz and Wright 2005). For women with paranoia or panic disorders, facing real threats in the shelter can exacerbate their struggles to cope in the environment. Evelyn, for example, struggles with paranoia that is amplified by her experiences:

There's one girl around here – well, I haven't seen her in the last two days, she's still here. You can't really function around her. She's like this [holds up pinky finger, denoting thinness]. She threatens you constantly. I haven't seen her for two days. She leaves her things in the TV room all the time, so they don't seem to give her a room, but they keep her here. Or they used to. I haven't seen her, maybe she's gone. I'm glad if she is gone. But there's others just as manipulative, but I don't think they'll hit me, so. Yes, I've been hit since I got here. I got my head bashed against a wall.

Evelyn's fears escalated after an altercation with another resident left her with bruises and a cut on her forehead. Evelyn's experiences reinforced her fears, making daily life more challenging for her. It is important to note that the facilities' staff members are aware of these issues and do what they can to address them, including conducting regular walkabouts, checking in with residents considered to be vulnerable and conducting room searches when warranted. However, the high resident-to-staff ratio, the physical layouts of the shelters (including many areas that are not directly supervised), and residents' complex and competing needs all make this a challenge (Holmes, Kennedy, and Perron 2004; Parton and O'Byrne 2000; Shibusawa 2009). As with Evelyn, Anna's health was affected by her fears. For Anna, the stress and anxiety created by the environment affect her mental and physical health. She explains:

But since I've been here – I think it's a month – two times a week I'm in the hospital. The Heart Institute. I just came out. But apparently it's not my heart. It's just stress that's causing my heart... I take pills for my heart rate to go down and my blood pressure to go down. But I find it's when I'm upset, yeah. So, that's where – and I don't have a family doctor. So I don't know where to take it from there. And I put myself down too much. I mean really down. But of course here,

you say, you try to just hide it and say good morning to someone, they'll tell you to f-off. You know, are they strange?

Anna's fear and anxiety exacerbate her depression, and are particularly worrisome due to her heart condition. Homeless shelters are not ideal places for individuals with health conditions; despite offering on-site health services, the stress in the environment and the lifestyles associated with homelessness are not conducive to good health (cf. Barrow et al. 1999; Deward and Moe 2010). While a different environment could help to improve her health and reduce her stress, homeless shelters are refuges of last resort: by definition, there are few, if any, alternatives available on an emergency basis. As such, she must wait at the shelter for an alternative to become available.

Safety, in its broadest sense, goes beyond one's right to freedom from physical harm. Indeed, the *Canadian Charter of Rights and Freedoms* guarantees individuals "... the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (Canada 1982, s. 7). The concept of "security of the person," has been interpreted to include both one's bodily health and psychological integrity (Blencoe v. British Columbia (Human Rights Commission), 2 S.C.R. 307 2000). For older marginalized women whose shelter experiences jeopardize their mental health and well-being, an argument could be made that the circumstances they face limit their freedoms under the law. Indeed, these rights are not breached in accordance with law; instead of being convicted of an offence, the women are simply guilty of being homeless (although the stigma and negative connotations between these two states often share some similarities) (Chunn and Gavigan 2004, 2006).

Kristin, for one, noted that the shelters exposed her to drug use that triggered her own addiction:

You step outside in the parking lot. People are doing drugs, they're buying drugs, people smoke drugs in the bathroom on a regular basis. This isn't something I need. I've never done crack, I've never done any drugs. I tried once or twice in my teens, but it put me to sleep. So I thought, well this is great. So I just said forget it and I stuck with alcohol. But I can walk to the bathroom on the other

side. And I've now learned to recognize the smell of crack. It smells like – it kind of smells like stale cigarettes. But I walk by and it's all over the place, and for me – the smell of drugs doesn't trigger me, *but the lifestyle I see does*; it's hard.

For those trying to stay sober, shelters provide myriad temptations, including easy access to drugs, little structure or programming to occupy one's time, and close contact with drinking or drug 'buddies'. Savannah noted these concerns for her sobriety in the shelters:

I've been to detox 3 times here already, but as soon as I get out of detox I go and get drunk. I lose my bed here [Cornerstone] and I go on my binges for 2 or 3 weeks, sometimes a month – until I can get back in here because when I'm at the Shepherd's, that's all I do, drink, drink, drink. Someone's always calling, "Come on, Savannah! Come with us! We're going to drink, we're going to drink, we're going to drink." I get tired of it eventually - and thank God they let me in last night on the couch. [Worker] is working with me on it. So many people worry about me when I'm gone. Like [my friend], she wanted to come and get me at the Shep's, but that's not a place for her to be, either.

Savannah's experience highlights the problems faced by the chronically homeless when attempting to stay clean and move forward (McNaughton 2008). For others, the missing sense of personal security relates to one's possessions. As Maggie indicated, security cannot be taken for granted in the shelter, even when it would normally be expected:

We do have some very nice staff. Like with everything, there's some good and some bad. But I'm not about to mention names or anything, but there's more good – there's more nice staff than there is bad. I've had my medication stolen, and the only ones I know have access to this is staff. And I'm not the only one. There's many. So somebody is taking our meds.

For Maggie, the loss of medication is particularly troubling and places her in a difficult situation; by shelter policy, her medication must remain locked in the medication closet, yet her experiences and those of the other residents indicate that this closet is far from secure. As she has very little money, she also cannot replace her medication once it is stolen. Small acts like the theft of medication make staying in the shelter more stressful and make women all the more thankful when they are able to find housing. When I met her, Bev had recently moved into a rooming house after staying at Hope Outreach. She highlighted the persistent problem of theft in shelters. This problem stems from the shared accommodations, limited security, and

transient nature of the facilities (Brassard and Cousineau 2000; Fischer 1992). Bev recounted the importance of personal security and not worrying about her belongings:

What's really nice is I've got my own place now and I can shut out the public again. You know, I – living here was okay. They were all good to me – I have no complaints that way. But I don't trust a lot of the women here. Okay, and they've proved it. Last month when I was here I got ripped off for forty bucks. Yeah, my wallet. I had to get a new bank card. That's what's nice about having my own place. Because I can come here – and spend all day here – not a problem. But I want to go home at night. Yeah, when I shut that door and lock it, I can lock out the rest of the world and that's what's important to me.

At the shelters, where most rooms are shared with anywhere between one and five other women and single rooms are a luxury<sup>59</sup>, locking one's door and shutting the world out quickly becomes an unknown indulgence. While physical safety was the primary concern of most of the women interviewed, the broader spectrum of safety needs – including maintaining sobriety and control over one's possessions – were also important to the women's sense of security.

Fear of the danger and unsafe conditions encountered by older women in shelters lead some older women to attempt to avoid the experience altogether (Cohen et al. 1997; Washington 2005). The women's fears of what they will encounter in shelters often are much greater than the actual difficulties they face. These fears, while emblematic of women's feelings, are often amplified through the process of retelling shelter horror stories to one another; through the grapevine of street life, negative incidents are often blown out of proportion and shared with anyone and everyone who is interested to hear them, which only reinforces fears and concerns. Indeed, in my own experience working in the shelter, it was not uncommon to mediate a dispute that involved yelling and physical shoving, only to later learn that the women who witnessed the incident told others that a fistfight or all-out brawl had occurred. Led by their fears, instead of

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<sup>59</sup> All of the rooms at Hope Outreach are dormitories. Most rooms at Cornerstone shelter house two women, although there are a few single occupancy rooms and several triple occupancy rooms. The single occupancy rooms are generally offered to women who cannot cope in a shared room due to physical and/or mental health needs.

reaching out to the community for support and assistance, some older marginalized women may attempt to find other options to stay out of the shelters. A worker from Centre 454 explains:

Some elderly women, specifically, they don't want to stay in shelters. If something happens to them, like one woman had her feet amputated, and she lost her housing ... [S]he was offered that she could go to the shelter. She said, "I'm not going to the shelter!" So guess what happened to her? She started to go to her friends' places. All of them had social housing, so they could keep her for a week or two, but that was it. So everywhere, they were jeopardizing their own housing by keeping her. ... Finally, at the Options Bytown building, they told her to leave and go to a shelter. She said, "I'm not going to a shelter!" This woman was spending the nights at McDonalds and then going back to the places where she was. Finally, the public nurses and everyone said that no, she had to go through the shelters, then they will find a place for her. Now she's in the shelter. She's unhappy. She was forced to be in the shelter, she's very unhappy, and everyday she's thinking of ways to run away from there, even if it would jeopardize her health.

Those who avoid staying in shelters and who are therefore not visibly homeless are sometimes referred to as the "hidden homeless" (Harter et al. 2005). While attempting to live in a fast food restaurant is far from an ideal situation, avoiding living in a shelter is sometimes seen as a way to maintain one's dignity, independence, and to avoid the stigma associated with being "homeless" (Phelan et al. 1997). Joan, who had recently been barred from the shelter<sup>60</sup> and who struggles with mental illness, used sarcasm to illustrate her frustrations with having to stay in shelters:

How things are here? The staff has been dealing with nutcases. They must think I am one too ... I've had it! This is my chance to get out of here; the feeling is mutual. How things are here? Everything is free! *Whee! I'm living for free!* How would *you* like to live in a box? No surveys, no trying to get through? ... These shelters – all of them – I've been through several in Montreal; they're all crazies, the people there. Some are worse than others. They're really the pits of the people who live on the street, which is the other one on Murray, have you been there? ... I was there once; I slept on a mattress on the floor. It was the overflow. They had no room. Total nutcases – they're drugs. This one's only marginally better. They've got a blacklist; what's it called? The "ineligibility list" or something. How things are in shelters? It's free. Everything's fine, it's provided. Food. But time is going. You sit watching TV. ... Put yourself in – simple, you can do this. Put yourself living here and that's what I've got to tell you.

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<sup>60</sup> Joan was barred for having weapons and medication in her room. Her hostile and negative attitude, including significant racist outbursts, was also a contributing factor in her being asked to leave.

Joan's acerbic take on shelter life highlights the frustration that is often part and parcel of living in a homeless shelter. Within the shelter, she is now a "crazy homeless person" and is often treated this way by other shelter residents, the general public, and sometimes by staff. While the label may fit her actions and self-presentation at times, it represents a total identity or master status under which she cannot be identified or understood based on any of her other attributes (Becker 1963). Wahidin and Powell (2004) indicate that carceral institutions assault one's identity. The attack on identity, and indeed on one's sense of normalcy, is part of being inside a total institution with regimented routines and constant surveillance (Foucault 1977; Goffman 1961; Wahidin and Powell 2004). For older women who are attempting to re-establish and reconfigure their identities, the experience of staying in a shelter challenges their self-perceptions and assumptions, especially relating to their autonomy, independence and status as a mature woman or capable adult.

#### **7.4 *Respect your elders? Infantilization in the service environment***

Some of the difficulty associated with staying in a shelter is linked to the limited autonomy and independence offered in the facility. For older women who have previously functioned independently in the community, the rules, regulations, and restrictions of shelters and drop-ins can be perceived as forms of *institutional thoughtlessness*. Institutional thoughtlessness is a term I borrow from the work of Elaine Crawley (cf. 2005). She examines prisons instead of community-based organizations, but there are strong parallels: both are services of last resort, serving the "least eligible"<sup>61</sup> of citizens. Crawley (2005:350) defines institutional thoughtlessness as "the ways in which prison regimes (routines, rules, time-tables, etcetera) simply roll on with little reference to the needs and sensibilities of the old." In contrast with

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<sup>61</sup> "Less eligibility" is a term arising from the British *Poor Law Amendment Act* (1834). The principle of less eligibility states that "the condition of the pauper supported from public funds must always be inferior to that which could be obtained by working at the lowest-paid job available... lest men prefer idleness to labour" (Sieh 1989:160). Since its inception, variants of this principle have appeared in welfare and correctional policies around the world.

Stanley Cohen's (1985) clinical iatrogenesis, this is not a case of an intervention exacerbating a situation; rather, here the *lack of action* or the *lack of problem identification* results in a negative outcome. One must note that, in many cases, the organizations are, to some degree, aware of the problems faced by older women, but cannot accommodate their needs due to financial constraints, the physical facilities, and the competing needs of other residents. Institutional thoughtlessness and infantilization affect older women in many ways, from the loss of freedoms and autonomy to feeling disrespected or belittled by staff (cf. Grenier 2011). Joy shared a room with two other women. She expressed the frustration she feels when her roommates change:

If there's a bed change, if the girl wants to change her bed, just tell me I have a new roommate. They didn't even tell me! No, you need to be respected! *And we know it's not our place, but God, you need to respect us.* You know, just "You have a new roommate tonight." I come in and I will not be surprised. When you come in you see these new things and this new person bringing new stuff and you don't know what happened. I don't know what happened to the other roommate, I have no clue. No, I need to know. You don't know *nothing* in this place!

For long-term shelter residents, returning home and opening one's door to find that a stranger has moved in can be upsetting and tiring, especially as this can happen several times in a week – even several times a day on occasion. The parade of new roommates is frustrating for women who are used to independent living and stable routines and who simply wish to have a roommate with the same level of stability. From a staff perspective, attempts are made to pair women with roommates who have similar routines and lifestyles, but this is not always possible.

Shelter rules and routines are designed to ensure fairness for all residents and to create basic rules for decorum and behaviour within the shelters. While their purpose may be to ensure that the shelters function effectively, these rules are often perceived by the women as condescending and infantilizing (DeVellis and Kilty 2010; Deward and Moe 2010). The shelter curfew is one such policy: women must return to the shelter by 1 AM each night or their belongings will be packed and they will lose their beds. Ekatarina found the curfew problematic:

I sing blues and jazz and I find that singing is a release. It's kind of hard because – if you're not in by one then you lose your bed. And it's kinda hard because they don't start karaoke until 11.... By the time you wait your turn, you get to sing one song, maybe two. You're just starting to feel the pressure leave, and then you've gotta go or you lose your bed. ... And there's no buses. There's no buses here so you can't go far, otherwise you've got to leave before you even get to sing because I know; I tried. And that makes it hard because there's no real stress release for me.

For women who consistently respect the curfew, lacking even occasional opportunities to stay out late can be disappointing and frustrating. The policy, however, is in place to ensure fairness for residents and those looking for a bed<sup>62</sup> and to reduce the women's opportunities to engage in drug or alcohol abuse. Because of her religious practices, Joy also struggled with the curfew:

Your cut off time is one o'clock. And for me, I don't go partying, but I love to go to church and sometimes we have church – we call it midnight vigil. It starts at 12 and then goes to 3, and it goes on for seventeen days. ... I don't want to lose my bed because I can't sleep on that couch. ... I can't sleep on that couch or the chair that other people use. It has to be a bed, otherwise I can't sleep. *It has to be a bed.* So that's why I don't go, because I don't want to lose my bed. I don't want to lose my bed. So the big difficulty is that you have to be in by a certain time, you have to abide by certain rules. You know, *when you're accustomed to turning your own key then you have this – it's not easy!* So for me, partying is not my thing. It's about freedom to be my own person. That's the main thing for me.

Joy's previous independence increases her frustration over her constrained choices. For women who have no other options besides staying in the shelter, the threat of losing one's bed is seen as particularly severe. For older women without histories of homelessness or marginalization, the potential loss one's bed is often seen as a major calamity.

Other small reductions in autonomy also affect the women. As in the prison environment (cf. Wahidin 2004; Wahidin and Cain 2006), a lack of control over food and nutrition stood out as particularly important. Many women thrive on the food provided in shelters; for those who otherwise lack access to regular meals and who do not have the skills, abilities, or means to cook for themselves, receiving three daily meals and nutritious food can bring significant health

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<sup>62</sup> Of note, the women's shelters, especially Cornerstone, are normally filled to capacity. When beds become available, they are generally filled within a few minutes or hours.

benefits (PHAC 2010; Health Canada 1999, 2002a). Meals also offer stability and predictability, which can help women to structure their days and develop routines. For women who are accustomed to selecting, purchasing and cooking their own food, however, having menus pre-chosen and being served food prepared by someone else at pre-determined times can be experienced as infantilizing and demoralizing. This is especially problematic when the food is culturally inappropriate or not to one's personal tastes. An Aging at Home nurse reflected on the significance of food in the shelters:

I can't tell you how often, and I'm sure you would agree, the women are complaining about the food at the shelters. It's a huge issue. Especially when you look at the new immigrants that get newly diagnosed with hypertension, they'll say, "If I could just make my curries like I was making in Africa, I would not have to be taking these damn pills!" I don't disagree with them. There are exorbitantly high levels of salt and fat and stuff in our processed food and that's what they get at the shelter. A high, high level of carbs for all of our diabetics. So even if they could just be getting healthier food, their physical and mental health would be so much better!

Food and nutrition are important for one's health. Delivering proper nutrition is difficult for shelters with limited food budgets; on most days, meals include pantry staples such as canned sauces and vegetables, processed meats, pasta and bread products, as well as sweet desserts.<sup>63</sup> Fresh fruits and vegetables, while representing healthier choices, are only available in limited quantities. Providing proper nutrition is one of the facilities' goals, but meeting the women's diverse health needs, including special diets, while also providing food that the women want to eat, can prove challenging. Anna, for example, needed a special diet for her heart condition, but found following her diet to be extremely difficult in the shelter:

Like the food isn't right and I'm on a diet for my heart. And I can't get that food here. She, next door there [at Special Care for Women], she gave me a list. Mainly no salt and no fat and stuff, but you don't get the good stuff anyway. Like the stuff I'm supposed to have. It's not that much, like the odd salad or your intake on salt. She – I wrote it all down anyway, but you don't get it here anyway. Like, you know. Popcorn or something, but it takes your cholesterol.

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<sup>63</sup> Of note, shelters often receive much of their food from the food bank and from private donors, including significant donations of sweets and bakery leftovers. As a shelter worker, it was not uncommon to serve sweets for breakfast, dessert at lunch, dessert with supper, and as an evening snack.

