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Understanding Psychological Care in the Context of Homelessness: Evidence and Experience

Study 1: The effectiveness of third-wave interventions with unhoused people: A mixed-methods systematic review

Study 2: *“They’re intertwined really... They make each other worse”*: An interpretative phenomenological analysis of living with epilepsy in the context of homelessness

Thesis presented by

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for the degree of

Doctor of Clinical Psychology

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List of Abbreviations

Abbreviation	Term
ACT	Acceptance and Commitment Therapy
CBT	Cognitive Behavioural Therapy
CFT	Compassion Focused Therapy
DBT	Dialectical Behaviour Therapy
MBSR	Mindfulness-Based Stress Reduction
PTSD	Post-Traumatic Stress Disorder
TBI	Traumatic Brain Injury
GET	Group Experiential Theme
IPA	Interpretative Phenomenological Analysis
JBİ	Joanna Briggs Institute
RCT	Randomised Controlled Trial
ETHOS	European Typology of Homelessness and Housing Exclusion
NICE	National Institute for Health and Care Excellence
QUASH-Epilepsy	Quality of Life, Unmet needs, Awareness and Stigma in Homeless adults with Epilepsy

Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

A handwritten signature in black ink, reading 'R. Corscadden', is displayed on a light gray rectangular background. The signature is written in a cursive style with a large initial 'R'.

Rebekah Corscadden

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Chapter 1: Integrated Literature Review

Introduction

Homelessness is a growing public health and social concern, shaped by structural disadvantage (Ingram et al., 2023) and often characterised by intersecting experiences of trauma, chronic instability, social exclusion and discrimination (Barreto & Cockersell, 2024). Rates of homelessness in Ireland have increased markedly in recent years. By February 2026, homelessness had risen to a record high of 17,308 individuals in emergency accommodation, including 11,851 adults and 5,457 children; representing an approximate 431% increase over the past decade (Department of Housing, Local Government and Heritage, 2026). These figures do not capture the “hidden homeless”, such as those in domestic violence refuges, direct provision centres, sleeping in cars, squats, floors and couches of friends and family, or those living in open air, or other forms of unsafe or insecure accommodation.

Against this backdrop of significantly increasing homelessness, the current literature review aims to (1) critically examine how homelessness is defined, experienced, and addressed within existing psychological intervention literature, and (2) explore the intersection of homelessness and chronic health conditions, with particular focus on epilepsy. First, homelessness will be examined in terms of its definition and terminology. The diverse needs of this group will then be synthesised and reviewed, followed by a critical discussion of existing interventions for unhoused people, including what is currently known and where important gaps remain. This provides a foundation for further investigation into the role and applicability of third-wave psychological interventions within homelessness contexts.

Subsequently, literature relating to homelessness and chronic health conditions will be described and evaluated, with particular focus on the intersection of epilepsy and homelessness. While chronic health conditions are disproportionately prevalent among unhoused populations (Omerov et al., 2020), the ways in which conditions such as epilepsy are experienced and managed in homelessness remain underexplored (Lucey et al., 2026). This highlights the need for in-depth qualitative exploration of how such intersecting experiences are understood and navigated in everyday life. To meaningfully

interpret these intersections, it is first necessary to examine how homelessness is defined and conceptualised.

Defining Homelessness

Unhoused people live without consistent access to safe, stable, and secure housing. However, there is no single universal definition of “homelessness”. The European Typology of Homelessness and Housing Exclusion (FEANTSA, 2017) provides a useful framework for understanding the different degrees of housing instability. Within this framework, a home is conceptualised as more than a physical shelter, and encompasses physical, legal and social domains. Accordingly, a person may be considered ‘homeless’, when at least two of the following are absent: a decent dwelling with adequate space, a legal title to a place for exclusive possession or tenancy, and a private and safe space to maintain social relations.

Moreover, this framework outlines four broad categories of living situations, (1) “Roofless”, comprising individuals sleeping outside in open air or in emergency overnight shelters, (2) “Houseless”, including those in homeless hostels, temporary or transitional accommodation, and individuals in institutions without housing prior to discharge (3) “Insecure housing”, which includes formerly unhoused individuals in receipt of long-term support, those temporarily staying with family or friends due to lack of housing, or individuals living under threat of eviction or violence; and (4) “Inadequate housing” such as those living in non-conventional dwellings unfit for living or in conditions of extreme over-crowding. These categories are outlined to capture the breadth and heterogeneity of experiences encompassed by homelessness.

A range of terms have been used to describe this group of people, including “the homeless”, “people experiencing homelessness”, “unhoused” and “houseless”. For the purposes of this dissertation, the preferred term of reference is “unhoused”. This term has been increasingly adopted in recent literature (Ahuja et al., 2020; Garfin et al., 2024; Townley & Leickly, 2026) and aligns with the use of person-centred language, which has been shown to support the humanisation of individuals who are frequently marginalised within society. Importantly, *unhoused* shifts the framing of the issue from an individual characteristic to a structural condition, foregrounding the role of systemic

and societal factors in the absence of adequate housing, rather than locating responsibility within the individual.

In summary, this conceptualisation highlights the various forms of housing instability and provides a foundation for examining how these conditions intersect with health, wellbeing, and lived experience, which are considered in the sections that follow.

Health Inequalities in Homelessness

Unmet basic needs dominate the experience of homelessness (Baggett et al., 2010; Omerov et al., 2020). Unhoused people have a shorter life expectancy (McNeill et al., 2022), have higher rates of mental health conditions (Carroll et al., 2021; McNeill et al., 2022) and physical health conditions (Carroll et al., 2021; McNeill et al., 2022), are at greater risk of suicide (Nilsson et al., 2025) and self-harm (Ingram et al., 2023; McNeill et al., 2022), and are more likely to have difficulties with substance use (Carroll et al., 2021; Ingram et al., 2023; McNeill et al., 2022), in comparison to the general population. Rates of physical and sexual assaults are also much higher in unhoused individuals than housed groups (Fazel et al., 2014). Unhoused people have higher rates of diseases related to alcohol and/or drug addiction (Fazel et al., 2014), and are more likely to sustain unintentional injuries from precarious living conditions, which places them at a higher risk for traumatic brain injuries and epilepsy (Laporte et al., 2006; Pontes & Marques, 2023). These disparities are well documented, with housing and health having a bidirectional relationship (D'Alessandro & Appolloni, 2020; Fazel et al., 2014; World Health Organisation, 2018). Across the literature, homelessness is associated with detrimental consequences for social, psychological, and physical health outcomes. These health disparities are produced through the cumulative impact of interactions between the individual, family, social, economic and wider structural inequalities; known as the social determinants of health (Stafford & Wood, 2017). Structural factors that increase the risk of homelessness include absence of low-cost housing, increases in costs of living, unemployment and reduced educational opportunities (Grattan et al., 2021). People who find themselves at risk of homelessness are more likely to have adverse childhood experiences (Liu et al., 2021), personal histories of trauma and/or violence (Adams et al., 2025), learning difficulties (Nishio et

al., 2015), cognitive impairments (Stone et al., 2019), and/or neurodivergence (Brown & McCann, 2020), pre-existing mental health difficulties (Barry et al., 2024), and problematic drugs and alcohol use (Gutwinski et al., 2021). Specific groups are more likely to become homeless, including young people exiting state care (Grattan et al., 2021), individuals leaving prison systems (Bashir et al., 2021), and minority groups, including ethnic and sexual minorities (Fraser et al., 2019; Ingram et al., 2023).

While there are multiple, complex and inter-related structural factors that contribute to the development of these enormous health disparities; these issues are further complicated by high usage of emergency and acute services among unhoused groups, higher rates of premature hospital discharge, and limited engagement with preventative and primary care services (O'Carroll & Wainwright, 2019). In Dublin, it was found that unhoused individuals have a 20-fold increase in the use of emergency care than housed individuals, which are notably higher than comparable studies in the United States, Canada and the United Kingdom (Ní Cheallaigh et al., 2017). These patterns have negative consequences for the individual where care is only sought in response to crises, resulting in delayed illness recognition and delayed or no treatment. This often leaves the individual managing the disease burden of often co-occurring illnesses (Warren et al., 2025).

Engagement with healthcare and support services in the context of homelessness is often complex and bidirectional. This reflects what Hart (1971) described as the inverse care law, whereby the availability and quality of healthcare varies significantly in accordance with the level of need, so those with the greatest health burden often have the least access to effective care. Understandably, help-seeking can be particularly challenging for individuals who often have difficulty trusting and feeling safe in relationships due to histories of trauma, discrimination, and interpersonal adversity (Magwood et al., 2019), alongside co-occurring mental health difficulties (Sheerin et al., 2016). Epistemic trust also provides a useful framework for understanding how relational care translates into engagement, shaping whether individuals perceive care as safe, relevant, and worth engaging with, and whether they are open to receiving and acting upon support, particularly where prior experiences have undermined trust in

others (Fonagy et al., 2015). In homeless contexts, reduced access to healthcare is frequently associated with lack of knowledge around services, competing demands, and practical bureaucratic and transportation barriers, all of which can be further compounded by negative healthcare interactions that act as deterrents to future engagement (Canavan et al., 2012; O’Carroll & Wainwright, 2019). Navigating fragmented systems can therefore be experienced as arduous, contributing to difficulties in sustained engagement (Omerov et al., 2020).

Unhoused people are also less likely to recognise when they have a health need that requires professional care (McNeill et al., 2022). However, when care is sought, healthcare interactions are often characterised by stigma and discrimination, where individuals feel unheard and dehumanised through these exchanges, disrespected and treated with minimal understanding or care, frequently met with suspicion and mistrust (Omerov et al., 2020; Reilly et al., 2022). This discrimination can be further exacerbated where individuals occupy multiple marginalized statuses (Thomas & Menih, 2022), such as ethnic minority groups (Ingram et al., 2023; Vázquez et al., 2020).

From a service perspective, these challenges are often viewed as an avoidance of healthcare services, individuals leaving emergency departments prior to being seen (Ní Cheallaigh et al., 2017) and/or non-compliance with medical guidance (O’Carroll & Wainwright, 2019). While unhoused populations have at times been described as ‘difficult to engage’ (Green, 2021), such patterns are more appropriately understood within the context of structural instability, competing survival demands, and past interpersonal trauma (Magwood et al., 2019). Further complexity arises from the disproportionate prevalence of intellectual disabilities (van der Laan et al., 2017), undiagnosed autism spectrum conditions (Boilson et al., 2023), and traumatic brain injury (Song et al., 2018), all of which are likely to remain under-identified within standard service provision. These factors compound both vulnerability to mental health difficulties and the challenges of engaging with systems not designed to accommodate such needs (Brown & McCann, 2020).

This highlights the complexity of engagement for both individuals and services, underscoring the need for approaches that are responsive to the realities of

homelessness. While structural interventions that prioritise housing stability are fundamental to improving quality of life, the psychological needs of unhoused people also require targeted and effective support (Bodley-Scott et al., 2024). First, it is necessary to more closely examine the nature and complexity of mental health difficulties within this population.

Mental Health Needs in Homelessness

This section explores the prevalence and complexity of mental health difficulties within homeless populations, situating these in the context of predisposing vulnerabilities and early life adversity. By examining how these factors interact over time, it aims to clarify the nature of need and the role of clinical psychology in responding effectively.

Alcohol dependence has been found to be one of the most prominent mental health difficulties among unhoused people (Fazel et al., 2014), with rates estimated to be approximately ten times higher than in the general population (Gutwinski et al., 2021). Johnson et al. (1997) proposed a multidirectional relationship, where substance use can both contribute to the onset of homelessness, and develop or worsen because of the stresses and conditions associated with being homeless. Within this context, alcohol use can be understood as a functional response to manage psychological distress and social isolation, while simultaneously reinforcing barriers to exiting homelessness.

Process-based research further suggests that experiential avoidance may play a central role in maintaining substance use, with alcohol functioning as a means of managing difficult internal experiences (Shorey et al., 2017). While this may provide short-term relief, it reinforces patterns of coping that sustain psychological distress over time. High rates of co-occurring mental health and substance use difficulties are well documented in homelessness contexts (Fazel et al., 2014), reflecting the entangled and mutually compounding nature of these challenges.

Rates of depressive symptoms and major depressive disorder exceed 25%, more than five times the global prevalence observed in the general population (Ayano et al., 2021). Psychosis is reported in between 3% and 42% of cases (Fazel et al., 2008), with

schizophrenia spectrum disorders identified in up to 12.4% of unhoused individuals (Gutwinski et al., 2021). Importantly, depression and anxiety have been identified as significant barriers to healthcare access in this population (Rathod et al., 2026), suggesting that psychological distress not only arises within conditions of exclusion, but actively perpetuates it. Processes such as experiential avoidance (Akbari et al., 2022; Cookson et al., 2020); emotion regulation difficulties (Lincoln et al., 2022), and interpersonal difficulties (McEvoy et al., 2013) have been identified as factors that underpin these presentations, contributing both to the development and maintenance of depressive and anxiety symptoms, and also reduced help-seeking and engagement with care.

Diagnoses of personality disorders are particularly prevalent and documented in 64–79% of unhoused individuals, with paranoid and emotionally unstable presentations most commonly diagnosed (Horácio et al., 2023). This disproportionate prevalence is also significant for what it suggests about underlying developmental factors. Childhood trauma is a well-established risk factor associated with a broad range of later mental health difficulties (McLaughlin et al., 2020), and has been related to the development of schizophrenia (Kingdon et al., 2010), paranoid personality disorder (Lee, 2017), and emotionally unstable personality disorder (MacIntosh et al., 2015); presentations that, as outlined above, are disproportionately represented among unhoused populations.

Within homelessness, rates of complex childhood trauma are particularly high (Woodhall-Melnik et al., 2018). Such trauma is characterised by repeated or chronic interpersonal harm within caregiving relationships and disrupts the development of interpersonal and self-regulation skills that are typically shaped through these relationships (Sundin & Baguley, 2015; van der Kolk, 2005). Due to this disruption, it has been associated with challenges in emotion regulation, impulse control, cognition, and interpersonal functioning (Putnam, 2006). As van der Kolk (2005) outlines, individuals who have experienced complex trauma may learn to rely on survival-oriented coping strategies that are frequently misunderstood as “*maladaptive*”, “*oppositional*”, or “*antisocial*”, reflecting a failure to recognise the constrained developmental context that shaped these responses. As a result, complex trauma is often

associated with reduced capacity to tolerate distress, which may manifest in behaviours such as substance use or suicidal ideation as attempts to regulate overwhelming emotional states (Corrigan et al., 2010).

