The Homeless Population and Self-Awareness

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The focus of this paper is on the health inequalities that revolve around the homeless community and how personal biases can influence the delivery of health care. This paper will examine the origins of homelessness and the aspects of homelessness that cause healthcare vulnerability. The author’s personal biases of the homeless population will also be explored, both before the research was completed, and again after the available information had been compiled and reviewed. The author will then compare these views in order to explain how her biases might affect the quality of health care she provides to this vulnerable population.

Vulnerable Population

Homelessness affects people of all ages, races, cultures, and locations. According to Seiler and Moss (2011) poverty, lack of affordable housing, violence within the home, mental illness, and substance abuse are among the leading causes of homelessness in the past 25 years. The Department of Housing and Urban Development (HUD) performed a survey in 2009 that estimated 110,917 adult Americans faced chronic homelessness and approximately 75% of the homeless population were men averaging 50 years of age. HUD also estimated that 242,000 families had experienced homelessness and that during the 2009-2010 school year nearly one million children were classified as homeless (Wheatley, 2012).

The homeless as a population represent a challenge in terms of meeting regular healthcare needs. This contributes substantially to the population’s overall vulnerability. “Many homeless people have complications from decreased hygiene, hypothermia, and hyperthermia; suffer from lice and scabies; and have diseases or conditions such as tuberculosis, HIV infection, substance abuse and addiction, and dental problems” (Harkness & DeMarco, 2012, p. 349). Not
only do the homeless have numerous medical complications but many of them have a deep distrust of others outside of their homeless cultural group (Law & John, 2012). This mistrust can cause them to stay away from outsiders, such as healthcare workers, “…thus increasing their invisibility and reducing their access to help and support” (Law & John, 2012, p. 372).

**Personal Reflection**

Prior to completing the research for this paper I had thought of the homeless population as lazy, uneducated, mentally ill, or handicapped by substance abuse. I believed that many people in this population had control over their situation and were to blame for their circumstances. Based on anecdotal evidence, I believed they faced their circumstances because of their poor choices and unwillingness to make changes. As a healthcare worker, I often felt that caring for this population was frustrating because they seemed to never want to better their situation. They usually seemed very distant and uninterested in participating in their own recovery and I tended to reciprocate their attitude. After looking into the demographics that make-up the homeless population I have found that many of the people in this population had encountered unfortunate situations and were victims of circumstances out of their control (Wheatley, 2012). I can understand how my actions may have caused the homeless population I was caring for to become more withdrawn and less likely to seek help and care from others. Seiler and Moss (2012) noted that many homeless patients “…found that they often waited to seek health care until a crisis occurred and faced many barriers such as feeling labeled, stigmatized, disrespected, and invisible” (p. 304).
Conclusion

After conducting the self-reflection and research on the homeless as a vulnerable population, I believe that an individual’s quality of healthcare can be greatly affected by virtue of that individual being identified as part of the homeless population. The homeless are much less likely to be active participants in their own care, which can generally frustrate the normal care plans administered by most healthcare providers. Over time, a health professional’s personal experiences with these types of patients, will very likely affect the interactions one has with future patients. After conducting this research and personal reflection, it is clear that it is up to every individual health care worker to evaluate each patient individually and without bias, in order to obtain the most effective outcome for the patient.
References