Anna's health concerns are particularly striking as the diet that she requested is recommended for *all* adults (PHAC Government of Canada 2010; Health Canada 2002a). Food and nutrition were an extremely important issue for the women staying in shelters. Food has a special place and a unique significance in many women's lives (Locher et al. 2005; Murcott 1982). Through the women's roles as mothers, they were often the food and nutrition providers for their families, managing their household food supply, creating menus, and cooking daily meals (Mandell 2004a). Many family traditions and special occasions also revolve around food and special weekly or seasonal meals, further increasing food's importance (Locher et al. 2005; Murcott 1982). Food is typically an integral part of one's lifestyle, as was the case for Mary, whose diet needs also went unmet in the shelter. She recognized the limitations of food services within the shelter, yet highlights the impacts that this has on her health:

My normal routine is completely screwed up here. I have a juicer, I juice, I'm on a special diet; I can't do any of those things here. ... Food, you know, I've taken courses in diet, and I look at diet as more like a pharmacy, because we can heal ourselves, and I've witnessed that. I've had it happen to myself, so I know that food is a big issue. And we're very fortunate here to have a good cook and lots of good donations, but still there's a lack of the really fresh stuff on a daily basis. So that's a concern.

Older marginalized women are more likely than their younger counterparts to have health concerns (Cohen 1999; Washington 2005); as such, proper nutrition is very important for this group. Food-related concerns span both nutritional *needs* and personal (including religious or cultural) *tastes*, and also include the timing of meals and the availability of nutritious food at non-meal times. As many older adults struggle with appetite and consuming enough protein and other nutrients (Campbell and Leidy 2007), lacking ready access to highly nutritious foods at other times may compromise their ability to eat healthfully. Food and nutrition are central to life; for older women, lacking control over one's food and diet is particularly frustrating and disempowering.

Although many of the infantilizing situations that older women face in the shelters and drop-in centres are temporary and linked to the time they spend in these environments, others are more long lasting. Some of the infringements of the women's rights are linked to attempts to protect their health, maintain their housing or otherwise look out for what are considered to be the women's 'best interests.' While living in the shelter, Adele was deemed to be incapable of managing her own affairs. Her finances are now managed through a public guardian and trustee. While Adele may indeed be incapable of managing her own financial affairs, the feelings of powerlessness associated with this realization affect her day-to-day life and outlook:

A doctor – he was a psychiatrist – he got me on the public trustee thing. And now I can no longer handle my own money. They give me my cigarettes as I go along, you know. I can't get out of here.

The goal of the public trustee is to ensure that Adele's money is managed and her daily needs are met. The arrangement is frustrating and problematic for those, like Adele, who do not fully understand *why* they require a trustee. Rather than feeling supported or assisted, Adele instead feels trapped and powerless in her situation. A Hope Outreach worker explored the feelings of powerlessness and the limited rights Adele experienced after having a trustee appointed:

The problem with the public trustee is that PG&T is that first of all, you have to agree to have a PG&T and pay for it, which a lot of our women don't because I think it's about \$300 or \$400 sometimes. Or you are actually hospitalized and you're deemed as being incompetent to handle your affairs, so a PG&T would then be assigned. Some of our women don't want that. Especially- because that's losing control, isn't it? So it makes it hard. ... Very few of the women have actually come and say, "I would like a public guardian and trustee" because normally, it's something that - because of their declining mental health issues – it's something that they're not too happy about.

Beyond the obvious loss in autonomy, the situation raises the question of how to preserve women's autonomy and ensure their quality of life, especially when few housing options are available. Aside from the loss of one's rights, as when a public guardian is appointed, the curtailment of women's freedoms occurs as a side effect of the routines, rules, and policies of the agencies, systems, and institutions with which the women come into contact (Crawley 2005). In supportive living environments, for example, extraordinary measures are sometimes

required to preserve a woman's housing. A housing manager explained the curtailment of a woman's rights that occurred to preserve the building's safety:

We have a woman right now who should be moving to [assisted living]. We're almost at a line where we can't keep her anymore.... Physically, she can't get out of her bed quickly; I wouldn't even call it slowly – it's incredibly slow. She can barely climb the stairs and she's smoking in her room. There's a fear of fire, and if she's smoking in her bed, there's no way she could get out in time. We have the *Landlord and Tenant Act* here, so it's very difficult because when push comes to shove, she can smoke in her unit. ... So now we're at this predicament: how do we keep everybody safe and keep her housed? So we're going into her unit once an hour, which under the *Landlord and Tenant Act*, I don't know how that would fly, but she knows we're going to do it in order to maintain her housing. But it's such an invasion, too, to go in every hour because we don't do room checks or any of that stuff here. ... it's really just holding on for dear life for [assisted living], worried that she could burn us down.

As the manager indicated, the situation is far from ideal and represents a genuine infringement on the woman's rights and an ethical dilemma: should the woman's rights be breached if the breach enables her to maintain her housing instead of facing eviction? In this situation, the manager and facility staff struggled with the "messy actualities"<sup>64</sup> of service delivery and have deemed that curtailing the woman's rights and freedoms is justified to ensure she has a safe and supportive place to live and so that the safety of the other women in the facility is also maintained.

Potentially infantilizing experiences are amplified for older women: while many women who have lived independently find shelter policies and routines frustrating, age disparities between staff and older women can exacerbate these feelings (Shantz 2008). Participants who had significant ties to their families and communities noted the juxtaposition between the respect and deference they received in these roles and the belittling treatment they sometimes received when accessing services. In reference to her situation in the shelter, Mary explained: "In some

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<sup>64</sup> The term "messy actualities" refers to how programs, policies and courses of action are not simply implemented, but instead are mediated and transformed through contestation and resistance (Barry, Osborne, and N. Rose 1993; Osborne 1993; O'Malley, Weir, and Shearing 1997).

ways I feel mature – I'm a mature woman; in other ways I feel like a baby." Depending on the situation, age disparities can cause frustration or give an emotional boost. France explains:

All the staff here are much younger. And that's not easy. Sometimes maybe, you're 55 or 60 and you don't want to be told by a young person. But I take it as if it would be my daughter, and I need to listen. She has the right to say what she thinks, and she has the right to tell me, okay it's better not to do that. But last time, last Thursday, I asked, "Can I do this? Can I take this?" She said, "You know better than me. You've been working here so many years in the kitchen; I don't need to tell you what to do." ... I always say, well if there's something I can't take I'll tell you. "You know what you're doing. You know better than me!" She's nice.

France's reflection demonstrates the emotional value of deference and respect. While she sometimes feels uncomfortable with young women telling her what to do, displays of deference minimize tension or ill feelings. Indeed, the deference shown to France is not unique; in contrast to the infantilization and disrespect toward older marginalized women that are often part of popular discourse and sometimes part of the service experience (Moe and Ferraro 2003; Shantz 2010), these attitudes and experiences are not universal. Indeed, aging and respect are deeply and intimately linked in many cultures and in the philosophies and practices of many organizations (Abu-Laban and McDaniel 2004; Shilling 1993). Marie, for example, found that the services for Aboriginal women were uniformly welcoming and respectful of her status as an older woman and an Elder. She described her experiences with her community:

I like to get involved in stuff, in things, in my community. I like to take part in stuff, like drumming. I want to meet people; I want to be in there with my own people. I want to be a great teacher one day. You know what I'm saying? With my spirituality, about respect, love and all those. They call it the Seven Grandfathers. Love, honour, respect, bravery, humility, forgiveness, yeah, all those. That's what we're supposed to do according to the Elders' teaching. Except they call them the Seven Grandfathers. Yeah, you learn so much, man!

Marie's pride in her culture – and her position of respect within her cultural community – illustrate how welcoming and open communities can be to older marginalized women. A manager at the Wabano Centre for Aboriginal Health reiterated that the organization offers its clients a safe, welcoming, and respectful place, especially for older women:

... You're talking about people who are 50 years old, this is prime residential school age. So this is a place where folks are dealing with the effects of residential schools in terms of their healing and well-being and their wellness. That's prime; that's the prime generation. So when you're speaking about women ... women who are usually the centre of our communities. Losing your family, being separated from your mother, those kinds of things were very traumatic and harmful. So these women are coming back here to be supported; to be recognized for their place in the community as leaders. Basically as leaders that – there's not a hierarchy, it's not a patriarchal situation. It's one of equality, interdependence, community; our communities have always been interdependent. So those are the kinds of things they're coming here for.

The warmth and sense of community described are not limited to the Aboriginal community; many service organizations attempt to create environments with the same levels of respect for older adults. A counsellor at Centre 454 reflected that many of the difficulties and disrespect older women sometimes face are linked to a lack of patience for her clients. She explains that, for one of her clients, accessing services such as healthcare is overwhelming due to the lack of respect she receives and the manner in which other professionals treat her:

That stigma is everywhere: what they look like; how they're dressed; how they behave; how they answer questions. That makes them isolated, and they feel it, so they don't even try. ... So what happens, if this woman has pain, she will tolerate that, but not go to the hospital by herself. So that's a horrible thing, but I see that. ...access to simple health services is limited for them, just by the way they express themselves. They have the same needs like everyone else. This woman is a big survivor, I guess. I understand the other part; I understand how difficult it can be to deal with her. But sometimes, as a counsellor, when I observe that, I think, Could you have just a little bit more patience, just a little bit more patience with these people? That's it. That's all they need, just a little more patience. Not just closing the door right away if they're difficult. Sometimes when you're patient, they appreciate that; they know their faults, too. They know that what they do can be kind of weird, they know that... We treat them with respect and understanding. But in many places, they're not treated this way.

By the very nature of outreach services and the diverse clients they serve, feelings of disrespect and infantilization will occur from time to time; indeed, this is part of everyday life and part of the messy actualities of delivering programs in a dynamic environment (Barry, Osborne, and Rose 1993; O'Malley et al. 1997). Although disrespect can occur, it is frequently a result of staff or other clients/residents not recognizing a situation as disrespectful and less frequently an example of an overt attempt to be disrespectful (cf. Crawley 2005). Both older women and

those who serve them attempt to create positive, respectful, and barrier-free environments. In this pursuit, however, they often face uphill battles. The realities of contemporary society – including the *institutions, policies and discourses* that frame older women’s lives – frequently reify the status quo, keeping older women at the margins of social life. The following chapter explores community life from a structural perspective, highlighting power, stigma and other forces affecting and influencing the status quo.

# Chapter VIII – The Problematic Everyday World

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## 8 The Problematic Everyday World<sup>65</sup>

Community – I mean, normally, I think I'm still in shock. Because I thought – I'm from the old school where I thought when people are experiencing poverty, people pull together as a unit and help each other. What I'm finding is that these days, people don't join together, but instead say, "Well, I've got to grab this for me" because they're so afraid they're not going to have enough. – Mary

I think seniors' residences have some responsibility to deal with their clients that aren't dealable, right? Right now, seniors' residences put out clients who smoke in their rooms, set a fire, got in a fight with someone. They are sent to a shelter. – Ottawa Inner City Health Nurse

Older marginalized women's negotiations of the physical and social worlds frequently include contact with organizations that help them to meet their basic needs. These organizations and their staff, however, often go beyond providing a place to go and access to life's essentials; they also offer support and companionship, something that is frequently lacking in the women's lives. The service community offers consistent support, in contrast with marginalized women's sometimes intermittent relationships with family or friends. Here, I focus on the service environment which constrains and structures older women's movements. To examine this, I discuss mobilities and movement, and how these affect the women's lives in terms of available and blocked opportunities and access to services. Next, I examine the challenges of service provision with those labelled 'difficult to serve.' In addition to community services and the physical environment, one must also consider the social forces affecting older women, including policies and popular discourse. While discourses about older adults have begun to shift, more often recognizing a range of abilities and social and financial situations for this group, policies and regulations remain relatively static. In the final section of this chapter, I examine policy and legislation affecting the women, as well as contemporary discourses and how these relate to the women vis-à-vis stigma.

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<sup>65</sup> The title borrows from Dorothy Smith's (1987) *The Everyday World as Problematic: A Feminist Sociology*.

## 8.1 *Around Town and Through Life: Services and Mobilities*

Ottawa offers many services to older marginalized women. This population is, however, *not* the specific focal group these organizations; they serve larger populations of which older women are a part, such as older adults, marginalized adults, homeless women, Aboriginal men and women, or women in general. Depending on a woman's needs and preferences, she may find support and assistance at one or many organizations, often switching between services depending on her needs and her assessment of the service agencies. I broaden the gaze from the women's direct experiences to their movements through the world around them.

In Ottawa, the community-based services for older marginalized women include:

- Two homeless women's shelters that are accessible to the general population – *Cornerstone* and *Hope Outreach*;
- Two English-language and one French-language drop-in centre exclusively serving women – *Centre espoir Sophie*, *St. Joe's Women's Centre*, and *The Well/La Source*;
- Two seniors' centres serving women and men – *Centre de service Guigues* and *The Good Companions*;
- Drop-in centres – *Centre 454*, *Centre 507*, *Ottawa Innerscity Ministries*, and *St. Luke's*;
- Services for Aboriginal women – *Minwaashin Lodge*, *Odawa Native Friendship Centre*, *Tungasuvvingat Inuit*, and *Wabano Centre for Aboriginal Health*;
- Numerous soup kitchens and free meal programs – including (but not limited to) *St. Luke's lunch club*, *Shepherds of Good Hope*, and *The Mission*;
- A variety of street outreach services – including (but not limited to) *Odawa Native Friendship Centre (the Bannock Bus)*, *Ottawa Innerscity Ministries*, *Ottawa Public Health Site van*, *Salvation Army*, and *Somerset West Community Health Centre – Safer Inhalation Program*;
- Abused women's shelters – *Chrysalis House*, *Interval House*, *Maison D'Amitié*, *Nelson House*, and *Oshki Kizis Lodge*;
- Medical and public health services;
- 14 community resource centres; and
- 68 community centres and community recreation complexes (cf. Community Information Centre of Ottawa 2012).

While accessing services requires older women to have knowledge of the resources, their conditions for service, and their geographic locations, the service network was often well-known to them. The women's knowledge is augmented through their interactions with one other and the aforementioned word of mouth information sharing process; indeed this is often the manner in which people learn about community services (Kissane 2010). Aside from services, the women's movements are structured around accessibility (cf. Burnett and Lucas 2010). For many older marginalized women, there are few options to facilitate or ease their mobility. Public transit is available, but is not always affordable for women who have little disposable income. Jane, who was 64 at the time of her interview, indicated that she could not afford an adult transit pass, but would be able to buy a seniors' pass once she turned 65. She explained the significance of the pass, noting that when she turns 65,

Number one, I'm going to get a bus pass. And then I'll be freer. Most definitely. Like I said, if I come here [to the drop-in] and wanted to take off at two, I'm gone. And I heard someone else on the bus say that, too. It gave them a sense of freedom because they can just pick up and go. Who cares if you're there two hours? Who cares if you go somewhere in the morning and come home at noon? Who cares? You've got the bus pass, you can just pick up and go. So yeah, I am looking forward to that. If they tick me off here, then it'll be just "Fine, I'm gone!" get up and go. It won't matter, and I can just pick up and go. So yeah, I am, in that respect looking forward to that. Big time. Yes, it's going to make a big difference, that. Yeah.

For relatively affluent seniors and near-seniors, "perks" such as seniors' days or special discounts are simply a way to save money in retirement. For those of limited means, however, discounted prices may represent the difference between a service being accessible and being out-of-reach; a seniors' bus pass, at less than half the cost of an adult fare<sup>66</sup>, will offer her freedom to move throughout the city. A worker at St. Joe's also indicated that transit cost was a problem for many of the drop-in centre's clients. She noted that the centre can facilitate the women's mobility by offering improved access to transit services. She explains:

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<sup>66</sup> As of March 2012, a seniors' bus pass in Ottawa cost \$37 per month (the equivalent of 11 regular cash-fare trips), while an adult passes cost \$94 per month (or up to \$145 for a rural express pass) (OC Transpo 2012).

We try as much as possible to help in the development of [social networks], whether it be by providing them with bus tickets to get here or bus tickets to get to groups that they choose to join; some of our women have regular para transpo that will bring them here. That's been worked out with para transpo; usually you would have to call the morning of, and it's the fight with the clock because they only take calls at this time, and it's busy from the moment they open to the moment the line closes, and if you don't get in, you're not getting anywhere. So we've made specific access arrangements for some women to get para transpo without having to call in the morning.

In acknowledgement of the challenges some older marginalized women face in navigating their communities, many of the professionals indicated that their facilities routinely accommodated women with mobility impairments by ensuring access to transit, renovating facilities, and modifying the facilities' routines. These two latter types of accommodation were used at The Well to ensure that older women were able to take part in activities. A worker explains:

We have a lift for women with mobility issues. When we serve lunch, we always ask women with walking devices, or walking aids to go first to get served. Yeah, we'll accommodate them. Actually, it's very interesting; we just got a donation of three or four mobile devices, scooters, donated. They're very nice ones, and we've already talked to staff as to which women we think would benefit from them, so we're already getting ready to make sure these women have them. We talked to ODSP, because most of the women here are on ODSP, and they will service them if they have service issues, so we're really excited about that. It's a big deal, because if they sold them, they could've got a few thousand dollars for them. But we're trying to find women who actually will use them and enjoy them and get a better quality of life because of them. It's very exciting.

In deciding who will benefit from the donation, the centre must evaluate the women's mobility needs and possible ulterior motives; for some, improved mobility may be an insignificant opportunity cost in comparison to the cash value of the scooter, especially if they have grown accustomed to limited mobility (cf. Karelis 2009). Especially when one considers the care and attention dedicated to selecting women to receive scooters, the centre's approach to the donation highlights the physical and social value of women's connections to the agency; the women's low incomes preclude affording a scooter, yet their social capital can provide the mobility aid (Keating et al. 2005; Stone and Rosenthal 1996).