Consistent with this, insecure attachment styles are highly prevalent among unhoused people (Horácio et al., 2023), with evidence suggesting elevated rates of disorganised attachment, an attachment style that is often associated with early abuse and/or neglect (Barreto & Cockersell, 2024). Difficulties in emotion regulation and interpersonal functioning are therefore better understood as the result of disrupted early relational environments (Corrigan et al., 2010; van der Kolk, 2005). In this context, post-traumatic stress disorder is also highly prevalent, estimated at 27.8% (Ayano et al., 2020), and domestic violence poses an additional risk factor precipitating homelessness, (Mayock & Neary, 2025) further underscoring the significance of trauma-related processes in shaping mental health outcomes.

In addition to these extensive trauma histories, once an individual enters homelessness, their risk of sexual and physical victimisation, and exposure to violence increases once again (Davies & Allen, 2017). Homelessness is increasingly recognised as a traumatic event in itself (Hopper et al., 2010; Tsai et al., 2020). Therefore, the ongoing stressors associated with the conditions of homelessness, such as chronic stress, repeated exposure to stigma, social exclusion and threat (Hopper et al., 2010), often interact with pre-existing mental health vulnerabilities, creating cycles that make both recovery and exit from homelessness more difficult (Mayock et al., 2015). As trauma affects an individual's ability to develop trusting relationships (Lawson et al., 2013), the therapeutic relationship and developing safe alliances holds particular importance; whereby safe, consistent relational contact may begin to address what was disrupted developmentally and over the course of life experiences (Su & Stone, 2020).

Taken together, these findings point to a population whose mental health needs are characterised by considerable complexity. The co-occurrence of repeated trauma, disrupted attachment, emotion dysregulation, and experiential avoidance across presentations suggests these are not independent difficulties to be addressed separately, but interconnected processes that often share developmental roots (Hopper et al., 2010).

Formulations that integrate developmental, relational, and contextual factors are therefore essential in this context (Buckley et al., 2021), particularly given that adversity is historical, cumulative and ongoing. This points toward the relevance of process-focused approaches that target mechanisms such as experiential avoidance, emotion dysregulation, and interpersonal difficulties, which maintain many of the clinical presentations noted throughout this section. As such, the following section examines the evidence base for psychological interventions with unhoused populations.

Psychological Interventions in Homelessness

Despite the clear psychological burden and barriers to care outlined above, the evidence base on how best to intervene at a psychological level within homelessness contexts remains unclear. Case management and housing stability interventions are well-established within homelessness contexts, with Housing First, assertive community treatment, and critical time intervention demonstrating positive effects on housing stability (de Vet et al., 2013; Woodhall-Melnik et al., 2015; Saldanha et al., 2024). These approaches prioritise access to housing and coordinate support across healthcare and social services, including employment and ongoing recovery-oriented contact. However, while effective in improving housing outcomes, they do not adequately address the psychological sequelae associated with homelessness (Saldanha et al., 2024).

In terms of psychological intervention, the evidence base has grown considerably in recent years, though it remains uneven. Earlier meta-analyses found limited and inconsistent evidence for cognitive behavioural therapy (CBT), family therapy, and motivational interviewing in homeless contexts (Noh, 2018). More recent reviews have produced a more encouraging picture. Bodley-Scott et al. (2024) performed a meta-analysis of randomised controlled trials, and found CBT to demonstrate benefits across substance use, mental health and behavioural outcomes, with motivational interviewing showing relatively consistent effects in relation to substance use and mental health.

Complementing this, a recent qualitative synthesis of psychosocial interventions, which included both structural (e.g., housing-focused) and psychological approaches (notably CBT and DBT), found that unhoused individuals experienced these

interventions as meaningful and relevant, particularly in supporting the development of coping strategies and the fostering of positive relationships (Rabiah-Mohammed et al., 2025). Preliminary evidence also suggests that trauma-focused CBT can reduce PTSD-related symptoms for unhoused populations (Spiegel et al., 2022), though Bennett et al. (2022) identified variable findings across trauma-focused and non-trauma-specific therapies for PTSD and complex PTSD in homeless contexts, calling for the need for more well-designed trials with mixed-methods approaches to capture experiential data. Mindfulness-based approaches have also shown promise, though their evaluation has largely occurred within multi-component interventions, making it difficult to isolate their specific contribution (Bodley-Scott et al., 2024).

The divergence in intervention findings across this literature likely reflects the expansion and maturation of the evidence base over time, with more recent studies incorporating a wider range of intervention approaches, and more comprehensive outcome measures, alongside increased attention to service-user perspectives (Rabiah-Mohammed et al., 2025; Spiegel et al., 2022). A key limitation, however, is the predominant reliance on RCT methodology in recent systematic reviews (Bodley-Scott et al., 2024; Hyun et al., 2020). While RCTs are the gold-standard and offer strong rigour, this offers limited insight into how interventions are experienced, adapted, and sustained within the complex and often unstable realities of homeless service provision (De Bruin et al., 2015).

A further limitation concerns the operationalisation of trauma-informed care, which is a perspective that seeks to integrate awareness and understanding of trauma into service delivery, and is widely recommended within guidelines (Edgar et al., 2025; Hopper et al., 2010), though its application in practice remains unclear (Bennett et al., 2022). Moreover, CBT has received criticism regarding whether cognitive-specific techniques offer meaningful benefit beyond behavioural components, and the extent to which cognitive changes reliably translate into emotional change (Gaudiano, 2008; Jacobson et al., 1996). Empirical findings within homelessness contexts are also mixed, with meta-analytic evidence indicating no significant effects of CBT on depression or anxiety (Hyun et al., 2020). Indeed, for some individuals whose histories are

characterised by relational trauma, disrupted caregiving and repeated experiences of invalidation – circumstances that are disproportionately represented within unhoused contexts – standard CBT risks being experienced as ineffective or invalidating (Linehan, 1993).

Against this backdrop, there are strong theoretical reasons to consider third-wave psychological interventions for unhoused people. Hayes' (2004) seminal work outlined the developmental trajectory of these 'waves', whereby the first wave focused on applying behavioural principles through interventions, such as Exposure Therapy; while the second wave represented a move towards Cognitive Behavioural Therapy (CBT) which argued that errors in cognitive appraisal and distorted thinking were the source of emotional suffering (Beck, 1979). According to Hayes (2004), third-wave therapies place less emphasis on the content of the client's thoughts and instead focusing on changing the individual's relationship to their internal experiences. This is typically achieved through practices such as acceptance, mindfulness, cognitive defusion, emotion regulation, values-based living and relationships, with experiential learning as a cornerstone of these approaches (Hayes & Hofmann, 2021). The overarching goal is typically to develop flexible and effective ways of responding to life difficulties.

As described, unhoused people have disproportionate experiences of trauma (Woodhall-Melnik et al., 2018) which is associated with long-term difficulties in emotion regulation, impulsivity, and relational functioning (Putnam, 2006). Experiences of homelessness further compound these challenges through ongoing threat exposure, hypervigilance, and repeated stigmatising encounters (Hopper et al., 2010). Third-wave approaches, including Dialectical Behavioural Therapy, Compassion-Focused Therapy, Acceptance and Commitment Therapy, and, in some classifications, Behavioural Activation (Dimidjian et al., 2016; Kahl et al., 2012), explicitly target these processes by focusing on increasing awareness, developing emotion regulation, strengthening distress tolerance, cultivating self-compassion, and improving psychological flexibility overall (Hayes, 2004). Meta-analyses have demonstrated strong evidence to support third-wave interventions for depression (Schefft et al., 2023) and a wide range of mental health conditions (Dimidjian et al., 2016), and as such, these approaches may be particularly

well suited to addressing both the underlying vulnerabilities (e.g., trauma) and the ongoing psychological processes (e.g., experiential avoidance, dysregulation, interpersonal difficulties) that contribute to distress in homelessness.

The experiential and skills-based nature of third-wave approaches may be particularly advantageous in homelessness contexts, where cognitive load, high rates of learning needs, traumatic brain injury, and lower literacy levels may limit the accessibility of more didactic interventions (Oakes & Davies, 2008; Stubbs et al., 2020). Emerging research within homelessness services suggests that such approaches are both feasible and acceptable when adapted to context and have been recommended within homeless services (Keats et al., 2012). For example, adaptations of Dialectical Behavioural Therapy have shown promise in reducing recidivism among female parolees (Nyamathi et al., 2018), although engagement remains a challenge, with longer durations of homelessness often associated with reduced uptake (Lynk et al., 2015).

Evidence from other clinical contexts also suggests that third-wave approaches may be effective in populations experiencing chronic health conditions and socioeconomic disadvantage. A pilot randomised controlled trial of Acceptance and Commitment Therapy for adults with drug-refractory epilepsy living in poverty in South Africa (N = 27) demonstrated significant improvements in seizure frequency, duration, and quality of life compared to supportive therapy, maintained at 6- and 12-month follow-up (Lundgren et al., 2006). The authors highlighted the potential utility of ACT as a low-cost, non-invasive intervention that may be adaptable across cultural and linguistic contexts due to its experiential nature. However, the small sample size and highly specific setting limit the generalisability of these findings. More broadly, ACT has demonstrated effectiveness across a range of mental health difficulties and chronic physical health conditions (A-Tjak et al., 2015), suggesting potential relevance for populations, such as unhoused people, who experience a high burden of co-occurring conditions.

Mindfulness-based approaches have also been explored across adult and youth populations, though findings remain inconsistent, often due to their inclusion within multi-component interventions (Bodley-Scott et al., 2024). Findings to date are

promising, with some evidence of improvements in psychological domains, emotional wellbeing, and coping; however, the evidence base remains limited. Many studies are small-scale, feasibility or pilot trials, with considerable heterogeneity in intervention design, duration, and outcome measurement. There are several studies that outline the processes involved in adapting such interventions to suit the unique needs within this context, demonstrating the need for bespoke and responsive interventions (Garfin et al., 2024; Santa Maria et al., 2023). In turn, while third-wave interventions are theoretically well aligned with the needs of unhoused populations, their overall effectiveness remains unclear.

Several key tensions are evident within the existing intervention literature pertaining to homeless contexts. First, there is a tension between the demands of psychological interventions and the realities of homelessness. For example, third-wave approaches often require sustained engagement, reflection, and practice of skills, though these conditions can be difficult to achieve when navigating unstable housing, competing survival priorities, and limited access to consistent support. Maslow's (1943) hierarchy of needs offers a useful framework for considering the effectiveness of psychological intervention under these conditions. The model positions physiological and safety needs as foundational, suggesting that they are likely to shape attention and behaviour when they remain unmet. Where individuals are focused on securing food, shelter and physical safety, their capacity to engage consistently in interventions requiring reflection, emotional processing and sustained skills practice may therefore be constrained. This challenge is reflected in qualitative work with unhoused women, where mindfulness was viewed positively as a coping strategy for trauma, though participants identified significant barriers to engagement, including distractibility, environmental noise, and difficulties trusting others in group settings (Garfin et al., 2024). This suggests that while such interventions may be acceptable in principle, their feasibility is constrained in practice and highlights the need to consider both structural conditions and lived experiential factors when implementing psychological interventions.

However, this does not inherently mean that psychological intervention has no value until housing and other basic needs have been secure. Although Maslow's (1943) original hierarchy proposed that lower-order needs must be sufficiently met before higher-order needs can be pursued, such as belonging, self-esteem and self-actualisation, homelessness research suggests that needs across different levels may be experienced and pursued concurrently, even where basic needs remain unmet (Henwood et al., 2015; Matulič-Domadžič et al., 2020). As such, psychological interventions may continue to support coping, emotional regulation, connection, and the management of immediate distress, particularly where they are flexible and responsive to context. This highlights the dual role of psychologists within homelessness services, both in providing psychological intervention and in advocating for access to housing, social supports and the material conditions necessary for such interventions to be feasible and effective.

Second, there are important considerations regarding the balance between individual and structural understandings of distress. Western psychology has been criticised for its individualistic orientation, where emphasis is placed on the individual, with limited attention to the systemic contexts that contribute to individual distress (Ingle, 2018). While third-wave psychological interventions may support coping to reduce suffering, there is a risk of over-emphasising individual-level change in contexts where distress is strongly shaped by structural factors such as poverty, housing instability, and social exclusion (Fazel et al., 2014). This underscores the need for approaches that acknowledge broader social and relational contexts (Johnstone & Boyle, 2018) and raises questions about how best to integrate psychological interventions within trauma-informed and socially responsive models of care.

Third, there is substantial variability in how interventions are adapted for this group. While flexibility is necessary, it introduces challenges in determining what mechanisms facilitate change within the intervention, and whether adapted approaches maintain fidelity to their underlying theoretical models. Bodley-Scott et al. (2024) found that a large proportion of RCTs lacked reporting on fidelity measures and outcomes, constraining understanding of how well interventions are delivered even under controlled conditions. This limitation is likely to be further complicated in routine

practice, where interventions are implemented within resource-constrained services and are adapted to meet contextual demands. This highlights the importance of examining how third-wave interventions are implemented in real-world contexts and the extent to which fidelity is maintained outside of trial settings, and the subsequent impact on effectiveness and efficacy in real-world contexts.

Finally, outcome measurement across studies is often inconsistent. Many studies prioritise symptom-based outcomes, with less attention to domains such as social connectedness, empowerment, or quality of life, which may be particularly meaningful in the context of homelessness, and is reflected in qualitative accounts of intervention engagement (Rabiah-Mohammed et al., 2025).

Overall, the existing literature on mental health needs and psychological interventions in homelessness contexts highlights several critical gaps. While there is growing evidence for psychological interventions, findings remain heterogeneous, with limited evidence regarding the effectiveness of specific approaches, particularly third-wave interventions, in real-world settings. The common focus on RCTs (Bodley-Scott et al., 2024; Hyun et al., 2020) risks losing valuable insight into how interventions are experienced, engaged with and sustained within the structural and relational complexities of homelessness. As a result, there remains a lack of integrated understanding of both outcomes and processes of change. Addressing these gaps requires a synthesis of both quantitative and qualitative evidence to examine not only whether third-wave interventions are effective for unhoused people, but how they are implemented, experienced, and adapted in practice.

Physical Health Needs in the Context of Homelessness

Alongside the psychological complexities outlined above, unhoused people also face a disproportionately high burden of complex physical health conditions (Fazel et al., 2014). These conditions often co-occur with mental health difficulties and are shaped by the same structural and contextual constraints, including poverty, instability, and barriers to healthcare access. As such, understanding health within homelessness requires a biopsychosocial perspective that attends to how individuals experience and manage

intersecting physical and psychological difficulties in the context of everyday life (Biggerstaff & Thompson, 2008).