While mobility aids and transit may be ideal options for some older marginalized women, not all will benefit; some require less mobility assistance due to their geographic locations, while others may go without services if they do not know how to access them or if their access is blocked. For example, for those living in the downtown core, far from a bus stop, or who feel that public transit is dangerous or unsafe, a bus pass will be of limited use. For these women, walking is often the primary means of locomotion. As walking from place to place can be taxing even for younger bodies, especially in inclement weather, it poses inherent challenges for older women's bodies, especially for women with health concerns (Burnett and Lucas 2010). Bev explains:

I walk. Sometimes [if] I've walked too much the top of my feet ache like toothaches. You can feel them. It's horrible. It's horrible if I take any too long a walk, I'm, I'm sore for days. Well, that's why I'm sore now [Tuesday]. Sunday I got all dressed up. I hadn't worn my heels in a long time. And I was never in pants before, I always used to wear dresses and I liked my heels. But my leg is still killing me – this one here – from wearing my heels on Sunday. I wasn't even sure I was going to make it home on Sunday. I took my shoes off halfway home. It wasn't too bad. But next time I'll like, I always bring my backpack with me so I'll stick a pair of flip-flops in there or something in there so I can wear them home. But I don't go too far, I really don't. Here [shelter] is about it – it's eight blocks from where I live to here.

Bev's experience highlights the compromises required to manage her mobility; while her identity performatives previously highlighted her attention to style and self-presentation, she must now assess the risk and benefit of movement and self-govern to determine *where* she walks and also *how* she walks (e.g., shoe choices) (Beck 1997; Holstein and Minkler 2003). While this problem confronts many women who wear high-heeled shoes, unlike Bev, most of these women are privileged to be able to take a bus or taxi home, or even purchase a pair of flip-flops to wear instead of walking barefoot, especially in the downtown core where the risk of stepping on broken glass or other dangerous objects (e.g., needles) is relatively high.

Physical barriers are not the only blockages of mobilities; indeed *internal* barriers often prove to be more powerful and limiting than *external* ones (cf. Cyrulnik 2005). These barriers may be

related to past experiences (e.g., avoiding a drop-in after a bad service experience), personal attributes (e.g., having claustrophobia), or mental health issues that make everyday places and spaces appear frightening or dangerous. A manager at Ottawa Innercity Ministries explains:

There's barriers of mobility, but a lot of what I've experienced the internal, psychological barriers from a lifetime of experience and a lifetime of trauma and abuse and again, fear of making that connection, fear of rejection, fear of being evicted, fear of whatever the case may be. A lot of the barriers are internal, ones that through their life experiences have been created.

Several of the women's narratives further illustrated this point, highlighting fear, anxiety or uncertainty as reasons for not reaching out or accessing services in the community, just as others have found for ex-prisoners (Richie 2001). Evelyn, for example, struggles with mental health issues that leave her feeling paranoid. Despite her able-bodiedness, her mental health limits her mobility, identity performatives and her enjoyment of her community. After indicating that she used to enjoy walking outdoors, especially to the park, she explained why her feelings about her environment had changed:

Well, I used to enjoy it a lot. And I would say to some of them here, you want to come up, go for a walk. And then no, but they'd follow me in groups behind. And I thought, well, at least they're getting out. And then about a couple of weeks ago, it started, someone's got an idea up there, you get this, you get that, you never know what they're talking about, maybe it was all made up. So I stay away from it. So you get this kind of – and they manipulate where you go. This is all behaviour from the drug trade that's taken them.

Evelyn's case illustrates how fear and paranoia can circumscribe older marginalized women's social worlds, but also demonstrates the challenges and barriers faced by those who seek to improve the women's integration into their communities (Parton and O'Byrne 2000). From this standpoint, community organizations struggle to work with the women to overcome *internal* barriers to mobility, including mental health issues, low motivation, or limited abilities. A manager and staff member at Hope Outreach explained how *internal* barriers limit mobility:

[Staff]: A lot of people say, "Why don't you guys get them to do this or this?" well, I'm pretty stubborn; I can just picture what I would be like if I had to stay in a shelter and someone was trying to tell me what to do, especially if you add the mental health and everything on top. It's not easy. ...

[Manager]: I think it's a switch to meeting them where they are and physically going to them to do things. ...if we have to refer someone out or ask someone to go out, that won't necessarily happen.

[Staff]: I might say, "It's just up at the Mission." "Well, I can't walk up to the Mission! I've got a bad foot" or "I'm too tired" or "I can't make it" or whatever. I've taken [client] from here to Sandy Hill [Health Centre] and driven her [about 500m] because she wouldn't have gone there on her own. But there's no problem if I give her five bucks to go up to Chez Lucien and have a beer. ...But then she couldn't get back from Chez Lucien and had to call the Sal Van. But she wants to do it, but she just doesn't get it, right? She just doesn't get that she can't.

Serving older marginalized women is not a one-size-fits-all exercise; it requires sensitivity to the various mobility impediments, both *physical* and *internal* within the community. Older marginalized women's multifaceted needs may both increase the level of service and assistance they require, while simultaneously limiting their access to services, just as with blurred 'needs' and 'risks' in other groups (Hannah-Moffat 2001; Kilty 2006, 2008; Munro 2010). In short, older marginalized women's mobilities, and therefore their access to services, are affected by the physical environment around them, including the services available, the proximity of services, and their methods of physically accessing services. Their access, however, is also mediated by their attributes and abilities, including income, familiarity with and comfort in the community, and psychological or other internal barriers to service. From this perspective of blocked mobilities and needs, service organizations often struggle to find ways to serve this group. The challenges associated with providing these services are described next.

## **8.2 'Difficult to Serve' Clients**

The research sample for this study favoured those who were (to some degree) actively engaged in the community, whether by chance – through ending up at a homeless shelter, or by choice – through choosing to attend activities at drop-ins. The sample included women who, although possibly having mental health issues or addictions, could cope in communal environments and were comfortable sharing details about their lives with me. While this recruitment strategy appears to have few restrictions, selecting women with these qualities stacked my sample in

favour of women who were relatively better integrated; my sample underrepresented the women who are considered to be the most “difficult to serve” – those who cannot or will not, through their personal characteristics or behaviours, access services in conventional ways, consent to receiving service or cope in group settings, such as shelters and drop-in centres (Balard and Somme 2011).<sup>67</sup> While this term and similar descriptors are frequently used to discuss a range of clients that pose service challenges due to their multiple needs (Danziger and Seefeldt 2003; Dart 2004), the Northwestern Ontario District Health Council<sup>68</sup> (2004) enumerated a variety of factors that – individually or combined – can make an individual difficult to serve in their context. While this council does not have jurisdiction over the Ottawa area, it shares a common federal and provincial regulatory framework and therefore the policy and structural-level issues and challenges that are present in Ottawa. For this Council, “difficult to serve” clients are those who:

- Have challenging behaviors
- Have an acquired brain injury
- Are mentally challenged
- Have dementia
- Have a profound physical disability
- Are obese with a physical disability
- Are smokers
- Have mental health and addictions issues
- Are homeless and have no family support
- May be any age, though the majority are seniors (Northwestern Ontario District Health Council 2004:2)

For marginalized and homeless women, the list could easily be extended to include: significant histories of institutionalization (in prisons or mental health facilities); health disorders that cause unpredictable behaviour (e.g., poorly managed diabetes); anger issues; or significant and

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<sup>67</sup> These clients are also sometimes referred to as individuals with “multiple needs” (cf. Brindis, Pfeffer, and Wolfe 1995) or “complex needs” (cf. Handron et al. 1998)

<sup>68</sup> In 2006, District Health Councils were replaced with provincially-mandated Local Health Integration Networks (LHIN). LHINs are responsible for managing healthcare services – including hospital, community and mental health services – at the regional level (L. H. I. N. Ontario 2012b).

persistent conflicts with others. When contrasting the list with characteristics common to older homeless women, the broad and vague nature of terms such as mental health issues also stands out; although one in five Canadians have a mental illness of some sort, the criteria make mental illnesses appear abnormal (Centre for Addictions and Mental Health 2012).

Organizations will often have their own definitions of 'difficult to serve' clients as the behaviours and situations they can manage will vary. For example, some of the criteria listed above – such as being a smoker or having mental health and addictions issues – would not generally make an older marginalized woman 'difficult to serve'; rather, she may be considered a 'normal' client.

Despite organizational nuances, the criteria offer a glimpse into the personalities, situations, and challenges that organizations serving the marginalized must address. Older 'difficult to serve' clients often face the stigma and aftereffects of a lifetime of marginalization. A manager at The Good Companions reflected on this, indicating that many of those who are difficult to serve are struggling with their own challenges as well as the stigma associated with these challenges.

She explains:

There's a lot of unresolved issues that are out there. ...the cumulative effects of a lack of support throughout a lifetime, or being marginalized throughout a lifetime – it's even more, doubly so. You just don't fit. Trying to find friends, trying to fit in a group, you look weird. Maybe you can't see and your makeup's on funny, so all the labelling and bullying continues in old age and it's a real problem. It's a problem with us too.... But as the numbers grow and there's fewer people to [provide] help, I don't know where we're going to go with this. It's going to become really critical. If you look at The Well right now, they're full. ... And then we've got people who won't even go to The Well – they've been there, don't like that and don't want to be there with "all those loonies." Even though they don't self-identify, they don't fit in that because of – it's often mental health. It's a lifelong time of that.

Older marginalized women who are considered 'difficult to serve' may resist the labels associated with mental illness or being considered 'difficult'; they challenge those who diagnose or offer treatment to them, refuse service if treatment requirements are attached, or ignore available help, all of which can exacerbate their stigmatized statuses. Despite their resistance, their marginalization creates challenges when they attempt to find places to "fit in." The clients

described by the manager often have significant involvement with helping services, and may “fall through the cracks” due to their behaviour or complex needs.

As someone who has worked as a frontline support worker in a homeless shelter, I recognize that the phrase ‘difficult to serve’ is – on top of being an umbrella status as outlined above – a euphemism used to describe clients who are at times difficult and frustrating to deal with. From my worker’s viewpoint, ‘difficult to serve’ clients are those who, intentionally or unintentionally, routinely test one’s patience; create controversy; offend others; purposefully instigate arguments or fights; and generally disrupt what could otherwise be a relatively easy day at work. To be blunt, these are often the clients that many staff would prefer not to deal with on any given day at work. As such, the term functions as a way of bifurcating the client population; identifying, classifying and demarcating those who are ‘difficult to serve’ implicitly creates a category of individuals who are ‘easy to serve’ and who are therefore – from both managerial/administrative and front-line/implementation perspectives – more desirable clients. These ‘easy to serve’ clients can be understood in a similar manner to Foucault’s notion of ‘docile bodies’: while they are not conditioned to meet the schedule of a prison or work-house, they are individuals who demonstrate self-awareness and care of the self; can and do take direction from staff; respect rules; and who are generally easy to manage (cf. Foucault 1977, 1988b). In turn, the ‘difficult to serve’ – through this label of notoriety – are labelled and stigmatized as different or difficult (Goffman 1963). This stigma plays out in interactions between clients and staff; the clients still receive services, but workers may treat them differently: interactions are often more structured and formal, less congenial; in-depth conversations are accelerated, truncated or avoided altogether. In this way, while service is still rendered, the stigmatized person is cast as part of an out-group of less desirable clients, exacerbating her marginalization (cf. Becker 1963; Dudley

2000; Goffman 1963). While this observation reflects my personal experiences, it was reinforced by the professionals I interviewed. A manager at The Good Companions illustrates:

Personality often, it could be personality disorders or dementia; it's often personality that keep us with our guard on. They're very much attention seekers. I know I'm guilty of it; I've seen someone walk down the street and crossed the street so I didn't have to run into her. But I also realized other health care professionals were doing the same thing. This woman lives in Centretown and is well known to all the service providers because she's been through us all. At the same time, she's got us all burnt out. She's an endless vacuum of need that we can't fill – that I don't think anyone can fill.

The behaviour and actions of older marginalized women who are labelled 'difficult to serve' often leave them doubly marginalized: their statuses – as aging, in poor health, having a limited income, and possibly being homeless – provide one layer of marginalization; in addition, their actions and behaviours – ranging from the peculiar and/or frightening behaviours associated with mental health distress to general surliness, disagreeability, and negative and hostile attitudes – further marginalize them, creating a tightly-woven barrier between themselves and their communities (cf. Crenshaw 1991). While these behaviours can be ways for the women to respond to past events and protect themselves from further hurt or trauma, or to challenge injustices or difficulties in their lives (cf. Bonanno 2004; Bosworth 1999; Cyrulnik 2005, 2007; Kingfisher 1996), they also create barriers to receiving services. For example, in addition to offering day programs, The Good Companions also provides a range of outreach services for those who are shut-in or who need assistance in order access basic community services, such as grocery stores or medical services. The Good Companions' services are also offered to those who cannot cope in the group setting at the centre, and therefore represent a catch-all for those who otherwise do not receive assistance. A manager at The Good Companions noted that even these outreach services for 'difficult to serve' clients sometimes need to be withdrawn due to clients' persistent problematic or disruptive behaviour. She explains:

One woman we go to visit, she's very marginalized - Fuck! It's difficult for her to have a conversation without fuck this! Fuck that! It's the street in her, but you can't speak to the [friendly caller] volunteers like that. ... So if you want to talk,

this is how you need to behave. So it is kind of like a parental role, but teaching with an expectation that you have to behave in this way if you want the services, otherwise they'll be cut off. ... We have had to turn our back on some people, but when you investigate a little further, so has CCAC<sup>69</sup>, so has the health centre. At this point, we're left to let people have a fall or let something tragic happen so that they'll get into the health system. Then there's something they can do with them. But apart from that, these people are living on our streets and in our corners and accessing services and functioning however well or not well.

Individualized outreach services can offer some women who would not otherwise receive assistance access to services, but as the quote above reveals, these tactics do not meet *all* women's needs; not everyone will agree to the conditions of service or *want* to be served. In some instances, the client may receive no intervention until their challenges have progressed to the level at which *service providers cannot say "no"* – that is, they arrive as clients at hospitals, police stations, or homeless shelters. For these organizations, while there may still be a risk evaluation or assessment and possibly a referral to other services, their mandates require them to offer services (Castel 1995a). This is particularly true for homeless shelters where, as noted previously, housing providers, nursing homes, hospitals – even the police – can and do relinquish responsibility and care for 'difficult to serve' older women. Indeed, clients often become ensnared in webs of intervention, correction and need, circulating between these services on an ongoing basis (Castel 2003; Cohen 1985; also see Gladwell 2006). In their interview, a manager and staff at Hope Outreach discuss such a client:

[Manager]: We have one [senior] woman here... I don't think she could live anywhere anymore because of her smoking, verbal abuse. The woman has really bad dementia. Her health is really going downhill quick. She hasn't been able to make it anywhere else. Here – even though we're a homeless shelter – we make it work. ...it's almost appreciating her for who she is and not always saying, "She does this wrong" or "She does that wrong," but what is it about her that's good and what does she bring to our working relationship with her?

[Staff]: Frustration! She drives me crazy!! [laughs]

[Manager]: No, humour! She participates in the social activities sometimes. But it's just having patience with her and understanding it's dementia and the effects

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<sup>69</sup> CCAC refers to the Community Care Access Centre, a service operated through the Local Health Integration Network that connects individuals in need with home care services to assist them in maintaining their independence with the goal of reducing nursing home or residential care placements for individuals who can live in the community with supports (L. H. I. N. Ontario 2012a).

of that. Getting angry quickly and that – that’s not her fault; that’s not controllable. No medication can control that.

[Staff]: But you see, if she was in an environment with like-minded, or people very similar, it would be expected. She stands out here. There’s a difference. She’s – you get all the pigs lined up and you have all white but one red – she’s going to stand out. [*Client*] *stands out*. But if you put her in [a nursing home], where everyone’s doing pretty much the same thing, she doesn’t stand out. It’s normal. It’s normal to see that behaviour. We don’t expect it here.

In short, ‘difficult to serve’ clients in the shelter are those who are the neediest and also those whose needs most community organizations are ill equipped to address and manage. As they have a limited ability to refuse service, the shelters must try to adapt and provide services, even when this creates challenges for the staff, other residents, and for the overall running of the facility. While the same woman mentioned above, if placed in a residential care facility with some capacity to address her needs, would still have challenging behaviours, she may not be labelled in the same manner. However, as these facilities have the option of saying *no* and refusing service, she must be managed in the shelter. This bifurcation of care clients, demarcating needy and difficult from those who are simply needy, leads to those who often have the greatest needs being placed in the environments least able to offer assistance, just as criminalized women with mental health needs are often classified to maximum security instead of receiving mental health care (Hannah-Moffat 2001; Kilty 2008; Martel 2000). The following section further explores how organizations attempt to manage and meet older women’s needs.

### **Management and Support: Balancing Client Needs**

As with any other group, older marginalized women’s needs vary dramatically. “Needs” can oscillate between, at the extremes, a client who requires minimal supports and few, if any, staff interventions, to another who epitomizes the “endless vacuum of need” described above, requiring ongoing attention and support. The challenge with the latter group is that their needs must be balanced against those of women in the former category, as well as other individuals like themselves. For organizations that serve dozens – if not hundreds – of clients daily,

meeting these women's needs is a balancing act. Returning again to the Northwestern Ontario District Health Council's discussion of 'difficult to serve' clients, we see how organizations, from administrative/policy and operational perspectives, understand the significance of this group.

The Health Council notes:

When an inappropriate [residential care] placement occurs, *it is almost impossible to have the client moved to a new location*. This creates problems within the system as the difficult to serve client occupies a bed that was originally designated for someone else (Northwestern Ontario District Health Council 2004:3, emphasis added).

Interestingly (although not surprisingly), the *first* action considered in managing 'difficult to serve' clients is their removal from a facility, not an attempt to meet their needs (cf. Crawley 2005).

This rationality reflects the bifurcation of client populations inherent in the term 'difficult to serve'; those who are *least* desirable, ideally, become someone else's problem. As noted previously, nursing homes' management of 'difficult to serve' clients sometimes ends in just this way, with the clients being becoming someone else's (i.e., a homeless shelter's) problem. Although the desire to move the client is understandable due to the difficulty the facility may have in serving her, the fact that there are so few places to move the client highlights the nature of the administrative problem posed by 'difficult to serve' clients. The discussion continues:

It is *very stressful for staff* in long-term care facilities when individuals with difficult behaviours are admitted. Long-term care facilities are not staffed to provide adequate care to these clients. Though nine extra shifts are covered by the Ministry of Health and Long-Term Care (MOHLTC) in extraordinary circumstances, the extra care requirements do not go away after nine shifts. ... *The quality of life for residents in long-term care facilities is compromised when individuals with disruptive behaviours are admitted*. It is often very frightening for other residents (Northwestern Ontario District Health Council 2004:3, emphasis added).

Together, these quotes highlight a common organizational understanding and approach to 'difficult to serve' clients. While nursing homes can try to find alternative placements for their clients (although such attempts often prove futile), this path is not an option for community organizations serving older marginalized women. As these are 'services of last resort' (Henderson 2005), the concept of an "inappropriate placement" is moot: there is *nowhere else*

to send them. Instead of relocating the woman and limiting the organization's responsibility for her, management strategies are employed to address her needs. In shelters, 'difficult to serve' women are sometimes demarcated those who are easier to manage based on the ease with which they can be placed in housing. A shelter manger explains:

[W]hen senior women come in with us, [Housing worker] tries to get the housing for them rather quickly. I'm not sure where she goes to do that, but she works miracles. When women come to us who are seniors, she often tries to get them into housing as soon as possible, because there are different places in town where that is possible to do, at least according to [her]. It's when they come with more complicated stories and more complicated situations that it takes longer to get them housed.

The 'complicated situations' alluded to by the manager are often those that make an individual 'difficult to serve' – including physical health concerns, past housing problems that make them unattractive tenants, and, most frequently, mental health issues. The following section explores discursive understandings of how the needs of older marginalized women labelled 'difficult to serve' are interpreted and addressed at an organizational and policy level.

Research on correctional services for women indicates that categories of "need" and "risk" are often conflated. That is, a 'difficult to serve' client's *needs* are instead interpreted as *risks*, marking her as 'dangerous' instead of 'needing help.' In practice, this results in women with service needs being labelled "riskier" or more dangerous than those with fewer needs, even though they may not pose any risks to the community or to themselves (cf. Hannah-Moffat 2000, 2001; Hannah-Moffat and Shaw 2000; Kilty 2006, 2008; Shantz et al. 2009). For example, a criminalized woman's need for addictions treatment instead becomes a *risk* that she will re-offend or fail to integrate into the community. These issues are also addressed in examinations of social services (Cohen 1985; Kemshall et al. 1997; Lerner 2000a; Parton 1998). While social service clients are not always criminalized, the interlinkages between these systems, from shared goals to similar mandates, lead to a heavy overlap of clients. Indeed, as

Cohen (1985) argues, the target populations, or 'client bases' of community and criminal justice services increasingly grow and overlap as more and more individuals are labelled 'different,' 'deviant,' 'dangerous,' or as 'difficult to serve.' As such, the muddled language of risk and need finds its way into community services where, from practical and policy standpoints, the *neediest* clients become the *riskiest*. A manager at The Good Companions highlighted how client needs for services become risks, particularly in situations of hoarding. In the interview, she used a visual guide rating degrees of hoarding to illustrate her point<sup>70</sup>:

The City of Ottawa Public Health and Social Crisis will go in after 10 [extreme hoarding]. So what we are pointing out clearly – we were here (#6), and we just pulled it back down to here (#4). Because we don't have trained [staff] – they are just wonderful people who just want to make some money and clean a house. They can't cope with this. So let's say we stop here (#4) – the crisis is here (#10) – what about all the people [in between]? ... Hoarding is a huge issue and we see it. So then there's another legislation that's come in – *Bill C-45 – all about workplace safety and responsibility being the homeowner's, the client's, the worker's and the staff. So for us to put a worker in to an environment that's not safe, we can be held criminally liable; it's in the Criminal Code now.* So we have our own safety things and we're clawing back on this as well. ... So they become more marginalized, they continue to hoard, and then *they put themselves and other people at risk. And there's not a lot we can do about it until it becomes a whole thing where it's fire risk or animals are involved* (emphasis added).

The woman's hoarding behaviour, while driven by a mental health issue and signalling numerous *needs* (cf. Steketee and Frost 2003, 2007), becomes a *risk* for the woman on the grounds of health, safety and well-being; for the community organization due to the potential for workers to be injured in the hoarding environment; and to the woman's family and neighbours due to the fire and pest hazards of the situation. While hoarding is an extreme example, community organizations engage in risk identification and management on an ongoing basis.

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<sup>70</sup> The illustrations depict various levels of hoarding, ranging from a clean room with no evidence of hoarding (1); through mild clutter (2,3); severe clutter (4,5); rooms that are not fully usable (6,7,8); to, at the far end of the continuum, rooms that are completely unusable and where their purpose is no longer apparent due to hoarding (9). See Steketee and Frost (2007) *Compulsive Hoarding and Acquiring – Therapist Guide*, p. 202-204.

Although categories of “risk” and “need” are not always explicitly identified or assessed and managed in the same way, these categories are analogous to the policies and practices employed in managing clients in shelters and drop-ins. In addition, *risk management* strategies also figure into the facilities’ tolerances (or lack thereof) for disruptive behaviours. To continue the analogy, “risky” homeless clients (just as with prisoners) are those who are known to have committed acts of self-harm or violence; have severe addictions issues; have poorly managed mental health issues; and/or those with the most disruptive behaviours (Hannah-Moffat 2001; Kilty 2006, 2008; Martel 2000). These clients tend to have a higher level of “need” related to these “risky” behaviours and attributes: they frequently require varied and intensive interventions, including those of a medical, behavioural and/or emotional nature, as well as frequent contact with emergency services (e.g., police, paramedics or mental health crisis teams<sup>71</sup>). For older marginalized women who are ‘difficult to serve,’ these needs are often paired with limited mobility and health concerns such as arthritis or heart disease that limit their activities and increase their vulnerability in the shelter environment (Baggett et al. 2010; Whitzman 2006). While the women themselves are not always considered particularly “risky”, their *needs* are transformed into risks for the agencies and organizations involved.

Although the risk literature generally focuses on the individualization of risk and assuming responsibility for oneself (Castel 1991; Ericson and Doyle 2003), organizations also encounter various sorts of risk. As Kemshall et al. (1997) explain, the neoliberal transfer of responsibilities has not only affected individuals; organizations are increasingly preoccupied with results and accountability. As such, *risk* – through risk evaluations, risk management, and risk monitoring – also becomes an organizing principle at the agency or facility level. This occurs through an

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<sup>71</sup> The Assertive Community Treatment Team (ACTT) is a service of the Canadian Mental Health Association (CMHA) that offers on-site mental health crisis response in the community for individuals living with severe and persistent mental illness. The Royal Ottawa Hospital (ROH) also has a Mental Health Mobile Crisis Team that responds to individuals in crisis in the community.

interpretation of client needs as either *risks* (as outlined above) or individual *vulnerabilities*. Shelters and drop-ins are mandated to provide services; are increasingly expected to meet targets or goals (e.g., shorter shelter stays, new programs, increasing service uptake, etc.); and also must ensure the health and safety of staff<sup>72</sup> and clients, all of which involve managing risk (Henderson 2005). Their clients may pose health and safety risks to themselves or others, or they may instead be exceedingly vulnerable, creating *risk* as the agencies attempt to respond to their needs and protect them. A manager at Hope Outreach noted that older women's multiple and competing needs frequently cannot all be met in a single environment, creating risks for the individual and the organization, as well as challenges in responding to the women's needs:

And even the safety component, too with the shelters. Cornerstone and us [Hope Outreach], we're the ones who serve the most marginalized, the most addicted and the most mental health. So if an older woman's coming in and needs a safer environment, the ideal place would be Cornerstone, but because there's never any movement there, and it's not an accessible building, and there's not enough medical staff like there is here, so the best supports would be here, because we're accessible, we've got the medical staff and we've got more programming, but it's also the most unsafe environment to have them in.

Each of the shelters can meet some, but not all, of older homeless women's needs. Rather, their *needs* for accessibility, health services, and safety are transformed into organizational *risks*: of accidents or health emergencies at Cornerstone shelter; or, at Hope Outreach, ensuring the safety of *vulnerable* older women in the uncertain and sometimes unstable environment. The limited availability of services, and their limited abilities to meet the full range of many older clients' needs, sets up an environment in which shelters and drop-in centres must struggle to meet client needs in the face of myriad demands and challenges.

### **Struggles in Service Provision: Meeting Complex Needs**

Service organizations have different policies, procedures, and techniques for managing 'difficult to serve' clients; depending on the environment and the services provided, community

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<sup>72</sup> Several of the professionals who participated in interviews mentioned the importance of Bill 168, a bill that amended the *Occupational Health and Safety Act* to provide workers with increased protections against workplace harassment and violence (Government of Ontario 2011).

organizations may have relatively strict or permissive rules regarding behaviour, comportment, and other qualifications for service. In examining *how* these services offer assistance, it must be noted that these organizations are also, frequently, services of last resort: they provide help when others will not. Therefore, these organizations are often placed in positions where they must balance the needs of different clients. As there are often no other programs or services available to 'difficult to serve' clients, the services offered are often examined using the principle of less eligibility, ensuring that the service provided is no better than that received by the most destitute (Thane 1978). As marginalized and homeless people are often considered to be among the most destitute, disaffiliated, and poorest citizens (cf. Castel 1995a), these measures are a natural fit for examining these services. Despite their marginalization, however, homeless people are still entitled to the rights and freedoms associated with living in Canada. As such, one expects that their basic needs are met and that they are treated in a respectful manner throughout their dealings with the service system. This section explores how older marginalized women enter this system and how service providers attempt to provide care for them.

Shelters, in particular, fill needs for housing and support for clients who cannot be served elsewhere in the social service system. Shelters are designed to meet individuals' basic needs, offering a warm place to stay with a bed or a mat to sleep on. The emphasis within the shelter system is on efficiently and cost-effectively providing accommodations to a large, diverse group of individuals who have nowhere else to go (cf. Barge and Norr 1991; Deward and Moe 2010; Kline and Saperstein 1992). As such, the shelters are neither designed for, nor capable of, providing specialized and individualized services to all of their clients. However, due to the fact that they are services of last resort, they often must attempt to manage many clients who require specialized care – including care which would be best delivered by other service systems, such as long term and residential care facilities. While the shelters are widely

acknowledged to be a poor fit for these clients, they often end up providing care for these women because no one else will. A nurse relates how clients labelled “difficult to serve” find themselves in shelters:

I've had some [women] that have been around in my program, in outreach, out and housed for short periods of time, back in outreach, for two or three years. ... The housing options for an older woman, especially for a smoker, are really difficult. That's where your problem comes in. If they need housing and their behaviour is bad or they're a smoker, they keep being kicked out of it. So a better old folks' home for our clientele would be nice. Add in dementia and cognitive impairment on top of an addiction and resistance to taking your meds regularly; you're usually not the one that the seniors' residence is rolling out the red carpet for, right?

The high demand for nursing home beds allows the homes to be selective when admitting new residents. Also, the shelters are mandated to help and house those who otherwise have nowhere to go, meaning that these individuals will find shelter, even if it is inappropriate and inadequate to fully meet their needs. While this scenario is somewhat common, it can also be the result of compassion fatigue<sup>73</sup>, which occurs when caring resources – often the clients' families – are pushed to their breaking points (Figley 1995). When compassion fatigue occurs, there may be no other avenue of assistance available to meet the needs of the 'difficult to serve' person. As many community supportive services for the 'difficult to serve' have significant wait lists, finding quick solutions may be impossible. A manager at Hope Outreach reflected that compassion fatigue is common, but there are few easy solutions:

That's been shown, eh? With compassion fatigue in front-line workers, but also for family members who take care of aging parents or whatever. Even in nursing homes, you see it in the amount of abuse because frontline workers get tired with compassion fatigue and what do you do?

Day programs and drop-ins can offer some relief to caregivers, but these programs usually serve clients who can manage in group environments, where 'difficult to serve' people may not be welcome. A worker at Centre 454 illustrates further, noting that physical needs are often not

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<sup>73</sup> Compassion fatigue, also referred to as secondary traumatic stress disorder, occurs when caregivers (service providers, family members, etc.) experience stress, anxiety or other vicarious trauma as a result of the caring work they perform (Figley 1995).

the primary reason that an individual will be considered difficult to serve; rather, personal characteristics, behaviour, and emotional needs are often at the root of the women's struggles:

I was helping one of my clients who is over 65. ... Her life experience, she was in jail for 10 years I think. She was abused when she was a child and experienced it all through her life. After being in jail and in institutions, she has a particular resistance and fear of authorities and defensive reactions to authority. She totally can't deal with doctors and nurses, with simple interviews and their questions. She cannot deal with this; her level of anxiety goes very high and she becomes verbally – not abusive, but very inappropriate. People cannot deal with her; they find her very rude; she's not cooperative. So many, many services were closed to her totally because of that.

'Difficult to serve' clients often have complex needs that are challenging to address and require constant and consistent support, which is very difficult for organizations to provide, especially in group settings where rules must be followed. These clients tend to have persistent needs; while other clients may also require significant support and attention from time to time, the older marginalized women who are considered 'difficult to serve' require a constant, high level of support, making them challenging to support and work with (Brindis, Pfeffer, and Wolfe 1995; Handron et al. 1998; Northwestern Ontario District Health Council 2004).

Meeting complex needs is especially difficult for community-based organizations with limited budgets. As the well-known story of "Million-Dollar Murray"<sup>74</sup> (cf. Gladwell 2006) illustrates, the emergency services (excluding social and community services) required to assist complex needs and 'difficult to serve' clients can amplify existing problems and create new ones, leading them to become enmeshed in a costly service system that oscillates between control, regulation, and support in its dealings with the 'difficult to serve' (cf. Cohen 1985). Although this trajectory is all too common, some programs and services attempt to break the cycle of service

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<sup>74</sup> "Million Dollar Murray" is the story of a client with complex needs who, through attempts to manage his behaviour, made significant and ongoing use of the police, emergency health, and social services in Reno, Nevada. When the costs of providing just emergency health services for the man were tallied over several years, the total came to well over \$1 million, far more than would have been required to provide the man with alcohol treatment and supportive housing (Gladwell 2006).

involvement and regulation. In Ottawa, the Aging in Place program has proven successful in slowing the cycle of service involvement. A program manager explains,

This is a program funded from the Aging at Home money from the Ministry of Health. It is a support program that was designed in response to high ER hospital stats from Ottawa Community Housing buildings. The original goal, and the goal still, is to reduce ER hospital bills by providing supportive services that will enable the tenants to remain at home safely and well as soon as possible. It started in 2007 with five buildings, and was originally funded through the Regional Geriatric Program and some money from hospitals.... The theory and the philosophy behind it was that because it's subsidized housing, most people in these buildings, if not all, cannot afford the supportive services.... The program was designed to provide a basket of enhanced services that would be available through retirement residences as well as enhanced community case management through the [Community Care Access Centre].

The manager also noted that these specialized supports have proven so successful that the program was expanded to additional buildings. This cost-effectiveness of community services is widely recognized (cf. Clark et al. 1998; Greene, Lovely, and Ondrich 1993; Rosenheck and Neale 1998); however, its recognition at the funding and policy-making levels appears to be limited (L. H. I. N. Ontario 2012b, 2012a). A manager at The Good Companions explains:

If you look at the dollars for funding for healthcare, 70% is locked in the hospital, it's stuck right there. 25% is in LHIN and CCAC, so it's again very much a medical model of physical care. 3% comes to our sector – community and social services, and 2% goes to mental health. We're in the bottom echelon, so that's what we're dealing with at the community level with not enough resources. We've got clients the mobile bus will not even help anymore because they've reached their limit. We know they're out there, we see them walking the streets and we hear about them, but our hands are tied. A lot of it is 'close your eyes and hope.' ...[H]ow else do we do it besides bury ourselves in the stress and invite people into our own homes? Again, that would be my last word. Frustration with an aging population, limited resources, the continuing lack of care, lack of mental health acknowledgement.

Many of the professionals expressed frustration with the funding system and with limited budgets. They noted that they often cannot adequately meet demands for service; while the organizations provide a wide range of programs and services, the number of clients who they serve is far lower than the population in need. A worker at Centre 454 highlighted the need for community-based counselling programs:

They need counselling; they need more than what we have. I struggle here to meet their needs.... It's never going to happen because of the volume, and the issues that people are coming with. That's overwhelming.... We need at least, in this agency, another three counsellors. One would be for outreach, because we have no outreach services here. Some of the clients, they attach to us and we build trust and long-term relationships. Something happens, they have to go to court or a tribunal, and I know this person very well, and they want me to be there and I can't .... [W]e don't have enough funds, or money, to have someone leave the agency, because we have only four counsellors and front-line workers, only four. Our place is pretty popular, pretty in-demand for counselling.

This sentiment – of stretching budgets and attempting to do ‘more with less’ – was echoed by all of the professionals. While the need for an improved network of community-based services has long been acknowledged in both criminological literature and elsewhere within the social sciences (Cohen 1985; Comack 1996; Garland 2001; Maidment 2006; Nemiroff et al. 2011), these needs are not always addressed in policy. A manager at The Good Companions highlighted problems with the current system:

Someone from the LHIN ... asked if mental health was an issue in the senior population. ... It was just like, “The emperor’s naked, folks!” Almost everyone we have who’s a senior has mental health issues. With depression, it’s 40% of the population and rising. And on it goes - phobias, personality disorders. I thought, what a dumb question from our funder of community health! ... There’s a quagmire out there. Even in our social services, we’re marginalized. We’re one of the problems. I’ve never thought about it in those terms, but it’s true. ... Our system is perpetually keeping us marginalized. And part of the problem is ourselves because we keep doing more with less. ... I’d almost like to encourage everyone, let’s back off! Let’s take the day off and just see what happens.... So again we continue to work knowing these people are out there, doing the best we can with these little band aids. Coaching them, doing the best we can to listen for a bit, then they’re good for a month. But we’re one among many for the people who are burning out the frontline workers. I guess that’s my comment – HELP!

The challenges of dealing with ‘difficult to serve’ clients are symptom of a larger problem of governmental priority-setting, focus, and funding. In addition to providing front-line service, many organizations struggle to bring greater attention to themselves to secure funding (e.g., through lobbying, grant proposals and various community fundraising activities) and to better serve their communities. Although there are some avenues for advocacy and resistance within the service system, as the manager indicated, the organizations remain focused on fundraising

while also doing 'more with less' to the best of their abilities. From this perspective, the workers attempt to make do and work with their clients to the best of their abilities.