Unhoused people have significantly poorer physical health than the general population, driven in part by the conditions of homelessness, including challenges gaining adequate nutrition, increased exposure to infection, harsh living environments, higher rates of victimisation and accidental injuries (Fazel et al., 2014). These reflect another layer of unmet needs in unhoused contexts, with recent evidence indicating that the majority of individuals attending an inclusion health service have complex medical histories and substantial unmet rehabilitation needs (Carroll et al., 2021). They are also at greater risk of neurological conditions such as traumatic brain injury (TBI) and epilepsy (Rosendale et al., 2019), with estimates of 53.1% lifetime prevalence of TBI among unhoused people (Stubbs et al., 2020).

A growing body of qualitative research has sought to explore the experience of managing chronic health conditions in the context of homelessness. These have included acquired brain injury (Jubinville et al., 2026; Warren et al., 2025), heart failure (Pendyal et al., 2021), diabetes (Campbell et al., 2021; Manser et al., 2024), cardiovascular disease (Bark et al., 2023) and broader samples of individuals managing multiple chronic conditions (Bowen et al., 2024; Merdsoy et al., 2020). Across these studies, several shared patterns can be observed. A pervasive sense of uncertainty appears to underpin experiences of illness management, with unstable living conditions disrupting routines necessary for medication adherence and symptom management (Manser et al., 2024; Pendyal et al., 2021).

Individuals frequently described being forced to prioritise immediate survival needs, such as securing food or shelter, over healthcare engagement, often in the backdrop of previously stigmatising healthcare interactions (Pendyal et al., 2021). Similarly, lack of secure storage, limited privacy, and reduced autonomy constrain individuals' ability to safely manage medication and maintain consistent self-care practices (Manser et al., 2024). For individuals managing a range of chronic conditions, often alongside co-occurring physical and mental health needs, negative emotional experiences were identified as one of the most difficult aspects of illness management,

which were said to be frequently exacerbated by the challenges of homelessness (Merdsoy et al., 2020).

Relational and systemic factors further compound these challenges. Fragmented service provision and gaps in coordination across healthcare and housing systems place additional strain on individuals managing complex needs (Jubinville et al., 2026; Warren et al., 2025). Services have been critiqued for adopting ‘one-size-fits-all’ approaches that fail to accommodate cognitive or health-related impairments, thereby creating barriers to both housing and healthcare (Warren et al., 2025). Despite these limitations, the presence of at least one consistent and supportive relationship within services has been identified as a critical protective factor, facilitating engagement and promoting a sense of stability (Jubinville et al., 2026). Non-medical relationships, such as family members and peers, have also been highlighted as important contributors to illness management (Manser et al., 2024).

In sum, this literature suggests that managing chronic health conditions in the context of homelessness requires ongoing negotiation between competing demands within environments that are often unpredictable, resource-limited, and, at times, stigmatising. These structural and relational constraints may be particularly consequential for conditions such as epilepsy, where effective management often relies on routine, safety, and timely response to seizures. In this context, the risk of unwitnessed seizures, injury, and inconsistent access to care may further compound both physical and psychological burden (Pontes & Marques, 2023).

Epilepsy and Homelessness

Epilepsy is a chronic neurological condition characterised by recurrent and often unpredictable seizures, which can carry significant physical, psychological, and social consequences (Fisher et al., 2014). Epilepsy in the general population is associated with higher rates of depression, anxiety, internalised stigma and reduced locus of control and quality of life (Baker et al., 2000; Quintas et al., 2012). Undiagnosed or poorly controlled seizures are associated with cumulative neurological risk, including physical injury, brain damage, and increased risk of premature mortality (Obregon et al., 2022). Unhoused individuals, who already endure a great burden of social stigma, are estimated

to be up to eight times more likely to be diagnosed with epilepsy than housed people, suggesting a heightened and overlapping burden within this group (Doran et al., 2021; Gabriel et al., 2020; Pontes & Marques, 2023). The unpredictable nature of seizures, alongside the need for consistent medication management, access to safe environments and the associated negative psychological and social outcomes related to the disease burden (Kazl & LaJoie, 2020), suggests that epilepsy may present particular challenges when experienced in the context of homelessness (Pontes & Marques, 2023).

At present, the existing literature on homelessness and epilepsy has largely focused on epidemiological and clinical outcomes, including prevalence, hospitalisation patterns, mortality, and treatment adherence (Laporte et al., 2006; Lewer et al., 2019; Rosendale et al., 2019; Pontes & Marques, 2023). There is a high rate of seizure-related deaths in unhoused groups, underscoring the serious potential consequences of this condition (Doran et al., 2021). A bidirectional relationship between homelessness and epilepsy has been suggested (Pontes & Marques, 2023), whereby seizure-related physical impacts and social exclusion compound the challenges of navigating homelessness, while the competing survival demands of homelessness both exacerbate epilepsy burden and impede effective management of the condition (Laporte et al., 2006). This can also be understood through a syndemic lens. A syndemic refers to the co-occurrence and interaction of two or more health conditions within a population, where these conditions are exacerbated by and rooted in social inequalities such as adverse social, structural, and environmental contexts. Rather than operating independently, the conditions interact synergistically to worsen overall health outcomes and exacerbate inequities (Singer et al., 2017).

Despite these seemingly intersecting and mutually intensifying factors, there is a relative lack of research exploring the lived experience of epilepsy in the context of homelessness. Emerging evidence suggests that epilepsy may be experienced as particularly frightening and disempowering under these unhoused conditions, as a case report describes an individual's experiences of unwitnessed seizures with injuries such as facial abrasions, without access to immediate assistance or support (Obregon et al., 2022).

In an effort to respond to some of the structural barriers that hinder unhoused people's services use, Inclusion Health services have been designed to directly target the structural determinants of health inequalities by delivering flexible, accessible and integrated care, to directly meet the needs of marginalised and socially excluded individuals, including unhoused people (Luchenski et al., 2018). For example, a specialist epilepsy Inclusion Health pathway has been developed in St James's Hospital, Dublin, which has strengthened coordinated care between hospital and community teams (Doran et al., 2021). A recent mixed-methods study in this inclusion health service offered important preliminary contributions to understanding the experience of epilepsy among unhoused individuals, by combining quantitative measures with brief open-ended responses relating to quality of life (Lucey et al., 2026). Results indicated significantly elevated depression, anxiety and epilepsy-related stigma among unhoused participants compared to housed counterparts. While open-ended responses pointed to experiences of social restriction and constrained life opportunities, the qualitative data was limited in depth. Lucey et al. (2026) proposed a potential feedback loop, whereby stigma and perceived loss of opportunities may exacerbate psychological distress, which in turn, worsens quality of life; but emphasised the need for more in-depth qualitative approaches to further explore how these intersecting experiences are understood and navigated in everyday life.

Altogether, the review of the present research points to a critical gap in the literature. While there is growing recognition of the challenges associated with managing chronic illness in the context of homelessness, and a substantial body of research on epilepsy in housed populations (Kerr, 2012; Mula & Kaufman, 2020; Weatherburn et al., 2017), there is a lack of research exploring how epilepsy is experienced and managed within the specific context of homelessness. Addressing this gap is essential to inform both clinical practice and service development, and provides a clear rationale for the present study, which seeks to explore the lived experience of individuals navigating epilepsy and homelessness.

Rationale for Thesis

Taken together, the literature reveals several key gaps in the current evidence base. Despite well-documented psychological need among unhoused populations, there is limited clarity regarding which psychological interventions are effective, how they are adapted to the structural constraints of homelessness, and the mechanisms through which they facilitate change. In parallel, research has paid comparatively little attention to how individuals experience and navigate the intersection of chronic illness and homelessness, particularly in the context of epilepsy. Addressing these gaps requires both a critical synthesis of intervention evidence and an in-depth, idiographic exploration of lived experience.

There are strong theoretical and practice-based grounds for the use of third-wave psychological interventions within homelessness contexts. Approaches such as ACT, DBT, MBCT and Schema Therapy are explicitly recommended within good practice guidelines for psychologically informed homelessness services (Keats et al., 2012), reflecting their emphasis on emotion regulation, acceptance, and relational processes in the context of chronic adversity. However, despite this alignment and growing use in practice, the evidence base remains fragmented and lacks a comprehensive synthesis specific to unhoused populations. A systematic review of third-wave interventions is therefore warranted to clarify their nature, evaluate their effectiveness, and examine how they are experienced by those accessing them. Such a synthesis may inform future research and support the development of more responsive and contextually grounded psychological interventions within homelessness services.

It was therefore decided that a mixed-methods systematic review would be most appropriate to address this aim, as such approaches are well positioned to examine both whether and how interventions work (Stern et al., 2020). As with all psychological therapies, the therapeutic alliance between clinician and client is a known contributor to intervention efficacy (Fife et al., 2013). When considered alongside the high prevalence of trauma among unhoused populations (Miller et al., 2018), it is likely that relational factors, including safety and trust, play a particularly important role in shaping intervention outcomes. By including both quantitative and qualitative evidence, this review aims to provide insight into intervention effectiveness, alongside the

practicalities of engagement and delivery that may not be captured through quantitative measures alone, including experiences of engagement, considerations of fidelity, adaptability and flexibility.

The second study of this thesis adopts a qualitative design to explore the lived experience of individuals navigating homelessness with a diagnosis of epilepsy. Given the complexity and underexplored nature of these experiences, interpretative phenomenological analysis (IPA) was selected as the most suitable approach (Smith et al., 2022). IPA is interested in how individuals make sense of their personal and social worlds, with an emphasis on in-depth, case-by-case analysis before considering patterns across participants (Smith et al., 2022). This approach recognises that human experience is context-dependent and shaped by multiple intersecting factors, including personal history, social context, and life circumstances. IPA has been widely applied within health psychology to explore lived experiences of illness, including acquired brain injury (Martin et al., 2014), epilepsy in older age (Yennadiou & Wolverson, 2017) and has also been used to explore under-represented and marginalised groups (Larkin et al., 2006).

However, several other approaches may offer alternative frameworks of analysis to understand experiences of epilepsy and homelessness. Grounded Theory seeks to develop explanatory models derived from participant data (Noble & Mitchell, 2016; Tie et al., 2019), while Thematic Analysis focuses on identifying patterns across participants (Braun & Clarke, 2006). In contrast, IPA prioritises the individual, subjective experience and the ways in which these experiences both converge and diverge. Given the focus on complex, deeply personal experiences such as illness, stigma, and identity in the context of epilepsy and homelessness, IPA, situated within a critical realist, contextualist framework, is considered the most fitting methodology to capture how these conditions intersect and are understood in lived experience.

In seeking to address this gap, conducting research in the context of homelessness raises important ethical considerations (Green, 2021; Hodgetts et al., 2022), particularly in relation to power asymmetries and experiences of stigma and marginalisation within services (O'Carroll & Wainwright, 2019). As such, fostering trust, respect, and psychological safety is emphasised, alongside the need for clear and

transparent communication (Lewis et al., 2023). Informed consent is conceptualised as an ongoing process, requiring accessible information and ensuring participation is fully voluntary and independent of service provision (Hodgetts et al., 2022). Trauma-informed approaches are recommended, with attention to participant autonomy and the potential for distress, alongside clear procedures for responding to this where it arises (Edelman, 2022). Collectively, these considerations highlight the importance of research approaches that are both ethically responsive and sensitive to the contextual realities of homelessness.

Together, these studies offer complementary but distinct contributions to understanding psychological need within homelessness contexts. The systematic review critically evaluates the existing evidence base for psychological interventions, while the qualitative study provides an in-depth, idiographic account of lived experience. By addressing both the current state of intervention research and the complexity of everyday experience, the thesis aims to inform more contextually grounded and responsive clinical and service approaches.

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Chapter Two

Systematic Review

Journal

Submitted and under review with Clinical Psychology & Psychotherapy Journal.

Guidelines available (Appendix A)

Title

The effectiveness of third wave interventions with unhoused people: A mixed-methods
systematic review

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The effectiveness of third wave interventions with unhoused people: A mixed-methods systematic review

Abstract

Background: Unhoused people experience high levels of mental and physical health needs, yet evidence for the effectiveness of psychological therapies in this context remains limited, particularly regarding lived experience. Third-wave approaches (e.g., ACT, DBT, mindfulness-based interventions, CFT) emphasise awareness, acceptance and emotion regulation, may be suited to contexts of ongoing instability and have been recommended within psychologically informed homeless services.

Methods: Four databases (PsycINFO, PubMed, Scopus, CINAHL) were searched to March 2026, alongside grey literature. Eligible studies evaluated third-wave interventions with unhoused populations and reported quantitative outcomes related to psychological functioning and/or qualitative accounts of participant experience. Quantitative and qualitative findings were synthesised separately and integrated using a convergent segregated approach.

Results: Eighteen studies (19 reports) were included: randomised controlled trials ($n = 5$), quasi-experimental ($n = 7$), mixed-methods ($n = 4$), and qualitative studies ($n = 3$). Mindfulness-based interventions were most frequently evaluated. Quantitative findings were mixed, with some improvements in psychological and behavioural outcomes, alongside selective or non-significant effects. In contrast, qualitative findings consistently described meaningful changes in awareness, emotion regulation, relational functioning, and perceived capability. Methodological quality varied, with common limitations including small samples, heterogeneous designs, and inconsistent reporting. Fidelity monitoring was limited, though acceptability was positive.

Conclusion: Third-wave interventions show promise in homelessness contexts; however, standard outcome metrics and behavioural indicators of engagement (e.g., attendance) may underestimate meaningful change in homelessness contexts. Future research should prioritise mixed-methods designs incorporating experiential and

relational outcomes, and develop approaches to fidelity that balance flexibility and intervention integrity.

Key Practitioner Message

- Third-wave interventions are feasible and acceptable in homelessness services when flexibly delivered
- Psychological change may occur at a process level (e.g., emotion regulation, awareness, confidence), even where symptom reduction is limited
- Attendance and retention are poor sole indicators of engagement; services should include relational and experiential measurements
- Relational safety, consistency, and trauma-informed delivery are central to effective intervention
- Fidelity should focus on maintaining core therapeutic processes while allowing flexibility in delivery to accommodate instability

Keywords (5 – 6 keywords)

Homelessness; unhoused people; third-wave therapies; mixed-methods systematic review; psychological interventions; social inclusion

Introduction

Homelessness is a complex social issue shaped by individual, social, structural and systemic factors (Ingram et al., 2023), encompassing a diverse range of living situations. The term ‘unhoused people’ is used throughout to reflect its growing use in the literature (Ahuja et al., 2020; Garfin et al., 2024) and to foreground structural drivers of homelessness, and is defined in line with the European Typology of Homelessness and Housing Exclusion (ETHOS), which captures multiple forms of housing exclusion characterised by the absence of stable, secure and adequate housing (FEANTSA, 2017).