The idea of 'making do' provides an overly simplistic picture of an organization's operations. 'Making do' often involves collaborative care where, as in medical settings, agencies work together to offer complementary services and ensure that a client's needs are met (cf. Gilbody et al. 2006; Piatt et al. 2006). While 'making do' involves *stretching resources* and working across organizations, it is also a matter of *attitude*. Chiefly, workers' attitudes are key to managing 'difficult to serve' clients; these attitudes can be the difference between having a supportive service environment and a hostile one that is unwelcoming or perpetuates negative stereotypes (Dudley 2000). An Aging At Home nurse notes her approach to understanding and working with older women labelled 'difficult to serve':

Why is it that they can't maintain [housing]? Is their mental health not stable? Maybe talk with their psychiatrist. Is it because they're drinking or using drugs and it's causing this kind of behaviour? The thing is, these people don't have anywhere else to go. In other places, in long-term care, these are the people who get kicked out for smoking in their rooms, so we've got to work with it and try to manage it. It's not as simple as saying, "Okay, you're out the door." We have to be creative about figuring out what they're going to do. Unfortunately that means, sometimes, taking away a bit of people's power. I think about our dementia clients that smoke in their rooms, they don't have cigarettes or matches on them. When they come in the door, we ask them to hand it all over. When they leave, then they can take their cigarettes and their matches with them.

Here, managing needs and risks does not require a denial of service, but does involve a limitation of freedom and autonomy. Similarly, a supportive housing worker highlighted how her organization must recognize its role in improving the quality of life for their clients. As women in the facility face numerous barriers to independence and social integration, compassionate and understanding workers can improve their quality of life (Dudley 2000). The worker explains:

... [W]hen I first started here, it was so insular. It was shocking to me how some of the women had never been out of it for a long time. ... People really were sent here because they were unwell and they could live here forever. I didn't have that same philosophy; I had a philosophy of yes, you're mentally ill, but that's one

very small part of you. So the house started to open up and that world opened up. We have a lot of volunteers; we have one to two volunteers a day and that's a major social network for the women who cannot leave for physical reasons. We have a lot of groups in the house, whether it's for arts and crafts or personal growth. We have outreach coming in as well. I would say for the senior women, in particular, there's very minimal outside socialization; it's all within the house. ... Really, outside of this house for the senior women, there's nothing.

As the worker's comments illustrate, the attitudes and approaches adopted by the service community are integral to ensuring that clients have access to services and positive interactions with others. In short, workers are a key component of the service environment and ensuring that 'difficult to serve' clients' needs are understood and addressed. The attitudes and understandings of staff are important to creating a positive environment. However, policy, rules, and regulations within the services are also important in providing service, finding a balance between *need* and *risk*, and ensuring that the women receive the assistance they need. These rules and regulations are examined in the next section.

### **8.3 Rules, Routines, and Regulated Spaces**

Organizations working with and for older marginalized women employ a variety of strategies to identify and manage 'difficult to serve' clients. They also create policies and procedures to regulate the organization and its environment. At the institutional level, these policies may address individual women's needs, but must also reflect the fact that the facilities serve an assortment of clients with complex and competing needs. Unlike correctional environments where most policies are set nationally or provincially, services are not uniform among community services; rather, due to the range of clients served, policies and rules vary widely.

As noted, contemporary society is bifurcated into accessible and inaccessible spaces (Lianos and Douglas 2000). Here, 'accessibility' does not simply refer to physical access, but reflects the division of spaces into *public* and *private*, with access to private spaces regulated by various means, ranging from an individual's ability to pay for use; to connections to 'insiders'; to the

targeted enforcement of 'in' and 'out' groups by police, private security or other means. This regulation of space effectively divides the world into zones of inclusion and exclusion, or to borrow Robert Castel's (1995a) terminology, zones of vulnerability – where the marginalized maintain some connections with society and community; and zones of exclusion where these ties are severed. Along this continuum, people may be more or less affiliated with society, affecting how they experience the world and how they are 'managed' by their communities. In Ottawa, although facilities and services for the homeless and marginalized are generally considered to be zones of *inclusion* or affiliation, the level and nature of inclusion offered is uneven and often qualified based on the client's attributes and actions. The conditional nature of inclusion further narrows older marginalized women's worlds, creating a hierarchy among marginalized clients, with the more favourable women finding more open doors compared to their 'difficult to serve' peers. A worker at Hope Outreach explains:

You know what we're dealing with [regarding 'difficult to serve' clients], and you also know that at Cornerstone that there's very little tolerance for any kind of infraction to the rules whereas at Shepherds of Good Hope, there are not. We tolerate above and beyond. Probably more so than most places. We have a client right now who was evicted from the domiciliary hostel ...She supposedly has the capacity of a two-year-old, but anyway. Very volatile. Dumped here. Just, *dumped*. It's like, okay?! Why?? Because she threw herself at a staff member at the retirement home where she was living and staff refused to come to work. Now, wouldn't that all be lovely if we had that? ...So we could say, "Gee, you know, you just did something to the Assistant Manager, so we're going to send you to ...." *But there is no other place besides the Shepherds, right?* So that's a sad, a very, very sad reality of the women that we are dealing with here.

The worker's comments highlight the importance of examining not only women's experiences of the different services and environments, but also the rules and regulations of these agencies. Policies and rules frame the service environment, structuring interactions between staff and participants. Policies may have varying degrees of flexibility and also may be translated into practice in varying ways (cf. O'Malley et al. 1997).

In discussing policy, it is important to distinguish between *permitted* and *tolerated* behaviours. The former category is often much more narrow and strict than the latter: policy is often incongruous with the practices that emanate from it as the realities and messy actualities of day-to-day life and interactions necessitate flexibility and accommodation (O'Malley et al. 1997). Most professionals indicated that their organizations have a code of conduct, policies, or rules for participants, whether these were formal or informal. In my discussions with the professionals and my review of these policies, the policies and codes proved to be nearly identical between facilities. The codes emphasized the organizations' open environments and respect for all clients, but also indicated that violence and negative behaviour (e.g., drug or alcohol use; threatening behaviour; and racism, sexism, or other discrimination) were not tolerated. These restrictions, while simple, straightforward, and sensible, also reinforce the hierarchy between 'difficult' and 'easy' to serve clients. This hierarchy is further nuanced based on the facility's enforcement of its rules. For example, if two drop-in centres both prohibit drug and alcohol use on the premises, but this rule is more strictly enforced at one drop-in, the other facility, by default, will see more clients who are intoxicated as news of the organizations' rule enforcement (or lack thereof) spreads. The level of tolerance for behaviour is well known by both service providers and clients, as illustrated above by a Hope Outreach staff.

Policy enforcement is also based on an organization's service mandate and regular clientele. As older marginalized women are far from homogenous, and as the organizations that serve them also vary widely, so do the expectations of the service settings. Just as Cornerstone serves a more behaviourally compliant clientele than Hope Outreach, The Good Companions, as a seniors' centre, also serves a somewhat easier to manage clientele in their on-site programs. The manager notes that, to be eligible to participate in the centre's programming,

You have to be a member, you have to be over 55, you have to be able to manage independently in the building, but apart from that, there aren't rules per

se. There are dignity and respect, the values we strive to live by, but there's also dealing with people. People have memory loss, people have attitudes, the cultural piece – some people were in war-torn countries, so we have to be a bit cognizant about whom you might be matching them up with for a visitor. Or even sitting beside one another, and “that person's been staring at me the whole time!” Well, that person can't see past their nose! “Oh!” So again, a lot of putting out fires. ... But we have asked people to leave when they've been just too rude or just not getting the fact that the world doesn't revolve around them.

The behavioural challenges encountered at the centre differ from those found in the drop-in centres; clients' unusual or unexpected behaviours are often age-related and the product of failing physical or mental health (cf. Galloway and Jokl 2000; Riche and Mackay 2009). While the manager indicates that the environment has few rules, the clientele – who are generally older, but often less marginalized, more affluent, and more compliant – also influence the environment (cf. Holstein and Minkler 2003; Keating et al. 2005). In contrast, the drop-in centres contend with different challenges, including, at times, violence, aggression, and other inappropriate and illegal behaviour. A counsellor outlines the rules for clients at Centre 454:

The basic rules are safety rules. We have to be respectful to each other, so no coarse language, no violence, zero tolerance for using drugs on the premises, no smoking inside – only outside, no selling drugs or illegal cigarettes on the property, and cooperation with staff sometimes. If things are happening, they have to cooperate.

In dealing with a more marginalized clientele, Centre 454's rules focus on maintaining order, limiting illegal behaviour and ensuring safety. Integration and positive interaction are certainly a major part of the environment, but are balanced against the need to mitigate risks to the centre's order and safety (cf. Kemshall et al. 1997). The central place afforded to risk ideologies in service organizations such as Centre 454 and Hope Outreach is necessitated by the clientele and location of the centres. As the two services are adjacent, both generally serve a clientele who, as previously noted, tend to have more behavioural issues and difficulties coping in a group setting. As these clients are thus considered *riskier*, an increased focus on safety and preventing illegal behaviours while offering services is the logical response. In the vein of risk management, many professionals cited the need to ensure the safety of clients and staff, which

often included enforcing strict rules around substance use and aggressive behaviour. The enforcement of rules ensures safety and reinforces clients' expectations for safe and welcoming spaces in which to spend time (Manzo 2005). These needs – of inclusion on one hand and safety/security on the other – sometimes contradict; thus, organizations must evaluate and prioritize these needs, balancing care for clients with security in the environment. It should be noted, however, that this balancing is sometimes achieved by offering outreach services that extend beyond a physical space. Street outreach programs, community caseworkers, and other similar supports can be used to offer services to those who are otherwise excluded. Of the participating organizations, Ottawa Innerscity Ministries was among the most accommodating in terms of client behaviours. A manager indicated:

We don't impose a lot of restrictions on people to be clean or sober in order to receive any kind of services. For us, they can't use on-site [at the drop-in], but if they arrive at our drop-in already inebriated, we don't turn people away. We all struggle with whatever our struggles are. They may not be obvious addiction issues, but there may be other struggles that we have in our lives. Friendships – true friends – are friends who come alongside you wherever they meet you in your journey. ... For us, we want to come alongside wherever they may happen to be, without judgment, without an expectancy.

As OIM operates a drop-in service one day per week and also serves its clientele through street outreach, its structure is significantly different from other drop-ins; OIM can reach clients who do not reach out to access services, but who will accept care when offered. This inverted relationship – of *going to clients* instead of clients *going to services* – allows for new levels of inclusion and connection (Greenberg et al. 1998). Many services and service providers indicated that, while there were some restrictions for service, that these needed to be minimized; the *risk of problems* must be balanced against the *risk of exclusion*.

Although their approaches and rules differ, all of the professionals highlighted the marginalized nature of the clients they serve and many noted how their organizations provided one of the only social outlets and service venues available to their clients, highlighting the value of these

places for clients (Manzo 2003, 2005). While the organizations' tolerances for negative behaviours varied – from lists of rules to which clients were expected to adhere, to organizations with almost no rules – the recognition of the vulnerability of the client population, and the risk of further marginalization and exclusion was recognized (cf. Castel 1995a). An Ottawa Public Health nurse explained that the programs offered by the health unit had few restrictions:

It's open to everyone. No conditions whatsoever. We service people as best we can. If we can't service them for one reason or another, we'll find someone who can.... Let's say we do a Sortie Santé and people show up intoxicated. Well, that's a condition. They'll say that, you know, "You can't stay today; you're intoxicated." The only conditions to come here in public is that you're not intoxicated, things like that. But if you're not, you're certainly welcome to come back the next time if you sober up. We do have a few issues with a few people in particular, but most of the time, not really any conditions for service, except that, you know, they can't be violent, can't be intoxicated. But even then we'll refer them to the appropriate service. We'll say, "Listen, you can't stay here today, but if you need help, here's where you can get it."

The nurse noted that she attempted to find assistance for those whose needs exceeded the health unit's ability to provide services. In this way, the health unit, and other services, attempt to create bridges for marginalized clients (Fawcett et al. 1995). This helps to ensure that the most marginalized clients can access some services, but it does not challenge the hierarchy of marginalization or the bifurcation of 'difficult' and 'easy' to serve clients.

In contrast to programs and services offered on-site at drop-ins and health and community centres and to street outreach that occurs in public spaces, the Aging in Place and Aging at Home programs<sup>75</sup> serve clients in their homes, whether those are independent apartments or supportive living hostels. For these services, there is no option of barring a client and asking them to return home as they *are* already at home. As finding and maintaining housing is often a difficult struggle for older marginalized women, home support programs can be an essential

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<sup>75</sup> Of note, the Aging in Place program provides services to at-risk seniors in low-income apartment buildings throughout Ottawa. In contrast, the Aging at Home program serves marginalized and homeless older adults, primarily those living in shelters, hostels and other supportive and communal living environments.

component in their daily lives. These organizations face different challenges (cf. Northwestern Ontario District Health Council 2004), but they nonetheless work with clients whose actions and behaviours are challenging. An Aging in Place manager noted that her organization attempts to work in an unstructured, yet supportive manner:

[A]nyone can come and talk; need can range from as simple as needing advice on completing a form or helping with a telephone call to something way more complex that they have where we've got to get the nurse practitioner in and get in the home supports. Really, for us, the line would be safety. If someone's going in and it's a very unsafe apartment, if there's hoarding or whatever, we'll work with community supports and agencies; we won't just say 'oh well, too bad.' ... I think if someone's violent or if there's drug or alcohol issues involved it can't be done. The other thing is we can't have them smoking when the home support worker's there. ... Certainly there is some hoarding, and certainly we've run into issues with infestations. You hear about bedbugs and cockroaches; we would report and work with housing on that. Help to find the community resources, work with housing on counselling someone on what needs to be done and counselling them through it because it's pretty upsetting.

An Aging at Home nurse concurred that most of her clients are long-term shelter or supportive housing residents, or have a pattern of short-term private residency punctuated with housing loss and recurring shelter stays. The nurse noted how her organization tries to break these cycles and create a positive "place meaning" (Manzo 2005). She explains:

Our code of conduct would be – there's not one right now. There are certain things, though, that people would have to follow. It's about respect for staff and for other clients. It's also about safety and maintaining a safe environment for everybody. People will not be able to smoke in their rooms, violence isn't tolerated, I can't really think of anything off the top of my head. The big thing is maintaining respect and creating an environment where people can feel safe and they can have a sense of being at home and that sense of security that home is supposed to give you.

Although the examination of rules highlights the accessibility and level of regulation in the facilities, the women's accounts of their experiences of the service environment also highlight how the sense of place created in part by these rules and expectations shapes their experiences. While all the organizations attempt to maintain a level of decorum for their facilities and structure for interactions, these, like all rules, are sometimes broken. The following section examines the process of rule-breaking and its meanings for the women.

## **Rule Breaking as Resistance**

While no two clients act in the same way – and indeed no single client will act in the same way across settings and situations – many ‘difficult to serve’ women are constructed as resistant in part due to their opposition to authority and rules. In the case of their ‘difficult to serve’ clients, the professionals recognized that the women’s behaviour was not only the product of her dislike of institutional rules, her desire to flout authority (although this was certainly sometimes the goal), or the aggressive and survival-oriented performatives that she developed to survive on the street, it was also due to the stressful environment and physical and mental health issues – from the irritability caused by chronic pain to dementia. Indeed, the stress associated with poverty and marginalization is linked to poor health outcomes, trouble sleeping, and even early death (Raphael 2006). This stress also arises from the women’s identity struggles and their changing circumstances; these major changes often result in fear, frustration, and anger (Clarke 2001; Dillaway 2006; Kratcoski and Babb 1990). In front-line service work, negative and difficult behaviour is often considered to be part of daily life; from a theoretical perspective, however, these clients’ actions may be understood as resistance.

As noted, resistance can take many forms. For marginalized women, these forms are often subtle, involving language, dress, and everyday actions instead of a formal challenge to an authority figure, institution, or policy (cf. Bosworth 1999; Kingfisher 1996; Scott 1986). Indeed, for those with relatively little power, who must generally submit to the will of others, or whose interactions include negotiations with state agents who exercise sovereign power (e.g., social assistance caseworkers, parole officers, etc.), small acts of resistance manifested in one’s everyday identity performatives may be the only feasible strategy to challenge authority. James Scott, in his study of peasants in Southeast Asia, notes that resistance can be seen in “gossip, slander, rejecting imposed categories, [and] the withdrawal of deference,” among other forms

(Scott 1986:22). Older marginalized women, like the Asian peasants, are often in powerless positions; thus, they have few means to resist authority, rules, and structures in more organized ways. With few options for resistance, the women may resort to back-talk, name calling, threatening, or general rudeness in order to make their wishes known and express resistance (Bosworth 1999). Joan spoke to me while sorting her belongings after being made ineligible at Cornerstone shelter for having drugs in her room and for her aggressive behaviour. She expressed her feelings about the shelter rules and staff:

How things are here? The staff has been dealing with nutcases. They must think I am one too; I don't think I'm crazy, but I'm getting very, very, very angry! Why am I [sorting belongings at the bottom of the stairs] here and carrying this back over there? Oh yes, I had a bottle of *calcium*. Calcium, I need calcium. And they found a bottle of calcium in my room. Well, I have a whole locker full of other stuff – vitamin C, eye bright, vitamin D, various vitamins – *not dope* – I don't take drugs, only various kinds of vitamins. I've probably got high blood pressure by now. They don't know the difference between vitamins and dope? I've had it! ... You want to know about staff? Staff is useless in dealing with idiots. *Because they're idiots!*

In Joan's case, resistance to rules and staff demands interpreted as controlling, insignificant, or ridiculous did not gain her any advantages; rather, it resulted in her being ineligible for service. While few participants were as openly sarcastic or angry as Joan, she was not alone in questioning, testing, or breaking the rules through her talk, actions, and performatives. Joy also expressed her frustration with the shelter's policies regarding belongings in residents' rooms; that is, that residents cannot have more than two bags of belongings in their rooms at any time.<sup>76</sup> While Joy is not a hoarder or likely to miss curfew, she must still comply with the rules. Staff enforces this rule through room checks: if a woman has excess belongings, she is required to take them to a locker in the basement and, if needed, can access them at pre-set times. Joy spoke with me while she was sorting her belongings and voiced her frustration:

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<sup>76</sup> These reasons include the limited storage space in the rooms (In rooms at Cornerstone shelter, each woman has a locker similar to those used in high schools in which to store her belongings. There is also a small shared closet in each room in which the women can hang their belongings.); to reduce the physical work required of staff when packing the belongings of residents who do not return to the shelter by curfew; potential fire hazards created by too many belongings, and to counteract hoarding situations.