Within the context of homelessness, people are disproportionately affected by physical and mental health difficulties, largely driven by enduring social inequalities and chronic adversity (Barry et al., 2024; Gutwinski et al., 2021). Unhoused adults are significantly more likely to report higher rates of adverse childhood experiences (Liu et al., 2021) and complex trauma (Woodhall-Melnik et al., 2018) compared to the general population, increasing vulnerability to mental health difficulties across the lifespan. These early adversities are often compounded by the experience of homelessness itself, which is characterised by chronic exposure to threat, instability, and repeated experiences of stigma, discrimination and social exclusion, further intensifying psychological distress (Marinucci et al., 2023; Narendorf et al., 2021).

Research suggests that 67% of unhoused people live with a mental health condition, with highest prevalence reported in North America at 77% (Barry et al., 2024). In Ireland, 36.9% of individuals residing in homeless accommodation reported experiencing a mental health difficulty (DePaul, 2025), while unhoused people are eleven times more likely to require a psychiatric admission than the general population (Ingram et al., 2023), indicating a disproportionate rate of more severe and crisis-level presentations. These patterns are further reflected in elevated rates of self-harm presentations (Ingram et al., 2023), substance use (Carroll et al., 2021; McNeill et al., 2022) and high rates of co-occurring difficulties (Fazel et al., 2014). In addition, unhoused people are more likely to have undiagnosed neurodivergence, learning difficulties (Brown & McCann, 2020), lower literacy levels, and traumatic brain injuries

(Oakes & Davies, 2008; Stubbs et al., 2020); all of which can create additional barriers in navigating services and daily demands.

Engagement with healthcare and support services in the context of homelessness is often complicated. Help-seeking can be particularly challenging for individuals who experience difficulties with trust and relational safety; often shaped by histories of trauma, discrimination, and interpersonal adversity (Magwood et al., 2019), alongside co-occurring mental health difficulties (Sheerin et al., 2016). Past experiences of prejudicial treatment within healthcare settings can create further mistrust of providers and deter engagement with support (Ferrari, 2014; Moynihan et al., 2024; Richard, 2023). This evidence highlights not only the scale of psychological need, but also the complexity and intensity of difficulties experienced, raising important questions about how best to provide effective and responsive psychological support within homelessness (Hopper et al., 2010).

Interventions targeting structural determinants of homelessness, such as Assertive Community Treatment, Housing First, and other housing and case management programmes, are well-established and consistently improve housing stability and aspects of quality of life by prioritising access to permanent housing and coordinated support (Aubry et al., 2015; Munthe-Kaas et al., 2018; Roy et al., 2024). Despite these gains, evidence from a large systematic review indicates that while such interventions substantially improve housing outcomes, their effects on mental health are inconsistent or limited (Moledina et al., 2021). This suggests that structural and housing-focused approaches alone are insufficient to address the psychological distress associated with homelessness.

Current recommendations from the National Institute for Health and Care Excellence (NICE) for unhoused people focus on integrated health and social care provision, service access, and multidisciplinary working (NICE, 2022). While psychological therapies are recognised as a component of wraparound multidisciplinary care, available evidence on the effectiveness of specific psychological interventions is scarce (Luchenski et al., 2018). There have been recent efforts to synthesize the evidence base. Hyun et al. (2020) found psychosocial interventions improved anxiety

and overall mental health across 14 randomised controlled trials (RCTs), but found no evidence of benefit for depression, PTSD, self-efficacy or quality of life. In contrast, Bodley-Scott et al. (2024), drawing on 30 RCTs, reported improvements in anxiety, depression and PTSD, and identified cognitive behavioural therapy (CBT) and motivational interviewing as providing the most consistent benefits.

Both reviews relied on RCTs, excluding a broader body of evidence derived from more ecologically informative designs; a limitation highlighted by Bodley-Scott et al. (2024), who highlighted the need for a broader evidence synthesis. In addition, mindfulness-based approaches were often delivered as part of multi-component interventions, limiting evaluation of their specific effects. The present review seeks to address these gaps by examining third-wave interventions, such as mindfulness, as a distinct therapeutic category and incorporating a broader range of study designs.

Third-wave psychological interventions may offer a strong clinical fit for unhoused people. Approaches such as Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), and Mindfulness-Based Cognitive Therapy (MBCT) emphasise acceptance, present-moment awareness, regulation-focused and compassion-orientated strategies that may be particularly useful for individuals, such as unhoused people, who face persistent adversity (Hayes & Hofmann, 2021). Several of these approaches have been recommended within good practice guidelines for psychologically informed homeless services, recognising the need for frameworks that are sensitive to trauma, relationships, and emotion regulation (Keats et al., 2012). Broader evidence indicates that third-wave interventions are effective across a wide range of mental and physical health conditions (A-Tjak et al., 2015), including psychosis (Louise et al., 2018) and alcohol dependency (Byrne et al., 2019), can reduce self-stigma and shame across a multitude of presentations (Stynes et al., 2022), and has demonstrated effectiveness in providing support to those experiencing poverty (Thompson, 2015), ethno-racial and culturally diverse groups (Hytman et al., 2025), and refugees and asylum seekers (Aizik-Reebs et al., 2021; Oren-Schwartz et al., 2022).

To our knowledge, no systematic review has focused exclusively on the effectiveness of third-wave interventions for unhoused people. This review, therefore,

examines the effectiveness and acceptability of third-wave psychological interventions for unhoused people, drawing on evidence from a range of methodological designs. A mixed-methods systematic review was considered most appropriate, as this approach is well suited to examine both whether and how interventions work (Stern et al., 2020). Beyond clinical outcomes, this design also enables consideration of the contextual and relational factors that shape implementation, fidelity, engagement, and delivery; dimensions that hold particular relevance given the high prevalence of trauma, and the importance of relational safety and trust in therapeutic work.

The overarching review question is: *What is the effectiveness and acceptability of third-wave psychological interventions for unhoused people, and what factors influence their delivery and engagement?*

Methods

Defining Third-Wave Psychological Interventions

Third-wave therapies are a group of approaches that developed from the cognitive-behavioural tradition. These therapies focus less on the content of thoughts and place greater emphasis on a person's relationship to their thoughts, emotions and bodily sensations (Hayes, 2004). They integrate behavioural strategies and differ in the core cognitive skills which build on processes such as mindfulness, acceptance, values-based action, metacognitive awareness, and emotion regulation, supporting the development of pragmatic skills and positive coping strategies that can be applied to everyday situations to reduce suffering and respond more effectively to daily stressors (Hayes, 2004).

Third-wave psychological interventions were operationally defined using established classifications from prior systematic reviews (Linardon et al., 2017; Makris & Dorstyn, 2022; Perkins et al., 2023). The following approaches were eligible to be included as third-wave therapies: Acceptance and Commitment Therapy (ACT); Dialectical Behaviour Therapy (DBT); Compassion Focused Therapy (CFT); Functional Analytic Psychotherapy (FAP); Mindfulness-Based Stress Reduction (MBSR); Mindfulness-Based Cognitive Therapy (MBCT); Behavioural Activation; Schema

Therapy; Metacognitive Therapy; Integrative Behaviour Couple Therapy (IBCT) and Cognitive Behaviour Analysis System of Psychotherapy (CBASP).

Search Strategy

The review followed PRISMA reporting guidance and was pre-registered with PROSPERO (Appendix C; registration number CRD42025603217). Four electronic databases were searched (PsycINFO, PubMed, Scopus and CINAHL) on 25 January 2025 to retrieve studies, with automated alerts monitored until the last search.

Forward and backward citation searching was then conducted, identifying a further three studies that met inclusion criteria and were subsequently incorporated into the review (McCay et al., 2015; Murthy et al., 2020; Vickery et al., 2024). The search strategy was rerun on 10 March 2026 to identify studies published since the original search, resulting in the inclusion of one additional study (Santa Maria et al., 2025).

All databases were searched (Appendix B) (for Concept 1 – ‘unhoused people’ in combination with Concept 2 – ‘third wave psychological interventions’. A comprehensive set of free-text keywords and database-specific thesaurus terms for Concept 1 (homeless*, people experiencing homelessness, roofless, rough sleeping, ill-housed persons) were included. Concept 2 included the pre-identified models of third wave psychological interventions (Acceptance and Commitment Therapy, Mindful*, Mindfulness-Based Cognitive Therapy, Mindfulness Based Stress Reduction, Compassion Focused Therapy, Behavioural Activation, Meta-Cognitive Therapy, Dialectical Behaviour Therapy, Schema Therapy, Functional Analytic Therapy, Integrative Behaviour Couple Therapy or Cognitive Behaviour Analysis System of Psychotherapy). Acronyms were also included.

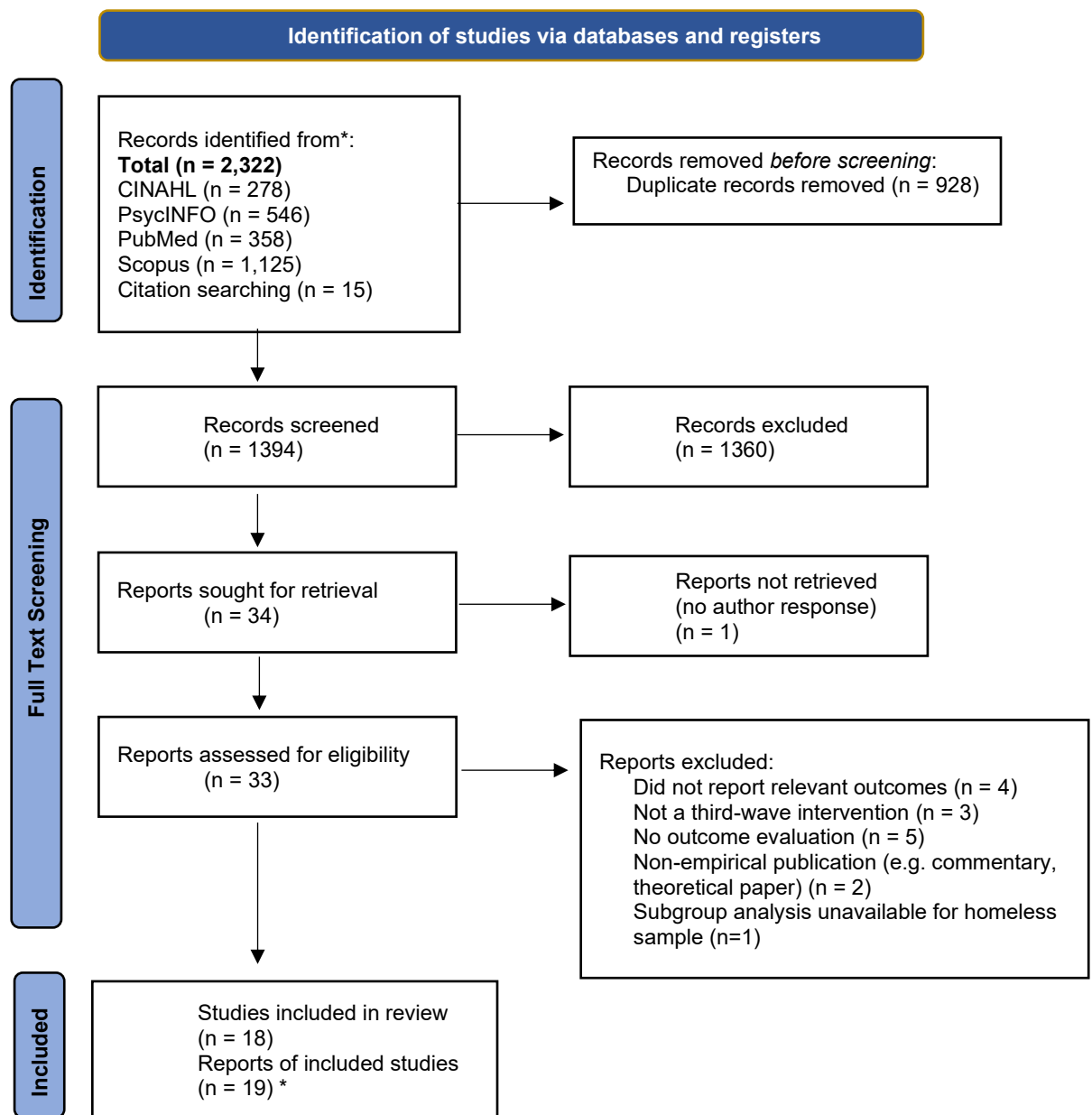
Study Eligibility Criteria

A modified SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was applied to determine study eligibility.

- Sample – Studies were eligible if they included unhoused people. Where unhoused participants formed part of a broader sample, inclusion required that

the study reported subgroup analyses to allow outcomes for the unhoused group to be extracted.

- Phenomenon of Interest – The intervention had to be aligned with a pre-defined third-wave psychological approach. This included adapted and manualised interventions.
- Design – Qualitative, quasi-experimental, randomized controlled trials, case series, and mixed-methods designs were eligible.
- Evaluation – The study had to report outcomes directly related to the intervention and relevant to the mental health or psychological well-being of unhoused people. This included formal pre- and post-intervention measures and/or qualitative interviews.
- Research Type – Empirical studies were included, defined as research based on direct observation or experimentation, or using qualitative methods. Grey literature including unpublished dissertations, reports, working papers and conference proceedings were also eligible for inclusion if they met all other eligibility criteria.

Figure 1*Prisma Flow Diagram*

*Note. Nineteen reports were included in the review, representing 18 unique studies.

One study was reported across two publications: the MYPATH intervention (Barr et al., 2021; Petering et al., 2021).

During full-text screening, studies that included behavioural outcomes such as substance use and violence that were clearly situated within psychological intervention frameworks were observed. This led to a refinement of the operational definition of mental health and psychological well-being to encompass these outcomes, recognising them not as peripheral behaviours but as clinically meaningful expressions of psychological functioning and distress, consistent with both the empirical literature and real-world service contexts. This decision was made prior to data extraction, documented transparently, and applied consistently. It ultimately enhanced the conceptual clarity and relevance of our included studies. This decision led to the inclusion of three studies (Barr et al., 2021; Nyamathi et al., 2017; Petering et al., 2021).

Study Selection

Retrieved studies were saved to Zotero (Zotero, 2025) and uploaded into Rayyan software (Ouzzani et al., 2016) to remove duplicates and perform data screening and extraction. Two independent reviewers (RC and KB) screened 100% of the title and abstract of each study. Disagreements were discussed and where agreement could not be reached, input from third reviewer (FOK) was sought.

The primary reviewer (RC) screened 100% of the full texts and the second reviewer (KB) independently screened 30% of studies for full-text review. Inter-reviewer agreement was 91% at the screening stage. Any disagreements that arose were resolved through discussion, and where a consensus could not be reached, input from third reviewer and academic supervisor (FOK) was sought. Following full text screening, eighteen studies (reported across 19 publications) were included for data extraction.

Assessment of Methodological Quality

All included studies were assessed using a structured quality appraisal tool to determine methodological rigour and potential sources of bias. The appraisal was conducted using the Joanna Briggs Institute Critical Appraisal Tools for Randomized Controlled Trials (Barker et al., 2024), Quasi Experimental (Barker et al., 2023) and Qualitative studies (Lockwood et al., 2015) which evaluate domains such as study

design, clarity of aims, appropriateness of methods, reporting of outcomes and consideration of confounding factors (Appendix D).

Several items in the JBI Critical Appraisal Checklists relate to the blinding of participants and intervention facilitators. Previous research has noted that pragmatic psychosocial and behavioural trials cannot feasibly blind participants or facilitators as both parties are aware of the intervention being delivered and therefore should not be penalised for blinding (De Bruin, 2015; van Nimwegen et al., 2023). For the present review, these items utilised the option “Not Applicable”. Marking these items as “No” would misrepresent this structural necessity as a methodological weakness and incur a lower quality rating. Coding them as “Not Applicable” avoided penalising studies for a feature that is unavoidable across these types of intervention.

Furthermore, as JBI does not provide a checklist specifically for single-case experimental designs, the quasi-experimental checklist was applied with minor adaptations. Items relating to the presence of a separate control group and equivalence of treatment between comparison groups were marked as not applicable, as participants in the randomized multiple-baseline design served as their own controls across baseline and intervention phases.

The primary reviewer (RC) performed quality assessment using the JBI Critical Appraisal Tools on 100% of the included studies, and the second reviewer (KB) assessed 78.9% of the included studies.

Data Extraction

An Excel sheet was created to support data extraction, which was trialled and piloted with three studies and appraised by reviewer (FOK). Data extracted from quantitative studies and the quantitative component of mixed methods studies included specific details about the populations, interventions and any adaptations for same, study methods and significant outcomes. For qualitative studies and the qualitative component of mixed methods studies, data extracted included specific details about the population, intervention, study methods and main themes or findings. Data extraction was

completed in-full by one reviewer (RC) and the second reviewer (KB) independently cross-checked the extraction dataset against each included study.

Data Synthesis

A convergent segregated approach to synthesis and integration was adopted (Stern et al., 2020). In line with this design, quantitative and qualitative evidence were analysed separately using methods appropriate to each strand before being brought together in the overall interpretation. Given the methodological diversity and small number of eligible studies within each design, a narrative synthesis was undertaken for both quantitative and qualitative findings. Interpretation of the qualitative findings were guided by established principles of qualitative rigour, including sensitivity to context, coherence, and the use of clinical and community experience to ground interpretations (Yardley, 2000).

Thematic Analysis

A reflexive thematic analysis (TA) was undertaken following Braun and Clarke (2022) to synthesise qualitative findings from three qualitative studies and qualitative components embedded within mixed-methods and intervention studies. This approach, grounded in an interpretivist–constructivist epistemology, views meaning as contextually-dependent and co-constructed through researcher interpretation.

Each study's reported participant quotations and author direct interpretations were treated as qualitative data, which was extracted from each study and formed the basis of analysis. The analysis followed Braun and Clarke's six phases. The process began with (1) repeated reading for familiarisation and note-taking to capture early impressions. (2) Initial codes were generated inductively, informed by both the data and existing theoretical understandings relevant to third-wave interventions, using NVivo (v14) to support data management and organisation. (3) Coded segments were then organised into provisional themes. Inter-rater reliability of theme development is not recommended for a reflexive thematic analysis (Braun & Clarke, 2022). (4) This theme development and refinement process was supported through supervision. (5) Themes

were reviewed, refined, and re-mapped through iterative discussion, subsequently informing (6) the completion of the current study.

Reflexivity

Reflexivity was essential throughout this process. Researcher subjectivity was viewed as a resource that shaped the analysis (Braun & Clarke, 2022). The analysis was conducted by a trainee clinical psychologist working from a position of relative privilege, educational and institutional power, concurrently training in Dialectical Behaviour Therapy and conducting qualitative research on experiences of homelessness and epilepsy for a Doctoral thesis. This dual perspective heightened awareness of how professional training and clinical experience can shape sensitivity to relational, emotional, and contextual processes in the data.

The second reviewer (KB) is a doctoral researcher specialising in homelessness. The academic supervisor is a senior lecturer and clinical psychologist, contributing expertise in clinical complexity of marginalized populations and methodological rigour. Co-author (SL) is a senior lecturer and has previously worked in community services. Reflexive journaling, note-taking which documented interpretive decisions, and discussion in research supervision supported transparency regarding the influence of these positionalities.

Table 1.
Characteristics of Included Studies

Author (Year)	Country	Design	Participants / Demographics	Setting	Intervention (Type, Duration, Facilitator)	Control Group	Phenomenon of Interest / Outcomes	Key Significant Findings	Key Themes
Barr et al. (2021); Petering et al. (2021)	USA	Quasi-experimental	n = 92 Aged 18–26 yrs Mixed gender	Drop-in community service	'MYPATH' peer-led mindfulness + yoga 1 x 4 h training workshop 7 x 1h weekly group follow-up sessions	No control group	Mindfulness, Violence Perpetration, Impulsivity	Mindfulness increased, violence decreased; Effects maintained at 1 month follow-up. No statistically sig change in impulsivity. Effect size not reported.	N/A
Maddock et al. (2017)	Ireland	Mixed methods	n = 7 men Aged 21–52 yrs All male	Short term emergency homeless accommodation	8-wk MBSR group 2 h sessions Social worker facilitator	No control group	Depression, anxiety, emotional reactivity; Impulsivity; Experience of mindfulness	Statistically sig decreases across depression; anxiety; emotional reactivity; impulsivity	Enhanced coping skills; Enhanced mindful traits; Enhanced well-being
Nyamathi et al. (2017)	USA	RCT	Intervention n= 65	All unhoused prior to	DBT-Case Management (DBT-CM)	Health Promotion	Drug / alcohol abstinence	6-mo follow-up: Drug abstinence	N/A

			Control n=65	prison release, residing in community services	12 wks; 6 group + 6 individual sessions led by nurses / community health workers	program (HPP)		favoured DBT-CM vs HP (OR = 2.60, p = .04).	
			Aged 19–64 yrs						
			All female					Alcohol abstinence favoured DBT-CM vs HP (OR = 3.12, p = .02).	
								Combined drug/alcohol abstinence not statistically significant (OR = 2.39, p = .07).	
McCay et al. (2015)	Canada	Mixed- Methods	Intervention n = 60 Waitlist n = 29	Unhoused youth previously living on street or shelter programs for 1 month minimum	DBT 12wk intervention incl. individual, group sessions	Wait list	Major mental illness; depression; hopelessness; suicidal ideation; alcohol use; self-esteem; social connectedness; resilience; global functioning	Statistically significant differences for the intervention group on all variables except for suicidality and substance use. Maintained at 4 and 10	Engagement driven by mental health need and recommendati ons from a trusted staff member. DBT experienced as validating and youth-centred, with reported benefits for
			Age range 16 – 24		Led by youth workers and social workers who completed DBT training				
			Mixed gender						

								weeks follow up.	self-concept, emotion regulation, relationships, and resilience. N/A
Held et al. (2015)	USA	Pilot RCT	n = 27 Mean 51 yrs All male	Transitiona l housing for unhoused male veterans	4-wk self- compassion focused therapy workbook Self- administered	Stress inoculatio n (SI) control group	Level of self- compassion Trauma-related guilt PTSD	Trauma- related guilt decreased significantly in both arms (SC d=1.56; SI d=1.58), with a significant interaction (F(2,44)=4.86, p=.012) reflecting higher baseline in SC. Self- compassion increased in both (d=1.03), no interaction. PTSD showed no overall change	

Clark et al. (2024)	USA	Quasi-experimental	n = 62 Age 18–78 yrs All male	Shelter residents	Health Advocacy Behavioral Activation (HABA), a one-time 90-minute group intervention.	No control	Self-efficacy for self-care General self-efficacy	Self-efficacy for self-care statistical sig increase ($p < .001$, $r^2 = .23$) General self-efficacy unchanged	N/A
Vickery et al. (2023)	USA	Mixed methods	n = 10 Mean age 57 yrs	Various community services Varied housing stability	Behavioural activation model “D-HOMES” 10 coaching 1:1 sessions via phone or in person Facilitated by social worker, physiologist, primary care physician with clinical psych consultation	No control group	Psychological Wellness; Mental Health; experience of coaching	No statistically sig change in mental health. or psychological wellness (all $p > .05$).	Stability shaped experience; less stably housed reported confusion and mixed benefit; more stable valued goal setting, tailored tools, and integrated wellness.
Vickery et al. (2024)	USA	Pilot RCT	Intervention n = 18 Usual Care n = 18 Mixed gender	Various community services Varied housing stability	Behavioural activation model as outlined in Vickery et al. (2023) Offered 1:1 and telephone	Enhanced usual care	Psychological Wellness	No statistically sig change in psychological wellness	

			Mean age – 52 years		meetings for approx 30 min weekly for up to 10 sessions from month 0-3 and up to 3 monthly 10-15 min booster calls from months 4-6				
Chavez et al. (2020)	USA	Pilot RCT	n = 29 Age 18–24 yrs Mixed gender	Drop-in centre for unhoused youth	Single-session virtual reality mindfulness exercise vs audio meditation exercise vs VR with neutral imagery	Audio mindfulness group; VR neutral imagery group	Anxiety, Physiologic stress via cortisol	No statistically sig differences for anxiety or cortisol	N/A
Viafora et al. (2014)	USA	Quasi-experimental	Unhoused cohort n=15 Housed cohort n=28 Control n=20 Aged 11–13 yrs Mixed gender	School based	8-wk classroom-based mindfulness program. 45 min sessions	Waitlisted students for intervention	Mindfulness, Psychological Inflexibility, Self-compassion, Psychological Acceptance; Participant Evaluation Questionnaire	Statistically sig change only observed in housed cohort; no statistically significant change observed for unhoused cohort	Unhoused youth reported more positive mental states, better anger management, and greater enjoyment of mindfulness than housed peers; both groups felt calmer and used practices beyond class.

Bender et al. (2015)	USA	RCT Mixed Methods	Intervention n=37 Control n=37 Mean = 19 years Mixed gender	Shelter for unhoused youth	'SAFE' 3-day mindfulness-based intervention (4 h/day) Delivered by clinical psychologist and intern with masters in social work	Shelter-based services as usual	Adapted mindfulness subscales; engagement experience	No statistically sig change for total mindfulness scores. Only statistically significant increase in observing subscale in intervention youth compared to control ($p = .05$, $\eta^2 = .05$)	Interactive teaching, personal sharing, peer activation enhanced engagement; challenges incl unmet basic needs, trauma history, and mistrust of providers.
Grabbe et al. (2012)	USA	Quasi experimental	n = 39 youth Aged 17–23 yrs Mixed gender	Community services for unhoused youth	'YESSS' spiritual self-schema mindfulness-based program 2 sessions weekly for 4 wks Program-specific trained facilitators with peer leadership input	No control	Psychological Distress; Depression and Anxiety; Mental Well-Being; Resilience; Spirituality; Impulsiveness; perceived benefits	Statistically sig decrease in distress ($d = 0.446$), depression ($d = 0.470$), anxiety (0.431) Significant increase in resilience ($d = 0.417$) /and	Valued calm, focus, and anger control; challenges incl time and distractions; reported greater self-understanding and reduced cravings.

								wellbeing (d = 0.379)	
								No sig change impulsiveness	
Santa Maria et al. (2019)	USA	Mixed methods	n = 39 Aged 18–21 yrs Mixed gender	Shelter for unhoused youth	.b mindfulness-based curriculum; Five 90-min sessions over 2.5 weeks Facilitators completed .b intervention training	No control group	Acceptability Pre and post session “affect” measured using adapted Likert scale	Statistically sig decrease in frustration, restlessness, stress, depression, boredom, mindlessness No statistically sig change in peace, aware of emotions, impulsivity, inability to focus, or lack of presentness.	Described how the content helped with their emotions; valued group cohesion; helpful structure; media use; suggested improvements re: app and hands-on tools.
Santa Maria et al. (2025)	USA	Quantitative	Intervention n = 45 Control n = 45 Aged 18 – 25 Mixed gender	Shelter for unhoused youth	.b mindfulness-based curriculum, as above Facilitators completed .b training, an 8-week MBSR	Health education program as control	Acceptability Feasibility Emotional and psychological well-being measures were	74% enrolment of eligible participants; 84% adherence; minimal missing data. Acceptable	N/A

					course and maintained personal mindfulness practices		tested for reliability	CEQ credibility; positive exit feedback	
Murthy et al. (2020)	Ireland	Quantitative (Advanced Online Publication)	n = 9 Age range 20- 26	Homeless shelters	Acceptance and Commitment Therapy-based single session individual intervention	No control group	Two single- item measures of shame and experiential avoidance	Significant improvements in experiential avoidance (9/9 participants) and shame (8/9). Meta- analysis indicated large intervention effects.	
		Single-case experimental design	Mixed gender						
Cervante s, (2023)	USA	Qualitative (Thesis)	n = 4 Age 27-53 All male	Permanent Supportive Housing for formerly homeless individual	Acceptance and Commitment Therapy Group 5 weekly sessions	N/A	Experience of engagement	N/A	Flexibility and trust; contextual sensitivity; mixed reactions; mindfulness valued; growing self- awareness.

Alhusen et al. (2017)	USA	Qualitative	n = 17 Aged 24-44 All mothers	Therapeutic Nursery serving homeless children	‘SHINE’ Mindfulness-based psychoeducation Hourly sessions across 10 wk; mothers could attend as many as desired	N/A	Experience of engagement	N/A	Greater self-care (“me” time); improved self-regulation and patience; stronger parent–child connection; perceived child benefits.
Little, (2013)	USA	Qualitative (Thesis)	n = 5 Aged 23-61 All mothers	Mothers in a transitional housing program	Mindfulness-based parenting content was integrated into the existing parenting curriculum 8 weekly sessions	N/A	Experience of engagement	NA	Strengthened mother–child bond; greater awareness of behaviour’s impact; mindful self-regulation and co-regulation.

Note. DBT = Dialectical Behaviour Therapy; MBSR = Mindfulness-based stress reduction

Results

Study Sample and Design Characteristics

Study characteristics are summarised in Table 1. Eighteen studies represented by nineteen publications were included in the synthesis. Sixteen were conducted in the United States, one in Canada and two in Ireland.

Psychological intervention modalities included mindfulness-based approaches ($n = 11$), behaviour activation ($n = 3$), compassion-focused therapy ($n = 1$), acceptance and commitment therapy ($n = 2$), and dialectical behaviour therapy ($n = 2$).