There ain't no way I'm bringing all this downstairs. If you want this downstairs you have to bring the manager. ...I go to school ... I get up at 5 o'clock, I'm leaving here by 7. ... There's no way I am getting up earlier to go get my stuff from downstairs. ... I'm so tired, I get up and go to church and come back. All I want to do is sleep. All they have to do is let it go, but because of her, I'm forced to [sort] it now. And I said, okay. I said, "I have to sort, and I have to go to church. I have to do laundry." But they still want... no way, no way! I have enough already. I won't pay her any attention because some of these staff – they don't know what they're doing and they just confuse people. They don't know what they're trying to do. They're making things worse.

While some workers may be sympathetic, others – those who Joy indicates “don't know what they're trying to do” – attempt to enforce rules despite her resistance. While not all of the women vocally challenged the rules, several participants noted that shelter rules did not fit with their needs and experiences. For these women, resistance was driven by a frustration with the status quo and was expressed through rule-breaking or back-talk. Adele wanted her own apartment so that she could smoke indoors and eat what she pleased. Although her mental health made this outcome unlikely, she was quick to point out her disdain for the rules:

A: I did say eleven Hail Mary's in the bathroom smoking a cigarette yesterday. And I prayed we'd have a good supper. And we did. We had one of the best suppers in my life. Fish and potatoes. And they were fresh potatoes. They weren't sour or anything.

L: Yeah?

A: We've had pretty bad food. They try to pass it to the people sometimes. Even just a few days [leftover] and I'll say they have maggots in them.

While smoking in the bathroom flouts shelter rules, Adele's comments on the food she is served are also interesting. Although she does not break any rules, her performance of resistance, while a simple act of back-talk, offers a way to voice her displeasure and to create challenges for the staff, who must contend with her complaints, and with the suspicion and disgust of others who may subsequently wonder about the quality of the food thanks to her remarks (Bosworth 1999; Kingfisher 1996). Although her actions may not change her circumstances, Adele voices her frustrations in a manner that ensures the maximum possible aggravation and inconvenience for staff, who must now reassure other shelter residents about the quality of the food.

Many participants linked their resistance to specific situations in the shelters. As the women have few, if any, alternatives to staying at the shelter, the stress of the environment and the inflexible and sometimes nonsensical-seeming rules often leave them feeling forgotten or desperate for more permanent housing (Deward and Moe 2010). After leaving the shelter, however, the women may still find themselves in positions of relative powerlessness due to their marginalized and stigmatized statuses. Bev moved into a rooming house, only to discover that the room she rented was infested with bedbugs. After bringing the problem to the attention of her landlord, Bev employed resistance and advocated for a quick solution:

You know, I've done that many, many time before – just had a mattress on the floor, never had any of that problem, never. This is the first time. I have to come to the nation's capital to find out bedbugs aren't a myth? [laughs] I could have done without it, gladly. Oh yeah, it was horrible. ... I said to [worker] here, I don't give a shit what you say, I don't care how poor I am, I don't have to live in that. And I won't. I refuse to. So she got them off their ass. ... I don't like being – I don't like being coddled, talked down to. Like the one worker: I'll fix that up nice-nice with a little border. Don't fix it up nice-nice. I can do that myself. I can get my own fucking border. You caulk what I tell you to caulk. And he – he just didn't feel it was necessary. So I went above him, his head. I went to his boss. I'm not takin' that. I've been on my own most of my life. I raised two kids on my own. I'm not taking that kind of shit. You guys taught me that I had to be a rough and no-nonsense woman in this – man's world? Well, piss on ya. You got me as hard as you wanted me. And don't coddle me. I'm not a woman to be coddled.

Bev's performative strategy involved adopting a masculine and aggressive manner in dealing with her property manager, highlighting how women's resistance may be demonstrated in gender performances. Mary Bosworth (1999), for example, notes that resistance in prisons can manifest in one's identity and mannerisms; if, for example, the routines in a women's prison are seen as feminizing (cf. Hannah-Moffat and Shaw 2000), prisoners may resist by acting and dressing in aggressive or anti-feminine ways. While Bev is certainly not imprisoned, she faces authority figures that try to infantilize her, in line with stereotypes that depict older women as passive, weak, and in need of assistance and support from others. As such, the resistance strategies of female prisoners in the face of the feminizing attempts of prison programs resonate with her experiences of advocacy and resistance (Carlen 1983, 2002).

Resistance may fill a number of needs: it can be an outlet for anger and frustration, a challenge to institutional rules, or simply a way to be heard over others with competing needs. However, this resistance does not usually challenge the *structural* and *discursive* environment surrounding the women. This broader environment structures their interactions, reifying their positions of relative powerlessness and perpetuating the dynamics that they seek to resist.

#### **8.4 *Invisible Fences: Discursive Understandings of Older Marginalized Women***

While some older marginalized women are considered 'difficult to serve' in their interactions with the service community, this label proves to be the tip of the iceberg when examining how older marginalized women are understood by society at large. Indeed, this label, as well as others applied by 'experts' and practitioners in the field are powerful, differentiating clients as being difficult or abnormal in some way. While this ensures a continuing client base for the experts (cf. Cohen 1985), it also demarcates the labelled person as "different" and implicitly deficient or *less than* others around them, further sedimenting them into these pre-assigned categories. This othering and differentness extends beyond professionals' discourses and understandings, permeating popular consciousness and the services available to older marginalized women.

In popular culture, stereotypes such as the bag lady, shut-in, or the old woman who has gone 'off her rocker' – all of which are reified as part of a social organization favouring youth and vitality – highlight our perceptions of older marginalized women (Shilling 1993). Indeed, these stereotypes are enduring and well-entrenched; today's depictions remain relatively unchanged from those of the past, harkening to the folkloric 'hag' archetype (Briggs 2002) and demonstrating the historicity and continuity of archetypal and normative discourses. As with stereotypes of aging and marginalization, negative stereotypes of "needy" or "poor" older

women also reflect welfare discourses (Chunn and Gavigan 2004). For example, Helen Codd, in her discussion of older criminalized women, notes that they are often considered “mad, sad, or bad” (Codd 1998:187). These depictions simplify the women’s pathways into conflict with the law, overlook the nuances and particularities of their experiences, and generally negate individual agency, similar to common understandings of other groups of women that pervade criminology and popular discourse in general (cf. Comack 1996; Gelsthorpe and Morris 1990; Smart 1989, 1990). The oversimplified discussion of older criminalized women reflects many of the same understandings applied to marginalized women. As Brenda indicated:

Old people are certainly portrayed as being either well-established and doing very well or ineffectual; they just disappear. If you don’t have the money to go to one of those lovely golf resort-type retirement centres you really don’t exist in the media as an older person. You don’t see a lot of poor people living with their kids in their basements or not getting along with their family or whatever.

Her thoughts were echoed by several other participants, including an Inner City Health nurse who discussed discursive representations of older marginalized women in contemporary culture:

I think they’re invisible in media, or very slanted as – you know, they’re just the old homeless bag lady – but I don’t think there’s a balanced view in media one way or the other. I think it’s almost an invisible population. If you asked someone about the shelters in Ottawa for women, you would be told, probably, about the drug addicts and the abused. I don’t know how many people would think to bring up seniors, because the belief is not that family members drop their women at shelters. Yet, historically, we know it happens.

While few descriptors can accurately link *all* older marginalized women, the terms and ideas used are frequently stigmatizing and often inappropriate and false. The terms generally highlight social expectations and biases regarding women, older adults, and poor or marginalized people (Codd 1998; Greer and Jewkes 2005). The descriptors and stereotypes can be understood as linkages in a chain fence – each stereotype, on its own and in an individual repetition holds little power; connected as a discourse, however, these stereotypes form a barrier that sets older marginalized women apart as different and difficult.

In popular culture, discourses are sometimes thought to be insignificant, immaterial, or “just words.” Discourses, however, are extremely powerful; they shape our understandings of the world around us, providing a framework that shapes not only *how* we think, but also circumscribing *what* we think about the world and events within it (cf. Cohen 1985; Foucault 1977, 1990; Kuhn 1962; Mohanty 1997; Smart 1976, 1989). Michel Foucault, for example, explored how we talk about, and ultimately understand, sex and sexuality, showing how these topics, while treated differently across culture and through time (e.g., “repressed” versus overt), always remain the subject of discourse (Foucault 1990). Indeed, these discourses affect *social institutions*, from medical systems to schools or family relations, delineating knowledge about sex; ideas about what is “normal” and “abnormal”; *how* it is understood; and *how* it is talked about. They also affect *individuals*, marking a person as normal or abnormal; setting limits and boundaries for behaviour (including identity performances); and reinforcing privilege (or the lack thereof). In these ways, discourses about older marginalized women have real consequences on their lives. While discourses on marginalization are less pervasive than those on sexuality, they still permeate popular consciousness: in media accounts of “bag ladies”; television shows such as *Hoarders*; discussions of agency (or a lack thereof) among seniors; or the expression of pity (and sometimes paternalistic responses) to cases of elder abuse. Mary illustrated how discursive understandings of homelessness affect her:

[Homelessness] strips you of your identity, I think. It strips you of your sense of independence, your identity, your self-worth. Just sitting on the side of the house and looking at people’s eyes as they go by. Right away, there’s judgment there. And it’s just – *you change*. I’ve changed.

Similarly, Bev found that the stereotypical depictions of homeless women did not fit with her experiences. She notes that these depictions have concrete effects on her life, altering how others perceive her:

I really, really resent the people who look down on people like me. Because we’re not all here because we’re heroin addicts or crack addicts – I never got into any of that shit. I like a good joint once in a while, but I never got into the other

stuff. And I don't drink – I'm 21 years clean and sober. So I don't fit the criteria of a homeless person in a lot of ways. So I resent when they look down on me. I didn't get here because I *want* to be here, I got here because I can't find a doctor who wants to find out what's the matter with me – who wants to listen to me. So yeah, I can be – when I see people judging me, it's really hard to walk away from them. Really hard. I have done it, though, because opinions are like assholes – everyone's got one.

Discursive understandings of marginalization can have personal significance; however, they also have effects at the *structural* level (Hannem 2012; Major and O'Brien 2005). The effects of these stigmatizing discourses, coupled with ageism and classism, as well as the attributes that can make older marginalized women 'difficult to serve' – physical and mental health issues, behavioural issues, and challenging personal situations and relationships – often have a number of social implications – from poorer physical and mental health to limited access to employment and housing, and to the women receiving overall sub-par or limited care (Major and O'Brien 2005). An Aging at Home nurse reflected how stigma affects her clients:

What that means is that it's harder for them to get good care. People don't understand why they're doing the things they do, they get kicked out of places where they do try to get care, they get barred, and I think, at an emotional, personal level they don't feel like they're understood most places. ... they're very, very isolated and marginalized. They've lost – most of them have lost so much. We just keep taking things away from them. The stigma is huge; it's huge. ... It took me five months to get into the one woman's room. That's because of her level of paranoia with her mental health. But it's also, part of it, why would they *want* to trust you? They've had how many other people reject them or be condescending toward them, or think that they should listen to everything that they say because you're a nurse or a doctor and you know better than them. The powerlessness is a big thing. The unfortunate thing is that sometimes as support people, we sometimes reinforce that powerlessness.

Relations of privilege are reified not only within discourse, but within daily interactions between professionals and clients (Dudley 2000). As the professionals have, through their education and experiences, more insight than most into older marginalized women's lived realities and needs, the fact that even this understanding and empathetic group can perpetuate infantilization and exclusion highlights the pervasiveness of these sentiments and experiences in society.

Discursive representations of aging are heavily influenced by neoliberal discourses of individual responsibility, self-sufficiency, and risk management. Historically, older age was a short life phase; the contemporary lengthening of lifespans, coupled with medical advances raises our expectations for aging. In this vein, the “successful aging” discourse argues that aging need not be a process of senescence and decline (cf. Rowe and Kahn 1987, 1997); rather, aging’s negative effects can be mitigated through lifestyle and controlling personal “risk factors.” In short, aging becomes inherently “risky.” Medical literature focuses on *health risks*, but risk proliferates within aging discourses. For many older adults, age brings changes in employment and, often, a reduction in income – such as transitioning from an earned wage to living off of savings or pension income (Schellenberg and Silver 2004)<sup>77</sup>. In addition, one’s health status often deteriorates, possibly limiting one’s capabilities and independence (Health Canada 1999). Spouses, close family members and friends are more likely to fall ill and/or die, limiting the woman’s social network and sparking demands for caregiving. Despite these challenges, aging – especially for the wealthy – is often seen as a time of new beginnings. Contemporary discourses highlight shining prospects for older adults, although the ‘shine’ of these prospects is increasingly dulled as ‘economic austerity,’ ‘constraint’ and similar catchphrases become more common (Kennedy 2012b). Overly optimistic and positive messages on aging have met with critical scrutiny (cf. Holstein and Minkler 2003; Katz 1996), and were problematized by research participants. Brenda noted,

But yeah, the portrayal of old people, it’s usually a very vibrant, very well-to-do and I don’t think we want to think of old people living like this [in homeless shelters], or being in and out of housing. We want to believe that we are taking care of our old people and that’s not really what’s happening.

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<sup>77</sup> It should be noted, however, that for women on welfare without dependents, reaching age 65 and receiving Old Age Security payments and the Guaranteed Income Supplement represent an *increase* in income, although this increase may also come with a decrease in other benefits, including health benefits.

Just as Brenda indicates that most discursive representations of older women overlook the experiences and realities of those who are marginalized, Mary also found the depictions of aging to be incongruous with her reality. She explained:

Picking up the 50Plus magazine, or the Over 50, it's like – yeah. You see these pictures of people with grey hair, they're on their retirement pension; mine would have been wonderful if I had stayed at [corporation], which I didn't. I feel very – even the retirement facilities – I've even called them and they're twice what I get in a month. So I know, my old age, I'm going to be living in poverty. And I'm not even there yet. That's what I'm looking forward to, is *abject poverty*. That's if I'm even lucky enough to find a place to live. So yeah, I feel extremely isolated from those who have the money. As a pre-senior or whatever I am; 55+. The way we're portrayed it's either – yeah, you're extremely wealthy and you've got the money to Botox and, you know, all of this nonsense, or you're just – useless. ... So there's a sense I'm used up – anything I'm done, I'm past, and I'm sort of out on the ice floe, so to speak. Yeah, not a good feeling.

Although more realistic portrayals of aging and retirement are increasingly common, many older women still find the world around them to be one that is inhospitable and indifferent to their performatives and counter-narratives that show 'unsuccessful' – or simply realistic – aging experiences. As the discursive focus remains on the relatively affluent, healthy, and integrated (Holstein and Minkler 2003), the voices of those who do not fit this ideal are seldom heard.

Stereotypes and discourses have real effects on the women who experience them. While they are neither the cause of the women's low incomes, nor the reason for their social isolation or poor health, stereotypes do amplify the negative light in which the women are perceived (Goffman 1963; Hannem 2012b; Silver 1995). A manager at The Good Companions notes how a confluence of disadvantages limit older marginalized women's access to services and abilities to participate in community life. She elaborates:

[T]hey just don't fit: they don't have the money to pay for the programs, to get the transportation or necessarily the social skills once they're in it. ... You try to acknowledge and help. ... We can lure them or offer – for some of them we've had to stop offering the idea of a friendly visitor because we know it's a false waiting list. Who is going to go visit this person who's depressed, has nothing good to say, and lives in a really crappy and stinky home? We don't want to give

them that false promise that a volunteer will come, because over the last few years, we're just getting short on volunteers ... It's really only a band aid.

Disadvantage, in various forms, limits the support older marginalized women can access in the community. In addition to their disadvantage, the stigma – of living in a crummy apartment, of having mental health disorders, or of being on welfare – amplifies their exclusion and isolation (Greer and Jewkes 2005). These labels are imbued with meanings – often negative ones – that close many doors. An Aging at Home nurse explains:

My take on that is that there are not enough placements for long-term care. How many people are stuck in the hospital taking up a bed who really just need long-term care? When you look at our population, nobody wants to take them in long term care. Nobody wants to take them, and that's a real problem. They don't have the money, people can't work with their mental health or behavioural issues and they don't want to, so that's a problem. The stigma with all that: you get a label of a schizophrenic, not a person living with schizophrenia. Nobody wants to take schizophrenics. It's like nobody can see beyond that label, there's a really nice woman under there even if she's presenting as irritable because she's cheeking her meds. That's very tricky. The women are complicated....

Stigma within the care system limits the care older marginalized women receive and further reifies the stereotypes through which the women are understood (Dudley 2000). These labels and discourses about homelessness and marginalization often precede older women; their interactions with others who know their statuses as “marginalized,” “mentally ill” or “homeless” are often structured by these understandings. A supportive housing manager reflects:

For the women who have been here a long time and have been institutionalized or in shelters for a long time, one of the reasons I think they don't have outside community is the fear of what people are going to think of them. ...[T]hey know as soon as they say “I'm mentally ill” or whatever, well, that's going to change the dynamic. ...[They] are isolated here not because of anything we're doing, but because of the outside world. “I've been there before” or the only place where the person feels included is APPLE<sup>78</sup> or somewhere. They don't want to be somewhere that is somewhere for people with mental illness; they want to be part of the bigger world. ... [T]he total lack of awareness around mental illness, homelessness, all of those issues – abuse, addictions, all of that. I think the women have lived with that for so long ... that they now view the outside world as not welcoming, not open. I think right now we're closing that barrier, that gap,

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<sup>78</sup> APPLE is an acronym for A Post-Psychiatric Leisure Experience, an organization that provides social and recreation programs to individuals living with mental health disorders (Community Information Centre of Ottawa 2012).

with the volunteers and teaching them that not all people are bad; not all people are going to see them that way.