In terms of design, studies comprised randomised controlled trials ($n = 5$), quasi-experimental studies ($n = 7$), qualitative designs ($n = 3$) and mixed-methods non-randomised studies ($n = 4$). One of the randomised controlled trials also included an embedded mixed-methods component.

Across the experimental studies, seven included a control condition. Control comparators included a stress inoculation group for a self-compassion intervention (Held & Owens, 2015), shelter-based services as usual including case management services (Bender et al., 2015), an imagery-based attentional control for virtual reality meditation (Chavez et al., 2020), enhanced usual care with a diabetes education session for a behavioural activation intervention (Vickery et al., 2024), a waitlist control (McCay et al., 2015) and two studies used health education or health promotion programs as control conditions (Nyamathi et al., 2017; Santa Maria et al., 2025). The remaining eight studies utilised uncontrolled designs (Barr et al., 2021; Clark et al., 2024; Grabbe et al., 2012; Maddock et al., 2017; Petering et al., 2021; Santa Maria et al., 2019; Viafora et al., 2014; Vickery et al., 2023).

Population

Participant demographics varied, though several patterns emerged. Sample sizes across studies were generally small to moderate, ranging from 4 - 92, reflecting the nature of recruitment and retention within transient and marginalised populations.

One study focused on early adolescents aged 11–13 years (Viafora et al., 2014), while nine studies included young people aged 16–26 years (Barr et al., 2021; Bender et al., 2015; Chavez et al., 2020; Grabbe et al., 2012; McCay et al., 2015; Murthy et al., 2020; Petering et al., 2021; Santa Maria et al., 2025; Santa Maria et al., 2019). Ten studies focused on unhoused adults aged 18–78 years.

Gender composition differed substantially. Six studies included only men (Cervantes, 2023; Chavez et al., 2020; Clark et al., 2024; Held & Owens, 2015; Maddock et al., 2017; Vickery et al., 2023), while three studies included only women (Alhusen et al., 2017; Little, 2013; Nyamathi et al., 2017), two of which focused on motherhood. Interventions with young people ($n = 5$) often included mixed gender and, in some cases, explicitly included transgender and non-binary participants (Barr et al., 2021; Bender et al., 2015; McCay et al., 2015; Santa Maria et al., 2025; Santa Maria et al., 2019).

Sexual orientation was reported in five studies, where heterosexuality was the most reported orientation (Bender et al., 2015; McCay et al., 2015; Murthy et al., 2020; Santa Maria et al., 2025; Santa Maria et al., 2019). Race and ethnicity were reported in fourteen studies (Alhusen et al., 2017; Barr et al., 2021; Bender et al., 2015; Cervantes, 2023; Chavez et al., 2020; Clark et al., 2024; Grabbe et al., 2012; Held & Owens, 2015; Little, 2013; Nyamathi et al., 2017; Petering et al., 2021; Santa Maria et al., 2025; Santa Maria et al., 2019; Viafora et al., 2014; Vickery et al., 2023). Race was not reported in three studies (Maddock et al., 2017; McCay et al., 2015; Murthy et al., 2020). A number of US-based studies included predominantly Black or African American participants (Alhusen et al., 2017; Chavez et al., 2020; Grabbe et al., 2012; Santa Maria et al., 2019, 2025), reflecting the disproportionate representation of these groups within homelessness contexts. One study included a predominantly Hispanic sample (Viafora et al., 2014). Other studies reported predominantly White samples (Bender et al., 2015; Cervantes, 2023; Clark et al., 2024; Held & Owens, 2015), while several included more ethnically diverse samples including Black, White, Latino/Hispanic, and mixed or other racial identities (Barr et al., 2021; Little, 2013; Nyamathi et al., 2017; Petering et al., 2021; Viafora et al., 2014; Vickery et al., 2023, 2024).

Time Spent in Homelessness

Length of homelessness was not specified as an inclusion criterion in any study, and reporting of duration varied considerably. Three studies provided overall ranges of homelessness within their samples, spanning from ≤ 6 months to > 5 years (Barr et al., 2021), between 9-84 months (Murthy et al., 2020), and 1-36 months (Little, 2013). Several studies reported mean duration of shelter stay, with averages of 3.22 years (McCay et al., 2015), 52 days (Santa Maria et al., 2019), 13.7 months (Bender et al., 2015), 7 months (Held & Owens, 2015), and 32 days (Grabbe et al., 2012).

One qualitative study reported individual-level durations, with three participants experiencing homelessness for 1–3 months and one for two years (Cervantes, 2023), and another defined housing status based on recent unsheltered homelessness, where participants had been unsheltered in the previous two weeks (Petering et al., 2021). Another described varied lengths of homelessness within the sample, noting that most participants had stayed in homeless shelters for most of the 30 days prior to enrolment (Vickery et al., 2024).

Eight studies did not report duration of homelessness (Alhusen et al., 2017; Chavez et al., 2020; Clark et al., 2024; Maddock et al., 2017; Nyamathi et al., 2017; Santa Maria et al., 2025; Viafora et al., 2014; Vickery et al., 2023).

Settings

Studies recruited from a variety of settings. Most recruited from shelters or transitional housing facilities (Alhusen et al., 2017; Bender et al., 2015; Clark et al., 2024; Held & Owens, 2015; Little, 2013; Maddock et al., 2017; Murthy et al., 2020; Santa Maria et al., 2025, 2019) though some studies recruited from residential treatment centres (Nyamathi et al., 2017), classroom settings (Viafora et al., 2014), drop-in centres (Barr et al., 2021; Petering et al., 2021; Chavez et al., 2020), long-term supportive housing (Cervantes, 2023), or utilised multiple recruitment pathways integrating a combination of the above (Grabbe et al., 2012; McCay et al., 2015; Nyamathi et al., 2017; Vickery et al., 2024; Vickery et al., 2023).

Intervention Delivery

Group delivery was the most common form of intervention delivery. Nine studies utilised a group format facilitated on-site at various community-based settings, including shelters, transitional housing programs and therapeutic nurseries (Alhusen et al., 2017; Bender et al., 2015; Cervantes, 2023; Clark et al., 2024; Grabbe et al., 2012; Little, 2013; Maddock et al., 2017; Santa Maria et al., 2025; Santa Maria et al., 2019).

Both DBT studies provided group delivery in conjunction with individual sessions, as consistent with the model (Nyamathi et al., 2017; McCay et al., 2015). One study provided a single-session intervention to each participant individually in a one-to-one format (Murthy et al., 2020).

Two linked studies were delivered using a novel peer-led social network model, where peer leaders informally shared mindfulness and yoga practices with peers, with training sessions conducted outside of normal service hours (Barr et al., 2021; Petering et al., 2021). In this adapted mindfulness-based intervention, focus was placed on developing mindful awareness to observe urges, control attention, and regulate emotions, reflecting core third-wave processes.

Other methods of intervention delivery included: participant self-administered workbooks (Held & Owens, 2015), in-person and phone coaching sessions (Vickery et al., 2024; Vickery et al., 2023), classroom-based for unhoused youth (Viafora et al., 2014), and virtual reality headsets (Chavez et al., 2020).

Intervention Duration

Intervention length varied considerably across studies. Session duration ranged from single-session interventions lasting approximately 10 minutes (Chavez et al., 2020) to longer group sessions lasting several hours (Bender et al., 2015), while programme duration ranged from single-session formats (Chavez et al., 2020; Murthy et al., 2020; Clark et al., 2024) to multi-week programmes lasting eight weeks (Little, 2013; Maddock et al., 2017; Viafora et al., 2014) or twelve weeks for condensed DBT programmes (Nyamathi et al., 2017; McCay et al., 2015).

One offered drop-in sessions with no fixed attendance requirement across a 10-week period (Alhusen et al., 2017), while others allowed participants to engage in

sessions as needed up to a maximum number available (Barr et al., 2021; Petering et al., 2021; Vickery et al., 2024; Vickery et al., 2023).

Intervention Adaptations

Only one study adhered closely to a standardised protocol, implementing a conventional eight-week Mindfulness-Based Stress Reduction (MBSR) course with weekly two-hour sessions (Maddock et al., 2017). All other interventions reported some form of adaptation in format, duration, or delivery to accommodate the needs of the target population.

The high prevalence of trauma histories and the effects on emotion regulation, cognition, and behaviour among unhoused people were often cited (Alhusen et al., 2017; Grabbe et al., 2012; Petering et al., 2021; Santa Maria et al., 2019, 2025; Viafora et al., 2014; Vickery et al., 2023), highlighting the need to adopt a trauma-informed approach to intervention delivery (Barr et al., 2021). In practice, this was reflected in deliberate adaptations to both intervention content and delivery. One study targeted trauma-related guilt explicitly (Held & Owens, 2015). Other approaches included modifying curricula to minimise stress-inducing activities and tailoring scenarios, imagery, and body-scan exercises in line with trauma-informed principles (Santa Maria et al., 2019). Other adaptations involved integrating somatic strategies (e.g. yoga) with mindfulness-based practices to support self-regulation, with attention to the potential activation of internal trauma cues during mindfulness exercises, alongside psychoeducation on trauma, limbic system functioning, and links to aggressive or violent behaviour (Barr et al., 2021). One study further extended this approach by providing trauma-informed care training for staff and coaches delivering the intervention (Vickery et al., 2023).

Interventions were routinely adapted to align with the contextual realities of homelessness settings. For the adolescent DBT programme, which usually involves family members, this element was removed in recognition that it would not be appropriate or feasible for many of the young people (McCay et al., 2015). In another, an existing parenting programme was adapted and incorporated mindfulness training, rather than being offered as a standalone intervention (Little, 2013). Other more structural adaptations included using plain and accessible language (Cervantes, 2023;

Santa Maria et al., 2019), with some studies allowing recruitment on a rolling basis to maximise engagement (Bender et al., 2015; Grabbe et al., 2012).

Intervention Facilitation

Several interventions required facilitators to complete intervention-specific training prior to delivery (Grabbe et al., 2012; Nyamathi et al., 2017; McCay et al., 2015; Santa Maria et al., 2025; Vickery et al., 2024; Vickery et al., 2023; Santa Maria et al., 2019). Professional backgrounds of facilitators were diverse, including qualified and/or trainee clinical psychologists (Bender et al., 2015; Murthy et al., 2020; Vickery et al., 2024; Vickery et al., 2023), a doctoral student in counselling psychology (Cervantes, 2023), a parent educator (Little, 2013), social workers (Bender et al., 2015; Maddock et al., 2017; McCay et al., 2015; Viafora et al., 2014; Vickery et al., 2023), youth workers (McCay et al., 2015), community health workers and nurses (Nyamathi et al., 2017), and primary care physicians and physiologist (Vickery et al., 2023).

Facilitation approaches varied across studies. Two linked interventions employed a train-the-trainer model in which peer leaders received intensive author-led training in yoga and mindfulness, then went on to co-facilitate follow-up workshops alongside facilitators, supporting delivery to unhoused youth (Barr et al., 2021; Petering et al., 2021). Peer involvement in facilitation was also incorporated in another study, where residents contributed to intervention delivery (Grabbe et al., 2012).

In contrast, some interventions were self-administered and required no facilitator beyond basic instructions (Chavez et al., 2020; Held & Owens, 2015). In two cases, facilitator backgrounds were not clearly specified: one noted only that delivery was led by facilitators already embedded in an existing project and trusted by residents (Clark et al., 2024), while another did not provide details on the clinicians involved (Alhusen et al., 2017).

Fidelity

Fidelity monitoring was explicitly reported in six studies, evaluated through the review of recorded sessions, and the completion of self-rating and supervisor rating checklists (Nyamathi et al., 2017; Murthy et al., 2020; McCay et al., 2015; Vickery et

al., 2023, 2024), with one other noting post-session debriefing between facilitators to ensure the intervention was delivered with fidelity (Santa Maria et al., 2019).

Participant Retention

Attrition patterns varied considerably across studies and appeared to relate partly to intervention duration and intensity. The highest retention was generally observed in single-session interventions. For example, a single-session ACT intervention enrolled 12 participants at baseline, with three withdrawing prior to the intervention; however, all nine participants who began the session completed it (Murthy et al., 2020). Similarly, other once-off interventions reported high completion among participants who initiated the intervention (Chavez et al., 2020; Clark et al., 2024). Short-term programmes delivered over brief periods also demonstrated relatively strong retention, with a three-day intervention reported 95% retention (Bender et al., 2015).

Several studies offered participants the opportunity to engage in multiple sessions with flexible attendance requirements. For example, a behavioural activation intervention offering up to ten sessions delivered either in person or via telephone reported 100% retention at three months and 94% at six months following booster calls (Vickery et al., 2024). A related pilot of the same intervention reported full retention; however, the sample size was small ($n = 10$) and initial uptake was low (Vickery et al., 2023). Other interventions offering optional weekly group sessions demonstrated more moderate retention, with approximately 63–64% of participants retained (Barr et al., 2021; Petering et al., 2021). In contrast, uptake was more limited in some studies, with only 44% of participants attending more than half of the available sessions (Santa Maria et al., 2019).

Longer or more intensive interventions requiring sustained weekly engagement demonstrated more variable rates of attrition. Four-week programmes reported attrition of up to 45.1% (Grabbe et al., 2012) and 43% (Held & Owens, 2015), while an eight-week intervention reported attrition of 42% (Maddock et al., 2017). In contrast, two 12-week DBT interventions demonstrated relatively lower attrition, with rates of 10.8% (Nyamathi et al., 2017) and 36% (McCay et al., 2015).

Outcomes

The primary domains of interest varied substantially across studies, as outlined in Table 1. These domains included psychological problems and global functioning (McCay et al., 2015) psychological wellness (Vickery et al., 2024; Vickery et al., 2023), psychological distress (Grabbe et al., 2012), measures of anxiety (Chavez et al., 2020; Grabbe et al., 2012; Maddock et al., 2017; Santa Maria et al., 2025), depression (Maddock et al., 2017; McCay et al., 2015; Santa Maria et al., 2025), hopelessness (McCay et al., 2015), perceived stress (Santa Maria et al., 2025) and PTSD (Held & Owens, 2015).

Process-based outcomes including self-compassion (Held & Owens, 2015; Viafora et al., 2014), psychological acceptance and flexibility (Viafora et al., 2014), mindfulness (Barr et al., 2021; Bender et al., 2015; Petering et al., 2021; Viafora et al., 2014), impulsivity (Grabbe et al., 2012; Maddock et al., 2017; Petering et al., 2021) emotional reactivity (Maddock et al., 2017), Likert scale measures of affect (Santa Maria et al., 2019). One study developed a single-item measures of shame and experiential avoidance (Murthy et al., 2020).

Psychosocial measures such as self-efficacy (Clark et al., 2024), spirituality (Grabbe et al., 2012), resilience (Grabbe et al., 2012; McCay et al., 2015) and social connectedness (McCay et al., 2015) were also included. Two studies used behavioural indicators such as substance use (Nyamathi et al., 2017) and violence perpetration (Barr et al., 2021; Petering et al., 2021).

The most frequently assessed constructs were mindfulness ($n = 4$), (Barr et al., 2021; Bender et al., 2015; Petering et al., 2021; Viafora et al., 2014) and anxiety ($n=4$) (Chavez et al., 2020; Grabbe et al., 2012; Maddock et al., 2017; Santa Maria et al., 2025) with other outcomes including impulsivity ($n=3$) (Grabbe et al., 2012; Maddock et al., 2017; Petering et al., 2021), and self-compassion ($n = 2$) (Held & Owens, 2015; Viafora et al., 2014).

Feasibility and Acceptability

Five studies examined feasibility and/or acceptability. These were typically assessed through recruitment, retention, and engagement metrics, as well as participant satisfaction measures or post-intervention feedback. Overall, interventions were generally feasible to deliver and well received by participants, with studies reporting high engagement and positive participant evaluations (Clark et al., 2024; Grabbe et al., 2012; Santa Maria et al., 2025; Vickery et al., 2024; Viafora et al., 2014).

Quantitative Synthesis

Quantitative outcomes demonstrated a mixed pattern of effectiveness. Eight reports (representing seven distinct studies) reported statistically significant improvements in at least one primary outcome. Reported improvements included increased mindfulness and reductions in violence (Barr et al., 2021; Petering et al., 2021), decreases in shame and experiential avoidance (Murthy et al., 2020), reductions in depression and anxiety (Grabbe et al., 2012; Maddock et al., 2017; McCay et al., 2015), improved emotional regulation and reduced impulsivity (Maddock et al., 2017), increased self-compassion and reduced trauma-related guilt (Held & Owens, 2015), greater resilience (Grabbe et al., 2012; McCay et al., 2015), improved self-esteem and social connectedness (McCay et al., 2015), and reductions in drug and alcohol use (Nyamathi et al., 2017). However, improvements were not consistent across approaches. Seven studies reported either selective or no statistically significant effects, indicating heterogeneity across the evidence base.

Mindfulness-based studies ($n = 9$) dominated the evidence-base (Barr et al., 2021; Bender et al., 2015; Chavez et al., 2020; Grabbe et al., 2012; Maddock et al., 2017; Petering et al., 2021; Santa Maria et al., 2019, 2025; Viafora et al., 2014). One study focused primarily on feasibility and acceptability and therefore did not contribute to the quantitative effectiveness synthesis (Santa Maria et al., 2025). While several mindfulness-based studies ($n = 4$) reported improvements in psychological distress, emotional regulation, or mindfulness awareness, aggression and violent behaviours, others demonstrated only isolated subscale effects (Bender et al., 2015; Santa Maria et al., 2019) or no statistically significant changes (Chavez et al., 2020). One study comparing unhoused students with a housed cohort found that a classroom mindfulness-

based intervention produced statistically significant improvements only among the housed participants, with no significant change observed in the unhoused group (Viafora et al., 2014).

Similar variability was observed across other third-wave frameworks. In a RCT of unhoused male veterans, both a self-administered, self-compassion workbook intervention and a stress inoculation control were associated with equal increases in self-compassion and reductions in trauma-related guilt over time (Held & Owens, 2015). PTSD symptoms did not change overall in either condition, as neither intervention directly targeted trauma; and overall, the self-compassion training was not found to be superior to the stress-inoculation control.

Both studies evaluating DBT programmes reported improvements in key outcomes. Nyamathi et al. (2017) found significant effects for drug and alcohol abstinence, while McCay et al. (2015) reported improvements across several psychological outcomes including depression, hopelessness, self-esteem, social connectedness, and resilience. However, no significant effects were observed for suicidality or substance use in the latter study. In both studies, improvements were maintained at follow-up.

In contrast, behavioural activation interventions produced mixed findings. A brief intervention improved self-efficacy for self-care (Clark et al., 2024), while two related behavioural activation studies reported no significant changes in broader psychological wellness outcomes (Vickery et al., 2024; Vickery et al., 2023).

Study design also appeared to influence findings. Quasi-experimental and pre-post evaluations (Barr et al., 2021; Grabbe et al., 2012; Maddock et al., 2017; McCay et al., 2015; Murthy et al., 2020) more frequently reported significant pre-post improvements, whereas brief RCT interventions produced limited effects. Brief mindfulness-based RCTs, including evaluations of the SAFE intervention (Bender et al., 2015), a single-session virtual reality mindfulness intervention (Chavez et al., 2020), and a behaviour activation intervention (Vickery et al., 2024) demonstrated limited or subscale-specific gains. In contrast, the DBT case-management trial (Nyamathi et al.,

2017) and the self-compassion workbook RCT (Held & Owens, 2015) reported improvements across several affective outcomes.

Qualitative Synthesis

A thematic synthesis was conducted to bring together participants' experience of engaging in these interventions. The resulting synthesis provides an interpretive, latent construction of meaning across studies, offering one theoretically grounded account of how third-wave interventions are experienced within homelessness contexts. We developed four main themes to describe participants' experiences of third-wave psychological interventions. These themes capture participants' accounts of therapeutic engagement and change, highlighting how internal, relational, and contextual processes interact to shape acceptability and participation.

Table 2

Overview of Themes

Theme	Sub-Theme	Illustrative Quote
Cultivating Inner Steadiness Amid Instability	Decluttering the Mind	““When I started practicing mindfulness, it took a while, but me head started to clear, you know, so I was able to de-clutter an awful lot of useless thoughts that were thriving in my mind at the time” (Maddock et al., 2017)
	Responding Rather Than Reacting	“Instead of reacting right away when [child] does something wrong, I take a minute to myself.” (Alhusen et al., 2017) “It just really shows that you can actually calm yourself down, you can actually make relationships, you can actually respect

yourself and self-sooth yourself” (McCay et al., 2015)

“When I am angry I breath and I calm down before I do something crazy.” (Viafora et al., 2014)

Growing Through Connection	Laying Foundations of Relational Safety	“Both Facilitator and participants described the importance of a therapeutic relationship in promoting participation and vulnerability” (Cervantes, 2023) “78% of the time youth actively engaged with the material, their engagement prompted their peers to engage” (Bender et al., 2015) “I got to kind of sit around with other people that were in the same boat as me just so I could relate and feel a little more human” (McCay et al., 2015)
	From Reactivity to Connection	“Significant change in her interactions with others, and remarked that it substantially decreased the number of altercations that she had with others.” (Alhusen et al., 2017) “I have more friends now and I get along with them pretty well. So I mean I can't really say there's any denying that my relationships with people have improved” (McCay et al., 2015)

Meeting People Where They Are At	Designing Delivery for Instability and Diversity	“And they broke it down really good. They really like...Sometimes people go through the material too fast, I guess. So it’s really broken down into like little tiny chunks that you could understand.” (Cervantes, 2023)
	Engagement Is Hard When Life Feels Unsafe	“There’s no way I can stick to any of the plans I’ve been given by a doctor. . . because my life is chaotic.” (Vickery et al., 2023) “Daily stressors related to their homelessness and lack of basic needs that made it difficult for them to focus their attention on internal, interpersonal, or environmental risk cues.” (Bender et al., 2015)
“My head is lifted higher”: Regaining a Sense of Confidence and Capability	Overall culminating theme	“My head is lifted higher.” (Grabbe et al., 2012) “It helped me face some challenges I had.” (Santa Maria et al., 2019) “I just feel that it changed my outlook on how I can feel about myself and now I know the right way and what steps to take when I'm not feeling 100%. ... I think just being able to pick myself back up and say “Y” you can. That's really important” (McCay et al., 2015)

Theme 1: Cultivating Inner Steadiness Amid Instability

This superordinate theme and its subthemes capture how participants were described by researchers across multiple studies as developing a stronger awareness of

internal states, fostering a growing capacity for self-reflection and the development of emotion regulation amid the chronic instability of homelessness.

Decluttering the Mind represents this emergent awareness. Across a number of studies, authors reported that participants developed greater awareness of their thoughts and emotions, for example, noting that participants “*spoke of their experiences becoming more aware of their internal experiences in the present*” (Cervantes, 2023). Reports suggested that interventions helped participants to observe rather than be consumed by their thoughts and emotions, enabling them to step back from rumination and to view thoughts as transient mental events.

Responding Rather than Reacting (Appendix E) reflects how this cognitive regulation supported more considered responses to stressors. Participants described learning to pause before acting, often using breathing or grounding techniques to steady themselves: “*For me, I would just like take a few deep breaths ... and say, ‘Can you please give me some moments so I could breathe and think for a minute?’ And then I’ll just calm down and just be cool*” (Bender et al., 2015). This deliberate pausing was commonly interpreted by authors as reflecting a growing sense of control and agency over automatic reactions, supporting emotion regulation and reducing distress.

Theme 2: Growing Through Connection

Relational processes were identified across multiple studies as central to participants’ experiences of third-wave interventions, with connection described as both a foundation for engagement and a therapeutic outcome in its own right.

Laying Foundations of Relational Safety captures how intervention contexts were reported to foster feelings of safety, respect, and trust, which are conditions that both participants and facilitators viewed as essential for meaningful engagement. Group settings were described as providing spaces to form supportive peer relationships and a sense of belonging. For instance, one study noted that a participant “*liked the togetherness and cohesion formed during the group activities*” (Santa Maria et al., 2019). Various facilitative strategies, such as authenticity, selective self-disclosure, and encouragement of peer support, were reported to help participants engage more

effectively in group contexts (Bender et al., 2015; Cervantes, 2023; Santa Maria et al., 2019).

From Reactivity to Connection extends this theme, capturing patterns where authors described participants becoming steadier in their interpersonal interactions. As emotional regulation improved, relationships were reported to shift from reactive to more connected. Several studies indicated that interventions facilitated greater perspective-taking and self-compassion, allowing participants to approach others with increased understanding and empathy. As illustrated in one study, a participant reflected: *“I see meself with a wider view now... I know meself that me attitude towards people has changed positively since I started it. I don’t react to them cause we’re in the same boat”* (Maddock et al., 2017).

Theme 3: Meeting People Where They Are At

This superordinate theme and its subthemes capture how responsiveness and flexibility were identified across studies as central to the effective delivery of interventions. Meaningful engagement was reported to depend on approaches that acknowledged instability, competing demands, and individual needs.

Designing Delivery for Instability and Diversity reflects the varied efforts described across studies to adapt intervention pacing, format, language and setting to provide accessible and relevant content. Authors in many studies noted that flexibility in settings and structure, and clear explanations of relevance to participants lived realities were often valued (Bender et al., 2015; Cervantes, 2023; Grabbe et al., 2012; Santa Maria et al., 2019; Viafora et al., 2014; Vickery et al., 2023). As one participant noted in terms of practicality, *“structure and delivery helpful - catch up sessions, length of sessions and frequency of x2 per week.”* (Santa Maria et al., 2019). Balancing structure with choice and emotional safety allowed participants to remain engaged without feeling overwhelmed.

At the same time, *Engagement is Hard When Life Feels Unsafe* synthesises how authors and participants described the ongoing challenges of engagement in the face of persistent uncertainty, past trauma, and mistrust of professionals and others. Even with

thoughtful adaptations, these contextual factors were frequently reported to influence participants' scope to engage fully or apply skills in daily life. As one study explained, *"daily stressors related to their homelessness and lack of basic needs made it difficult for them to focus their attention on internal, interpersonal, or environmental risk cues"* (Bender et al., 2015).

Theme 4: *"My head is lifted higher"* The Broader Picture of Regaining a Sense of Confidence and Capability

This superordinate theme captures a renewed sense of confidence and capability that was reported across studies as participants engaged with third-wave interventions. Developing coping skills and gaining mental clarity appeared to restore trust in one's own judgment and draw attention to personal strengths that had previously been overshadowed by adversity. Across studies, authors reported participants describing a sense of progress, self-belief, and pride in their efforts, illustrated by one participant, *"I'm proud of myself for trying to make these changes"* (Alhusen et al., 2017), and another, *"And all in all, my self-esteem is up. Either a combination of DBT and, I mean, something's finally getting done in my life"* (McCay et al., 2015).

This theme reflects the culmination of the broader trajectory evident across the synthesis, from developing inner steadiness, to re-building relational safety and connection, to rediscovering confidence and capability within ongoing contexts of instability.

Integration of Quantitative and Qualitative Synthesis

Across strands, there was convergence around improvements in awareness and emotional regulation. Quantitative reductions in distress, emotional reactivity, depression and anxiety corresponded with qualitative descriptions of feeling calmer, more aware of internal states, and better able to manage emotions. These qualitative accounts reflect processes aligned with the domains where measurable improvements were most consistently detected.

However, some divergence emerged between strands. In two studies, participants described strong perceived benefit, such as feeling calmer, more focused, or more able

to manage emotions, despite quantitative findings that were not statistically significant (Viafora et al., 2014) or limited to small subscale changes (Bender et al., 2015). These discrepancies might potentially be explained by methodological differences in evaluating effectiveness. Standardised outcome measures may not always capture the gradual, subtle or early-stage psychological changes participants described qualitatively, such as increased awareness, connection or calmness. Moreover, two studies additionally converged on housing stability itself as a potential moderator. In Viafora et al. (2014), a classroom mindfulness-based programme produced statistically significant quantitative improvement only among housed students, although unhoused participants reported positive qualitative experiences. Similarly, Vickery et al. (2023), found that participants with less stable housing described more confusion and mixed benefit from the behavioural activation programme, while those in more stable accommodation reported greater value from the programme. Together, these findings suggest that acute housing instability may influence measurable symptom or wellness change even where qualitative engagement is positive.

Qualitative findings elaborate on several mechanisms that help explain quantitative outcomes. Reports of greater moment-to-moment awareness and coping skills reduced emotional reactivity, and for some participants, supported behavioural change. These accounts complement observed quantitative improvements in distress and emotion regulation. However, certain quantitatively assessed domains, such as substance use, self-efficacy, or physiological indicators, were not directly explored qualitatively, limiting cross-strand comparison for these outcomes.

Qualitative evidence highlighted several contextual factors that help explain variability within quantitative findings. Some studies noted specific barriers that can limit the effectiveness of an intervention, such as acute housing instability, trauma histories and mistrust of services based on past prejudicial treatment, which offers insight into why some interventions produced mixed or not statistically significant results.