The discourses framing older marginalized women can be challenged and changed, but discourses, just like the women's identities and performatives, are often *sedimented*, resisting attempts at change or modification. Even when unspoken, these discourses form invisible fences, relegating the women to the edges of popular consciousness and understanding.

These invisible fences play a part in constraining identity performatives; limiting and blocking mobilities and movement; and discursively silencing the women. While talking over the fence is possible, moving or breaking down the fence requires older marginalized women to *talk over* it, but also for those on the other side of the fence to *listen*.

Chapter IX –  
Conclusion:  
Talking Over the (Invisible) Fence

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## 9 Conclusion

[Homeless people] are getting a raw deal. *They are really getting a raw deal.* The government should take from what they call – these big fancy places – and give them the help. They need shelters; they need places for people who are handicapped. They need places for people who are [blind], they need places for people who need access to a wheelchair. They need that. C'mon, get off your pedestal! Get off and help them out. That's the way I see it. *Because you're going to be in that spot one day, and you're not going to like it.* – Danielle

I know what it's like for someone to steal your boots when you're out there freezing cold – right off your feet, okay, and you're half frostbitten in the morning. And I know what it's like not to have any meals, I know what it's like to eat out of garbage cans. I know what it's like to be a hooker. I know what it's like to be a drug addict. I know what it's like to be a con. I've lived every walk of life, only because I had to survive. You know what? I didn't like half of them things. Most of them, three quarters, I hate with a passion. But you know what? I had to move on, and I was by myself. And if I didn't do those things, I would not be here to this day. *So that's what it's about. Support. Caring. Affection. Listening, listening, communication is one of the most important things. And trust.* – Deborah

In Chapter IV on methodology, I revealed my personal background, biases and the personal significance of this research. Having reached the final chapter of this thesis, I once again reflect on Howard Becker's (1967) famous question, *whose side are we on?* While conducting this study and presenting its results offers some answers to this question, this chapter continues this line of interrogation. Specifically, it summarizes what we now know about older marginalized women's lives and navigations of community life, but also offers suggestions as to *what to do with this knowledge*, in the form of policy recommendations.

Older marginalized women, although representing a small share of the overall Canadian population, have distinct needs relating to their past and current experiences, abilities, and the places and spaces in which they live and mobilize. This research documents their lives in the form of an institutional ethnography by focusing on the lived experiences of older marginalized women and the professionals working with them. This work is informed by the small but growing body of academic research in the areas of aging, marginalization, criminalization and homelessness, as well as my experiences of working with older marginalized women as a

shelter worker and through the field work I conducted in the places and spaces that the women frequent. From this background, I interviewed twenty-seven older marginalized women and fifteen professionals, asking questions about identities, social networks and the world around the women. I then analyzed the responses provided by the participants and reported my results in the form of this dissertation. From this foundation, some generalizations about these women can be made.

First, older marginalized women's lives are marked by limited ties to the social and work worlds and to the policy and legislative frameworks that circumscribe their interactions and navigations of community life. They are often experiencing significant changes that accumulate to form *points of rupture* in their lives and many struggle to find their place in the community. In addition, older marginalized women often have few social ties, but still may form close bonds with their peers, families, and workers, and with places and spaces in their communities. They are often overlooked by institutions (including governments, large organizations, and society as a whole). Conversely, if older marginalized women are considered, they may be seen as posing *risks to an institution* instead of women in *need of support or assistance*. Finally, the women are ignored or misrepresented in contemporary discourses on aging and marginalization, often presented in an essentialized and negative manner that belies their diversity, complexity, and individual agency. As the population (particularly the baby-boom generation) ages, the numbers of older marginalized women grow. While their realities are rarely explored, their growing numbers make the concerns of older women the concerns of society; older marginalized women are mothers, sisters, daughters, friends, and just simply citizens with rights and needs that need to be addressed. In light of this, what can be done to improve the lives and circumstances of older marginalized women?

## 9.1 *Policy Recommendations*

Regulation and policy shape everyday life. Policies – in the form of legislation and directives that outline our rights and freedoms as well as prohibited behaviours – are generally well-known to us all. In addition, there are myriad regulations that structure and circumscribe our lives in more subtle ways, ranging from regulations that affect the programs and services available in our communities, to those structuring the way businesses operate, and even those that ensure the safety of the food we eat and water we drink (cf. Cohen 1985; Foucault 1990). These policies and regulations exist at the national, provincial, and local levels. At each of these levels, there are policies that affect older marginalized women’s lives. Many of these policies simply treat older marginalized women no differently than any other group. This approach is expected and appropriate in the cases of most policies; however, in some instances, special attention to this group is warranted to ensure they are treated fairly and appropriately and indeed *equally* to others (Payne 2001; Sen 1995). As a supportive housing manager explained, “[It’s about] the outside institutions – whether they’re helpful or not helpful. What we’ve found in this house is a lot of times they are *not* helpful.” Indeed, policy is a tool through which the world can be made more or less navigable, more or less hospitable, and more or less welcoming. Indeed, the realm of policy and legislation holds the potential to create social change. As Sherry indicated,

Life doesn’t have to be like that [with poverty and deprivation]. Like, personally, I’ve learned from the research I’ve done over the years, there’s more than enough food to go around for everybody. More than enough shelter, more than enough clothing. *It doesn’t need to be the way it is.* It really doesn’t. I believe that everybody could have a good quality of life.

While policy cannot offer a ‘silver bullet’ or panacea to the world’s ills, adjustments and reconfigurations of policy can have dramatic effects – both positive and negative – on individual lives. The following policy recommendations, which examine policies at the national, provincial, municipal and organizational levels, highlight pathways for making *positive* change in older marginalized women’s lives.

At the national and provincial levels, the policies with the greatest direct impacts on older marginalized women's day-to-day lives are *financial* policies. These policies dictate the amount of income and supports that the women receive and are thus integral to their day to day lives, affecting their ability to secure and maintain housing and obtain the necessities of life (Nemiroff, Aubry, and Klodawsky 2010). Income policy-wise, the most striking aspect of how older marginalized women are managed is the *lack* of policy surrounding this group. The Ontario Works (OW) and Ontario Disability Support Program (ODSP) frameworks offer a range of special accommodations based on one's *demonstrated needs* – which generally must be corroborated by a professional in what can be a lengthy and confusing process. However, despite the challenges older marginalized women face with their aging bodies, *age* is not a category with which any special needs are associated. While special accommodations based on particular illnesses are acknowledged, the spectrum of challenges associated with accelerated aging – including reduced mobility, chronic illnesses, and increased frailty – all increase the needs of older marginalized women, from requirements for more nutritious diets, to transit options beyond walking.

Federal income assistance programs for seniors include Old Age Security (OAS), the Guaranteed Income Supplement (GIS), Canada Pension Plan (CPP) and Canada Pension Plan-Disability (CPP-D) programs.<sup>79</sup> Unlike recipients of OW and ODSP, individuals receiving benefits under these programs can have unlimited assets, including homes, savings accounts, and vehicles, a luxury not afforded to those on welfare. These programs do provide more money than is available to an individual under provincial social assistance programs and are

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<sup>79</sup> CPP-D benefits are available to those who were working at the time that they incurred a work-limiting disability. The program offers a higher monthly income than ODSP, but does not include drug benefits or access to the training and support programs offered to provincial social assistance recipients (HRSDC Government of Canada 2009).

indexed to rise with inflation; however, the benefits provided are modest<sup>80</sup> (Service Canada Government of Canada 2011; Green et al. 2010:75). Despite the seemingly positive nature of the transition to these benefits, there are drawbacks. For example, these programs do not offer the same level of responsiveness to individual needs as OW and ODSP, which offer special allowances to cover various personal needs – including allowances for a special diet, required medical devices and supplies, the care and maintenance of a guide dog or service animal, and even a lump sum of money to assist with setting up a residence and moving. Also, just as under the OW/ODSP framework, a person's GIS benefits are reduced if they have other sources of income (Service Canada Government of Canada 2011). In addition, CPP and OAS benefits are taxable, further reducing the income provided (Green et al. 2010). The federal government's responsibility for older Canadians and pensions masks a hidden challenge for some older women who are not yet seniors. As welfare programs are not designed to care for seniors, those who face accelerated aging and chronic health problems may find that welfare services are not prepared to meet the needs of those who are prematurely aging. With the government's recent move to raise the age of eligibility for the OAS program to 67 from 65, these difficulties will only increase, with the adverse impact most clearly felt by the most marginalized older adults (Schellenberg and Ostrovsky 2008; Schellenberg and Silver 2004)

One must also examine these programs from the perspective of society as a whole.

Discursively, the differences between being a "senior on a fixed income" and a "welfare recipient" are striking (Chunn and Gavigan 2004, 2006; Green et al. 2010). The OAS and GIS programs generally come without the stigma of being "on welfare" as they are provided to *all*

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<sup>80</sup> The benefits received by low-income individuals under the OAS/GIS system guarantee an income that approximates the After-Tax Low Income Cut-Off (LICO-AT) (Service Canada, 2008).

older adults.<sup>81</sup> Indeed, as the recent parliamentary debates over Old Age Security show (cf. Kennedy 2012a, 2012b; Kennedy and Fekete 2012; Milligan 2012), these benefits are seen as foundational to Canadian society. While offering an anecdotal examination of discourse on older marginalized women, this example highlights how our collective analytic lenses often result in false divisions and hidden realities, as in the case of older marginalized women.

In Ontario and other provinces, the social assistance program makes special accommodations for individuals with documented health conditions. While some special benefits are available to welfare – also known as Ontario Works (OW) – recipients, those with disabilities receive additional benefits under a special program. Indeed, the Ontario Disability Support Program (ODSP) is offered to those with special needs based on health conditions or disabilities. While administered in a similar manner to Ontario Works (OW) (welfare) benefits, the ODSP program provides recipients with more money and in some cases, additional benefits related to one's disability. To receive benefits under this program, however, one must complete paperwork that is sometimes confusing; have a family doctor who can provide confirmation of one's disability – something many people lack, marginalized or not; and then be approved for the benefit by the provincial government. As older marginalized women more often than not have poorer health than most individuals, these benefits could allow them to experience an improved quality of life and to increase their abilities to participate in their communities.

In terms of the women's *mobilities*, OC Transpo offers two discounted bus pass options that help some older marginalized women: a seniors' bus pass that is available to those age 65 and older and a "Community Pass" for individuals in receipt of ODSP (OC Transpo 2012). This

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<sup>81</sup> Of note, while OAS benefits are provided to *all* Canadian citizens over age 65 who apply to the program and have lived in Canada for at least 10 years, these benefits are reduced, or "clawed back" for those with incomes above a certain threshold (Informetrica Limited 2009).

policy could better improve the mobilities of older marginalized women by being expanded to allowing older adults between ages fifty and 65 to access a community pass if they have low incomes. In practice, this could be accomplished by extending the subsidized pass benefit to those who receive social assistance benefits under OW, CPP disability, OAS/GIS survivor benefits, or other pensions and disability benefits.

Ottawa Public Housing operates twenty apartment buildings that are for seniors only (Ottawa Community Housing 2012). Eleven of these buildings also offer the Aging in Place program that provides additional supports to residents to assist them in maintaining their housing. Ottawa Public Housing sets the eligibility cut-off for residence in its seniors-only apartment buildings at age sixty. While this is five years below the standard definition of a senior, this age cut-off has not been reduced enough to meet the needs of many of the older marginalized women who could benefit from this housing arrangement. Due to the pressing need to find suitable and affordable housing for older marginalized women in shelters, the housing authority would be well-served to address applicants on a more individualized level, considering their physical age instead of simply their chronological age in deciding on housing placements. In practice, this could be done by using a frailty or need scale to assess applicants between ages fifty and sixty for their suitability for these units. Accommodating these older adults, or “near seniors” would also help to address the long waiting lists for housing in buildings not specifically assigned to seniors that were noted by research participants.

It is also important to address the women’s feelings of being useless or worthless. Some of these feelings undoubtedly arise from individual predicaments, but they also reflect the unfortunate realities of aging and marginalization. Many of the women wanted to work (or volunteer) to earn income, pass time and feel useful. As Strimelle and Frigon (2007, 2011)

note, however, criminalized and marginalized women have few employment options, due to both the stigma they experience and a lack of skills. These difficulties are compounded by the employment discrimination faced by older workers (Bendick, Brown, and Wall 1999; Rowe and Nguyen 2002). As these conditions are common to large numbers of criminalized, marginalized, and older individuals, a large-scale specialized employment program could be used at the national, provincial, or local levels to assist these people in finding and maintaining employment. Such a program could include a job bank of supportive and accommodating employers and also assistance to develop or improve employability skills, thus reducing the marginalization, isolation, and stigma that older marginalized women (and others) experience.

At the community and organizational level, the majority of organizations and facilities did not have special policies or programs for older marginalized women. While this may at first appear to be a policy gap, older marginalized women's needs were usually accommodated to the best of the organizations' abilities. Older adult policies could be useful for some organizations, but this is not the only way, or necessarily the best way, of addressing older marginalized women's needs; older marginalized women are not homogenous and community organizations differ in their locations, facilities, policies, and practices, limiting the effectiveness of a single universal policy. Indeed, the presence of a fixed policy may be counterproductive when what is often needed is simply to understand and recognize older marginalized women's needs and to have a demonstrated *flexibility* in response to clients. Thus, what is required is not a policy, but a *policy lens* that challenges organizations and their staff to examine their environments, procedures, and practices from the standpoints of older marginalized women. In particular, such a policy lens could drive change in the daily operations of shelters and drop-ins, helping to better reflect the diversity of clients' needs. A policy lens for older marginalized women would highlight common attributes of this group beyond age and sex, such as:

- A high rate of chronic physical illnesses and conditions, including (but not limited to) arthritis, diabetes, hypertension, and chronic obstructive pulmonary disorder;
- A high rate of mental health issues, including (but not limited to) addictions, anxiety, depression, paranoia, and suicidal ideation;
- The emergence of signs of dementia and cognitive decline (e.g., Alzheimer’s disease, vascular dementia);
- Limited mobility that reduces the women’s abilities to climb stairs, sleep on top bunks, use washroom facilities, and otherwise go about their day-to-day lives;
- An increased risk of isolation and loneliness;
- A history of past abuse and trauma, ranging from childhood abuse and molestation to troubled relationships as an adult; and
- Increased vulnerability in the shelter and service environment, especially as many older marginalized women are experiencing homelessness and marginalization for the first time.

While these attributes and conditions are not exclusive to older marginalized women, they are extremely common and thus should be considered in policy, program, and practice decisions.

While these attributes form the policy lens, the question of *translation* – or how to put the lessons learned by using the lens into practice – must also be addressed (O’Malley et al. 1997).

Applying a policy lens requires a consideration of environments, routines and practices from older marginalized women’s perspectives. Such a lens can be used as an analytic tool for policy examinations; as a minimum standard for the built environment; or as a frame of reference in program design. There are many areas in which such a policy lens could be applied, ranging from infrastructure improvements, to funding allocations, to programming decisions. Specifically, vis-à-vis community organizations, some policy considerations include:

- Examining older marginalized women’s needs when applying for and conducting building retrofits or infrastructure upgrades. Accommodations for older marginalized women in these instances would include:
  - the addition of ramps and elevators to provide better access to facilities (as opposed to access via stairs),
  - wider hallways and grab bars to assist with movement,
  - brighter lighting to help women with deteriorating eyesight,

- retrofitted washrooms including shower benches, grab bars in tubs and near toilets, and
- larger washrooms to accommodate women with mobility issues;
- Special diet provisions to ensure that older women have access to adequate nutrition to support their health (Campbell and Leidy 2007; Green et al. 2010), including additional nutrient and protein-rich foods, reduced sugar and sodium foods, and nutritious foods available outside of scheduled meal times;
- Access to quiet spaces and quiet rooms, both for sleeping and for quiet activities such as reading, meditation or study;
- Offering education and awareness workshops or mini-courses on aging-related issues (e.g., fall prevention, menopause, heart disease, etc.), possibly in partnership with other community organizations (e.g., Ottawa Public Health); and
- In shelters in particular, an older women’s policy lens would note the limited programming and activities offered. For women who have difficulty accessing drop-ins and day programming, the facilities would be well-served to offer a wider range of programming and activity options, possibly in partnership with other facilities and organizations, or with the assistance of volunteers.

In summary, there are a range of possibilities and options for organizations to review their environments, policies, and practices with an eye to better accommodating older marginalized women. While not all of these suggestions will apply to all organizations, they offer insight into how organizations can respond to older marginalized women’s needs and also how they can review their practices in light of the ‘older marginalized women’ policy lens.

The policy and program changes recommended above are wide-ranging and implicate all levels of government and community organizations serving older marginalized women. While diverse, these recommendations and considerations would all improve the quality of life and community experiences of older marginalized women. Although the focus of many recommendations is on financial mechanisms (e.g., OAS/GIS and OW/ODSP benefits), as noted, the introduction of a *policy lens* through which to examine older marginalized women’s lives and needs would allow for older marginalized women’s needs to be highlighted and addressed in different settings, ultimately offering a better accommodation of these individuals in their communities.

## 9.2 *Where do we go from here?*

Making positive change for older marginalized women involves altering both policy and *discourse*. Older marginalized women's needs are often dismissed, ignored, or simply *not recognized* by policy-makers or by society in general (cf. Aday and Krabill 2011; Crawley 2005; Washington 2005). As such, one must break down the discursive fence surrounding older marginalized women to create awareness about their needs. While this seems simple, it is a daunting task amid a climate of risk assessment, individualism, expert authority and "austerity measures." Indeed, the women find themselves behind an invisible fence: they are embedded in but are not a part of our communities; therefore they are seldom recognized or heard. As Jane explained,

It's like two sides of life. You've got *that* side of life [gestures out the window], and you've got *this* side of life. You cannot get people on that side of life who can go out and buy cars every three years to know about *this* side of life. It's just a no-go ... You are not going to change the people on the other side of the fence. ... And that will always, always be. That's the way it is, and you probably hear that a lot yourself, so you pretty well know the difference. And you're not going to change the people that don't believe in you. Because you've been on the other side of the fence. You've needed help and you got it. But for the people on the other side, you can talk to them until you're blue in the face and they're not going to understand. And they're never going to come close to understanding. You know the difference, you've been there. It's too bad it's like that, but it is.

Despite Jane's sense of futility with changing discourses, I find myself feeling slightly more optimistic. Fully bridging this gap is most likely futile; however, there is no reason why older marginalized women cannot *talk over* the invisible fence surrounding them, nor eventually find the fence around them slowly lowering and becoming more permeable. This work of talking over fences is ongoing in many ways and many places. For example, members of the service network in Ottawa have formed The Alliance to End Homelessness, a group that advocates on behalf of these organizations and raises awareness of homelessness-related policy, programs, and issues in the city. In Montréal, the magazine *L'itinéraire* explores issues related to homelessness and aims to improve the quality of life for the city's homeless population. Similarly, research collaborations and online communities such as the homeless hub online

research forum improve access to resources and materials on homelessness. While these are just some examples of advocacy routes and information sharing mechanisms, they all highlight the potential for raising awareness of older marginalized and homeless women's needs and concerns.

Part of this discursive change involves increasing the awareness of older marginalized women in Ottawa and the issues and concerns particular to this group. To this end, I hope to continue working to bring their words, thoughts, issues, and concerns to a broader audience. As most of the women I met will never see this work, I hope to share my findings with them in a more accessible format and also to advocate for their needs and concerns to hopefully improve their experiences in the longer term. While I cannot singlehandedly break down the discursive fence, I may still hold the megaphone through which their stories can be heard, and also wield one of the hammers as the women and their communities work together to break down the fence.

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# Appendix A – Ethics Approval Form

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**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

## Ethics Approval Notice

### Social Sciences and Humanities REB

#### Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Sylvie	Frigon	Social Sciences / Criminology	Supervisor
Laura	Shantz	Social Sciences / Criminology	Student Researcher

**File Number:** 08-10-01

**Type of Project:** PhD Thesis

**Title:** Talking Over the (invisible) Fence: Older, Marginalized Women, Identity and Social Networks

<b>Approval Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
09/09/2010	09/08/2011	Ia

**(Ia: Approval, Ib: Approval for initial stage only)**

#### Special Conditions / Comments:

N/A

**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:  
[http://www.rges.uottawa.ca/ethics/application\\_dwn.asp](http://www.rges.uottawa.ca/ethics/application_dwn.asp)

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:  
[http://www.rges.uottawa.ca/ethics/application\\_dwn.asp](http://www.rges.uottawa.ca/ethics/application_dwn.asp)

If you have any questions, please do not hesitate to contact the Ethics Office at [contact information removed]

**Signature:**

Isabelle Robert,  
Protocol Officer for Ethics in Research  
For Barbara Graves,  
Chair of the Social Sciences and Humanities REB

## Appendix B – Consent Form for Older Women

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[Original on University of Ottawa letterhead]

## **Consent Form**

### **Title of Study: Talking over the (invisible) fence: Older marginalized women, identity and social networks**

Laura Shantz  
Department of Criminology  
University of Ottawa

Professor Sylvie Frigon  
Department of Criminology  
University of Ottawa

**Invitation to Participate:** I am invited to participate in the abovementioned research study conducted by Laura Shantz under the supervision of Professor Sylvie Frigon. The project has been funded by the Social Sciences and Humanities Research Council (SSHRC).

**Purpose of the Study:** The purpose of the study is to learn how older marginalized women form identities and experience community life. This includes the role of communities in improving quality of life. The study will look at the experiences of older women and of those who help them. We hope to learn what can help older women in their communities.

**Participation:** Participation will consist of taking part in one interview, lasting one to two hours, during which I will be asked to answer questions regarding my thoughts and experiences. The interview will be audio recorded.

**Risks:** My participation in this study will entail that I volunteer information about my personal thoughts, feelings and experiences about my life, activities and relationships, and this may cause me to feel uncomfortable or upset. I have received assurance from the researcher that every effort will be made to minimize these risks, and I have been provided with a list of organizations that can help me if I experience any negative effects.

**Benefits:** My participation in this study will add to the knowledge about older marginalized women's identities, social networks and experiences in the community. This information could be used to help improve services and quality of life for older marginalized women.

**Confidentiality and anonymity:** I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for this. My name and identifying details will not be disclosed during the research or in any publications resulting from it. **Anonymity** will be protected in the following manner: no identifying details about me, my life, or my location will be published.

**Conservation of data:** The data collected, including field notes, tape recordings and transcripts will be kept in a secure office at the Department of Criminology, where only Laura Shantz and Sylvie Frigon will have access to it. Data will be conserved for five years, after which time it will be destroyed.

**Compensation:** I will be offered \$25 in cash as compensation for my time. I will receive this compensation even if I choose to withdraw from the study.

**Voluntary Participation:** I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

**Acceptance:** I, \_\_\_\_\_, agree to participate in the above research study conducted by Laura Shantz of the Department of Criminology, University of Ottawa, under the supervision of Professor Sylvie Frigon.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research,  
University of Ottawa,  
[address and contact information]

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C – Interview Guide for Older Women

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## **Interview Guide – Older Women**

### **Identity Narrative**

1. As you know, I am conducting research on older women, marginalization, identity and social networks. That is, I want to know how you see your place in the world, about the people around you, and about your identity – who you are. I can assure you that all of the information you provide will be kept confidential and your anonymity will be protected. There are no right or wrong answers; I'm just interested in knowing about you. What you think is important to tell me is what I'm interested in hearing. If it is all right with you, I would like you to start off by talking about your identity. To better understand who you are and how you see yourself, I would like to hear your story. Tell me about you.
  - 1.1. Tell me about how your life has changed as you've gotten older.
  - 1.2. Tell me about an event that's shaped who you are today.
  - 1.3. What kinds of challenges have you had?
  - 1.4. If you had to pick just 3 or 4 words to tell me about yourself, what would you say?
    - 1.4.1. Why those words?
  - 1.5. Is there anything else you'd like to add before we move on?

### **Interactions in the Social World**

2. Now, if it's all right with you, I'd like to move on and talk a bit about the world around you. I'm interested in knowing about the kind of things you do (how you spend your time), things that you look forward to – that are interesting or enjoyable, things you don't like or that you don't enjoy doing, as well as the boring, everyday stuff.
  - 2.1. Tell me a bit about your routine. What do you do in a typical day?
    - 2.1.1. Let's start at the beginning. What do you do when you get up in the morning?
    - 2.1.2. Who do you talk to in a normal day?
    - 2.1.3. What services do you use?
  - 2.2. Where do you like to go?
  - 2.3. What do you do for fun or to have a good time?
  - 2.4. Is there anything else you'd like to add before we move on?

### **Social Networks**

3. Now, if it's all right with you, I would like to move on and talk about social networks. So, I'm interested in learning about the people you regularly talk to and spend time with – be they friends, family, or workers. Tell me about the people you are close to.
  - 3.1.1. What about family?
  - 3.1.2. What about friends?
  - 3.1.3. What about your support workers?

- 3.2. What does community mean to you? Can you describe your community?
- 3.3. Are there any other communities to which you belong – e.g., circle of friends, groups, clubs, etc?
- 3.4. I'm also interested in how your family/friends/workers fit into your life. So, I'd like to know what you do socially and what help or benefits you get from and give to others that you're close to.
  - 3.4.1. Who do you turn to when you have a problem or you need help?
    - 3.4.1.1. What kinds of things do your family/friends/workers do to help you?
  - 3.4.2. Tell me about meeting new people/making friends.
  - 3.4.3. Do you help out others? What kinds of things do you do that help others?

### **Community Services and Supports**

- 4. I would also like to ask you about all of the programs and services that you have access to. I know that there are a number of agencies and programs in Ottawa that work to meet needs, like shelters (Cornerstone, Shep's), health services (Centretown CHC, Wabano, Inner City Health), and drop-in centres (Odawa, The Well, St. Joe's).
  - 4.1. Can you tell me about some of the services that you know about?
    - 4.1.1. Do you use these services?
    - 4.1.2. What do you think of these services?
      - 4.1.2.1. What programs and services would you like to see offered to you?
  - 4.2. How do you find out about services and programs that you can access?
  - 4.3. Where can you go to get help?
  - 4.4. Is there anything else you'd like to add before we move on?

### **Social perceptions/portrayals**

- 5. Sometimes, we see older people portrayed on TV, or in movies or in ads as having lots of time to relax, travel and have fun and getting to do pretty much whatever they want. Other times, we see older people talked about as if they can't do anything. What do you think of these images?
  - 5.1. How do these images affect you?
  - 5.2. Do these images match how you see yourself?
    - 5.2.1. Do you think these are realistic?
- 6. We also see people who are marginalized talked about and portrayed in various ways. For example, some people say that poor people are always looking for handouts or are lazy. What do you think of these images?
  - 6.1. How do these images affect you?

6.2. Do these images match how you see yourself?

6.2.1. Do you think these are realistic?

### **Wrap-up**

7. We are now at the end of the interview.

7.1. Is there anything else you'd like to add?

7.2. Are there areas that I did not ask about that you think are important?

7.3. Is there anything you'd like to ask me about the research?

I want to thank you for taking part in this interview. I appreciate you taking the time to meet with me and discussing your life and experiences.

## Appendix D – Consent form for Professionals

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[Original on University of Ottawa letterhead]

## **Consent Form**

### **Title of Study: Talking over the (invisible) fence: Older marginalized women, identity and social networks**

Laura Shantz  
Department of Criminology  
University of Ottawa

Professor Sylvie Frigon  
Department of Criminology  
University of Ottawa

**Invitation to Participate:** I am invited to participate in the abovementioned research study conducted by Laura Shantz under the supervision of Professor Sylvie Frigon. The project has been funded by the Social Sciences and Humanities Research Council (SSHRC).

**Purpose of the Study:** The purpose of the study is to learn how older marginalized women experience community life. This includes the role of communities in improving quality of life. The study will look at the experiences of older women and of those who help them. We hope to learn what can help older women in their communities.

**Participation:** My participation will consist of taking part in one interview, lasting approximately one hour, during which I will be asked to answer questions regarding my work and my clients. The interview will be audio recorded

**Risks:** My participation in this study will entail that I volunteer information about my work, as well as my personal thoughts, feelings and experiences about my work and my clients; this may cause me to feel uncomfortable or upset. I have received assurance from the researcher that every effort will be made to minimize these risks, and I have been provided with a list of organizations that can help me if I experience any negative effects.

**Benefits:** My participation in this study will add to the knowledge about older marginalized women's identities and experiences in the community. This information could be used to help improve services and quality of life for older marginalized women.

**Confidentiality and anonymity:** I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for this project. My name and identifying details will not be disclosed during the research or in any publications resulting from it. **Anonymity** will be protected in the following manner: no identifying details about me, my life, or my location will be published.

**Conservation of data:** The data collected, including field notes, tape recordings and transcripts will be kept in a secure office at the Department of Criminology, where only Laura Shantz and Sylvie Frigon will have access to it. Data will be conserved for five years, after which time it will be destroyed.

**Voluntary Participation:** I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

**Acceptance:** I, \_\_\_\_\_, agree to participate in the above research study conducted by Laura Shantz of the Department of Criminology, University of Ottawa, under the supervision of Professor Sylvie Frigon.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research,  
University of Ottawa,  
[contact information]

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Appendix E – Interview Guide for Professionals

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## Interview Guide – Professionals

### Role as a worker

1. As you know, I am conducting research on older women, marginalization, identity and social networks. As part of that research, I am interested in the places and spaces in which these women live, receive services and assistance, and generally connect with others and interact. I'm also interested in their social interactions and those with whom they interact, including caseworkers/professionals. I can assure you that all of the information you provide will be kept confidential and your anonymity will be protected. There are no right or wrong answers to the questions; I'd just like to hear your impressions and thoughts as a caseworker/professional. If it's all right with you, I would like you to start by telling me a bit about the work that you do.
  - 1.1. What is your role within the organization?
    - 1.1.1. Tell me about your activities on a typical day.
  - 1.2. What kinds of contact do you have with older marginalized women?
  - 1.3. Is there anything else you'd like to add before we move on?

### Agency/Institution's role

2. In addition to learning about what you do, I would like to learn about your agency/organization in general. To better understand the places and spaces in which older marginalized women live, receive services and connect with others, I would like to hear about the services that your agency/organization provides.
  - 2.1. To whom are your services offered?
  - 2.2. What conditions are attached to receiving services?
    - 2.2.1. Are there any special rules about [staying here/being here]?
    - 2.2.2. What happens if someone doesn't follow the rules?
  - 2.3. Are there any policies or procedures for dealing with different groups of women with special needs (e.g., addictions, mental health, mobility issues, age)?
    - 2.3.1. Could you describe any special formal or informal policies and/or procedures at your agency/organization for working with older women?
  - 2.4. Is there anything else you'd like to add before we move on?

### Clients

3. Now that we've talked about your organization and how it operates, I would like to move on and discuss your clients. I'm not looking to know the names or personal details of your clients, but am instead looking for an idea of the kinds of situations and challenges faced by the older marginalized women who use your services.
  - 3.1. What situations/factors bring women to your organization/agency?
    - 3.1.1. Are these situations/factors specific to older marginalized women, or do they represent women more broadly?
  - 3.2. How do women usually find out about/access your services?
  - 3.3. For how long do women access these services?
    - 3.3.1. Is there a maximum length of time that women are able to use these services?
  - 3.4. Is there anything else that you'd like to add before we move on?
4. We know that older marginalized women often find themselves isolated from society to varying degrees. Based on your experiences with your clients, could you tell me a bit about their social networks?
  - 4.1. Do they have connections with others? Who?

- 4.1.1. Family?
- 4.1.2. Friends?
- 4.1.3. Workers, both here or through other agencies and services?
  - 4.1.3.1. What are your relationships with your clients like?
- 4.1.4. Other people in the community?
- 4.2. What kinds of social activities do you see them participating in (e.g., activity or support groups, going out for coffee with others, just hanging out)?
  - 4.2.1. Would you consider them as having big social circles?
  - 4.2.2. Is this similar to what you see for your other clients?
- 4.3. Do they have a formal or informal “support system” in place – people and services that they can turn to when they need help or are having difficulties?
  - 4.3.1. If so, can you tell me a bit about it? Does it include family/friends, or is it made up of caseworkers and formal supports?
  - 4.3.2. What happens when they need help or assistance?
- 4.4. Is there anything else you’d like to add before we move on?

### **Community and Social Services**

- 5. I would also like to discuss the social services and broader environment that older women face. So, I’m interested in knowing about other programs and services in the community, offered by both community service providers and government institutions within the community, such as drop-in centres, housing, food services, social services, et cetera.
  - 5.1. Can you describe the community-based services available to older marginalized women?
    - 5.1.1. Do you know of any services tailored specifically to older women?
  - 5.2. What are the processes to access these services?
    - 5.2.1. Are there any barriers to access (e.g., waiting lists, difficult application processes, location, hours, accessibility)?
  - 5.3. Can you describe the government-provided services available to older marginalized women, such as welfare or social assistance programs?
    - 5.3.1. How do women access these services?
    - 5.3.2. Are there any barriers to access?
  - 5.4. In your work, do you make referrals to other service agencies? What types of agencies?
    - 5.4.1. How do you choose where to send someone?
    - 5.4.2. How do you learn about other services that are available to your clients?
  - 5.5. Is there anything else you’d like to add before we move on?

### **Discourses/Broader Social Forces**

- 6. I am also interested in how older women facing marginalization, criminalization and poverty interact with the broader world, not just specific organizations and agencies. As someone who has worked with older marginalized women, I’m interested in knowing about how they are affected by social policies and programs, and also how they are portrayed in policy and by the media.
  - 6.1. Social policy largely comes from governments. How do you think government policies and programs affect older women? Can you provide any specific examples of policies and how they affect older women?
    - 6.1.1. Do policymakers consider older women’s needs? If so, how?
  - 6.2. How do you see older people being portrayed in the media?
    - 6.2.1. Do these portrayals reflect what you see working with older marginalized women? In what ways?

- 6.3. How do you see poor and marginalized people being portrayed on television shows and in movies? On television commercials – whether it is for travel, health, pharmaceuticals, insurance, etc? In the news? By social service agencies/workers? In social policies?
  - 6.3.1. Do these portrayals reflect what you see working with older marginalized women?
- 6.4. Is there anything else you'd like to add?

**Wrap-up**

7. We are now at the end of the interview.
  - 7.1. Is there anything else you'd like to add before we wrap up?
  - 7.2. Are there areas that I did not ask about that you think are important?
  - 7.3. Is there anything you'd like to ask me about the study?

I want to thank you for participating. I sincerely appreciate your time and participation in my research.

## Appendix F – List of Documents Reviewed

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## ***Policies and Documents included in the Document Review***

**Codes of Conduct and/or Rules of Facility/Program** were obtained from the following organizations:

- Centre 454
- Cornerstone Housing for Women
- Ottawa Inner City Health
- Ottawa Public Health
- Shepherds of Good Hope
- St. Joe's Women's Centre
- The Good Companions
- The Well

### **Government Legislation (listed alphabetically)**

While most legislative documents are relatively technical, these documents were useful in cases where background documentation was linked with legislation, and in cases where the related regulations were unclear or confusing. The following pieces of legislation were examined:

- *Canada Pension Plan Act* - R.S.C., 1985, c. C-8
- *Old Age Security Act* - R.S.C., 1985, c. O-9
- *Ontario Disability Support Program Act* and related income Regulations, 1997
- *Ontario Works Act* and related income Regulations, 1997

### **Background Documentation, Policy Documents, and Program Eligibility Criteria**

Background documentation for a variety of programs and services was included in the review. Specifically, this documentation covered the following programs, services and service groups:

- City of Ottawa Essential Health and Social Supports
- City of Ottawa Older Adults' Plan (draft document)
- City of Ottawa Poverty Reduction Strategy
- Old Age Security
- Ontario Disability Support Program
- Ontario Works
- Understanding Clients who are Difficult to Serve (Northwestern Ontario District Health Council)