The relationship between intervention duration and quantitative outcomes was not straight forward. Both single-session, targeted interventions (Clark et al., 2024;

Murthy et al., 2020) and multi-week, relationally intensive programmes (McCay et al., 2015; Nyamathi et al., 2017) demonstrated measurable change in at least one primary outcome, whereas several brief RCT formats (Bender et al., 2015; Chavez et al., 2020) yielded more limited or subscale effects. Qualitative themes such as ‘Laying Foundations of Relational Safety’ and ‘Meeting People Where They Are At’ help contextualise these patterns, suggesting that delivery context, predictability, and relational grounding may be more influential than duration alone, with stronger outcomes tending to cluster in interventions embedded within stable, service-based environments.

Taken together, integration suggests that third-wave interventions can enhance psychological processes of awareness, regulation, and connection among people experiencing homelessness, even amidst unstable living conditions. Mixed quantitative findings and qualitative reports of perceived benefit highlight the value of integrating process-level and relational indicators of change alongside conventional outcome measures.

Quality Appraisal

Methodological quality was assessed using the Joanna Briggs Institute (JBI) critical appraisal checklists appropriate to each study design (Appendix D). Across the seven studies assessed using quasi-experimental checklists, methodological quality was low to moderate 66–89% (Barr et al., 2021; Clark et al., 2024; Grabbe et al., 2012; Murthy et al., 2020; Petering et al., 2021; Santa Maria et al., 2025; Viafora et al., 2014). Only one study was appraised to have low risk of bias (Santa Maria et al., 2025). Common limitations included the absence of control groups, limited assessment timepoints, and insufficient reporting on whether attrition introduced systematic bias.

The mixed-methods studies ($n = 4$) demonstrated variability in quality (55–80%). Two were judged to be at high risk of bias (Santa Maria et al., 2019; Vickery et al., 2023) and two at moderate risk (Maddock et al., 2017; McCay et al., 2015), primarily due to weaknesses in design rigour, incomplete reporting and absence of reflexive consideration.

The methodological quality of the three qualitative studies ranged from 60% - 90% based on appraisal scores. Two were appraised as low risk of bias, reflecting strong methodological consistency, transparent analytic processes, and explicit reflexivity (Cervantes, 2023; Little, 2013). One was rated moderate risk due to insufficient detail regarding analytic procedures and the absence of reflexive consideration (Alhusen et al., 2017).

Five randomised controlled trials (RCTs) were appraised to have the highest rate of variability, with low to high risk of bias (36–90%) (Bender et al., 2015; Chavez et al., 2020; Held & Owens, 2015; Nyamathi et al., 2017; Vickery et al., 2024). Only one RCT was appraised to have low risk of bias (Vickery et al., 2024). In several cases, randomisation procedures were inadequately described, attrition was not systematically reported, and allocation concealment and blinding were unclear, which are limitations that likely reflect the challenges of conducting controlled trials in homelessness contexts, rather than design flaws alone.

Overall, eleven studies were classified as moderate risk, four as high risk, and four as low risk of bias. Although the general standard of reporting was acceptable, the dominance of quasi-experimental designs and inconsistencies within mixed-methods studies constrain the strength of findings. The included evidence supports a cautious and contextually informed interpretation of findings.

Discussion

This mixed-methods systematic review examined the quantitative and qualitative evidence on the effectiveness and acceptability of third-wave psychological interventions for unhoused people. In contrast to previous reviews that have focused on randomised controlled trials (Bodley-Scott et al., 2024; Hyun et al., 2020), the inclusion of quasi-experimental, qualitative and mixed-methods studies in the present review extends this literature by providing insight into the diversity of settings in which these interventions are being evaluated, how they are implemented in ecologically valid

settings and the ways participants experience therapeutic change within homelessness contexts.

Overall, current findings suggest that third-wave interventions show promise for supporting psychological functioning, although confidence in their effectiveness remains limited. Quantitative effects were heterogeneous and most included studies were appraised as having moderate to high rates of bias due to small samples, limited comparator conditions, and inconsistent reporting of attrition and intervention fidelity. Notably, qualitative findings consistently described meaningful changes in awareness, emotional regulation, relational functioning and perceived capability, suggesting a potential divergence between how change is measured and how it is experienced. Some confidence can be placed in these experiential findings as two of the three qualitative studies demonstrated strong methodological consistency, transparent analytic processes and explicit reflexivity (Cervantes, 2023; Little, 2013). However, confidence in qualitative components of mixed-methods studies remains limited due to inconsistent reporting of reflexivity and transparency of analysis.

These findings are broadly consistent with previous reviews, which found selective and variable improvements across quantitative psychological outcomes, within an underpowered, methodologically diverse evidence base (Bodley-Scott et al., 2024; Hyun et al., 2020). However, the current review extends these findings by demonstrating that, while symptom-based outcomes were inconsistent (Bender et al., 2015; Chavez et al., 2020; Clark et al., 2024; Santa Maria et al., 2019; Viafora et al., 2014; Vickery et al., 2023, 2024), participants frequently reported benefits associated with engagement (Alhusen et al., 2017; Bender et al., 2015; Cervantes, 2023; Grabbe et al., 2012; Maddock et al., 2017; McCay et al., 2015; Viafora et al., 2014).

The apparent divergence between quantitative and qualitative findings may partly reflect limitations in the outcome measurements used. This limitation has been previously noted by Bennett et al. (2022) in their scoping review of trauma interventions in homeless contexts, highlighting the need to better capture meaningful change beyond symptom reduction, through the inclusion of experiential data. Standard outcome measures used in isolation may not detect process-level or relational changes, and in

doing so risk underestimating the impact of intervention (Curry et al., 2021). This was particularly evident where measures were not well aligned with the theoretical targets of the intervention, such as self-compassion assessed within a mindfulness-based programme (Viafora et al., 2014) and overall PTSD severity in a self-compassion intervention (Held & Owens, 2015).

Engagement was similarly shaped by factors not captured by traditional metrics. Participants described structural barriers, including competing survival priorities, environmental instability, and limited opportunities to practise skills outside of structured sessions, as contextualised in the theme *Meeting People Where They Are At*. These findings highlight the limitations of relying solely on traditional engagement metrics such as attendance and retention. The importance of capturing cognitive, affective, and relational dimensions of engagement has been previously highlighted (Bijkerk et al., 2023), particularly in marginalised populations where participation is likely to be episodic (Curry et al., 2021). The current findings support this position, suggesting that engagement in homelessness contexts cannot be adequately understood through behavioural metrics nor standard outcome measures in isolation. Taken together, this suggests that third-wave interventions in homelessness contexts may be better understood as supporting adaptive psychological processes, such as increased awareness, self-confidence, perceived capability and emotion regulation as evidenced in themes, *Cultivating Inner Steadiness Amid Instability*, *Growing Through Connection*, and *“My head is lifted higher”: Regaining a Sense of Confidence and Capability*; rather than producing reductions in broad clinical symptom severity.

Beyond these patterns, modality-specific findings also warrant consideration. Mindfulness-based interventions represented the largest group of studies in this review and demonstrated mixed but generally promising findings. Several studies appraised as having moderate levels of bias reported improvements in distress, emotional regulation, and mindfulness-related processes (Barr et al., 2021; Grabbe et al., 2012; Maddock et al., 2017; Petering et al., 2021), while others identified only selective or non-significant effects (Bender et al., 2015; Chavez et al., 2020; Santa Maria et al., 2019; Viafora et al., 2014). The predominance of mindfulness-based studies within the evidence base limits

the ability to draw conclusions regarding the relative effectiveness of different third-wave modalities.

The two studies evaluating ACT found positive effects (Cervantes, 2023; Murthy et al., 2020), though both studies relied on small sample sizes (<10), and require further quantitative and qualitative evaluations. Similarly, the evidence base for CFT remains limited, with one singular study included in this review (Held & Owens, 2015); though the positive findings from both ACT and CFT intervention studies indicate encouraging evidence that warrants further evaluation. A lack of research on behavioural interventions for unhoused people with mental health difficulties has been highlighted (Roy et al., 2024), and the current findings offer some clarity. Both studies evaluating DBT reported improvements across several psychological and behavioural outcomes, including substance use, depression, hopelessness, and social functioning (McCay et al., 2015; Nyamathi et al., 2017). These interventions were among the most structured and intensive programmes included in the current review, combining group and individual components over extended periods, with a strong focus on the therapeutic relationship. This pattern suggests that relationally-intensive and well-structured interventions such as DBT warrant further evaluation with unhoused people, while acknowledging the current evidence is derived from only two studies, both of which were appraised as having moderate risk of bias (McCay et al., 2015; Nyamathi et al., 2017).

In contrast to DBT, behavioural activation interventions demonstrated more limited or selective improvements. One intervention improved self-efficacy for self-care but not general self-efficacy (Clark et al., 2024), while two related trials reported no significant change in broader psychological wellness outcomes (Vickery et al., 2023, 2024). Behavioural activation typically aims to increase engagement in reinforcing activities and establish consistent behavioural routines; however, such changes may be difficult to sustain in environments characterised by instability and limited control over daily circumstances. This may indicate a mismatch between the assumptions underpinning behavioural activation and the structural realities of homelessness.

Findings related to feasibility and acceptability were generally positive across studies, representing one of the more consistent aspects of the evidence base. However,

fidelity monitoring was infrequently reported. Consistent with previous reviews (Bodley-Scott et al., 2024), only a small number of studies in the current review ($n = 6$) described formal fidelity checks. This limited reporting raises important questions regarding the consistency of intervention delivery, particularly within homelessness contexts where flexibility and adaptation are often necessary to support engagement. A tension therefore emerges between the need to adapt interventions to real-world conditions and the ability to evaluate them against standardised protocols.

These findings provide support for psychologically informed good practice guidelines for homeless services, which identify several third-wave approaches as feasible frameworks (Keats et al., 2012). The current review illustrates how these interventions can align with the key areas of needs among unhoused people, particularly in supporting self-awareness, emotional regulation, and relational functioning, domains that are frequently disrupted by experiences of trauma, which are disproportionately high in homelessness contexts (Liu et al., 2021; Woodhall-Melnik et al., 2018). Overall, these findings suggest that third-wave interventions may be particularly relevant for supporting psychological processes that support individuals to cope more effectively with ongoing adversity and the conditions of homelessness.

Future Direction

Consideration is needed regarding how interventions are evaluated in the context of homelessness. RCTs have received criticism related to limited external validity and clinical salience (Mulder et al., 2018), which holds particular relevance in the unique context of homelessness. Traditional RCT designs rely on assumptions of stability, standardisation and sustained engagement, which are often incompatible with the realities of homelessness, housing instability, episodic service use, and the need for flexible delivery. Relatedly, commonly used risk-of-bias tools, largely developed for pharmacological research, may systematically penalise behavioural and contextually adapted interventions for features that are both necessary and appropriate (De Bruin, 2015).

As such, future research should move beyond a focus on symptom reduction to incorporate broader outcome domains including experiential, cognitive, affective and

relational processes through mixed-methods or qualitative designs (Bennett et al., 2022; Bijkerk et al., 2023; Curry et al., 2021), alongside traditional symptom measures. This resonates with wider critiques that key mechanisms of psychological change, particularly in the case of complex needs, are not easily captured through conventional RCT methodologies (Shean, 2014). Greater involvement of people with lived experience in identifying relevant outcomes would also enhance the clinical and ecological validity of research in this area (Luchenski et al., 2018).

There is also a need to expand the evidence base beyond mindfulness-based approaches. Modalities such as ACT, CFT, DBT and Behavioural Activation remain underrepresented in the evidence base despite being commonly used approaches in clinical settings, limiting conclusions regarding comparative effectiveness. Future studies should prioritise the evaluation of these approaches, alongside longer-term follow-ups, to better understand the mechanism of change.

Clinical Implications

The findings of this review highlight several implications for clinical practice within homelessness services.

First, third-wave psychological interventions appear well-aligned with the psychological and contextual needs of unhoused groups, particularly in their emphasis on emotional regulation, awareness of internal experiences and coping with distress; aspects of intervention that participants consistently noted as helpful across studies.

A consistent finding across studies was the centrality of trauma among unhoused people. Participants described sensitivity to interpersonal threat, the importance of pacing and choice, and the difficulty of practising skills in unsafe environments (Alhusen et al., 2017; Cervantes, 2023; McCay et al., 2015). This underscores the need to embed trauma-informed principles within intervention delivery (Hopper et al., 2010). In practice, this involves facilitators having sufficient training to recognise trauma responses, adapt exercises accordingly, prioritise predictability and relational safety, and prevent re-traumatization. These relational conditions may function as active mechanisms of change.

Flexibility in delivery also emerged as critical. Many interventions were adapted in terms of format, pacing, and setting to accommodate individual need, unstable living conditions and competing demands. At a service level, this supports the delivery of modular, open-access, or rolling programmes that can accommodate irregular attendance while maintaining therapeutic coherence. However, this raises an ongoing tension between flexibility and fidelity. Developing clearer frameworks for identifying core therapeutic components, (e.g. retaining the ACT hexaflex as a core component), from adaptable elements of delivery may help services retain therapeutic fidelity without compromising accessibility.

Across studies, attendance and retention were often variable, reflecting competing demands, housing instability, and episodic engagement. As such, these indices should not be treated as sole indicators of intervention success. Low or inconsistent attendance may reflect structural barriers rather than disengagement, and risks obscuring meaningful within-session or process-level change. Services may therefore benefit from adopting broader conceptualisations of engagement, incorporating indicators such as participation during sessions, perceived relevance and skill uptake. Given the divergence observed between symptom-based outcomes and participants' accounts of change, services are encouraged to select measures across complementary domains, rather than relying on symptom measures alone. These should include process measures aligned with the processes targeted by the intervention; measures of broader functioning and well-being that capture outcomes such as social connectedness, self-efficacy and quality of life; and relational measures. Baseline assessment may include perceived interpersonal safety and social connectedness, while therapeutic or facilitation alliance and peer connection should be monitored following initial engagement, and where feasible, across sessions. Assessment should remain proportionate and responsive to participants' literacy, cognitive and practical needs. This approach may be particularly relevant for monitoring the relational conditions identified as central to engagement and meaningful change.

Intervention intensity is another important consideration. While brief interventions were often feasible and acceptable, programmes involving sustained

engagement, relational contact, and skill development, such as DBT-based interventions (McCay et al., 2015; Nyamathi et al., 2017) and the eight-week MBSR programme (Maddock et al., 2017) appeared to demonstrate broader improvements. In addition, including people with lived experience in facilitation where possible appears to be a helpful mechanism to support trust and connection (Barr et al., 2021; Grabbe et al., 2012). This suggests that multi-week programmes with lived experience input, where service resource permits, may be particularly helpful for this group. Where such resource is not available, briefer interventions may still offer meaningful benefit, as evidenced in the single-session ACT intervention (Murthy et al., 2020), though expectations regarding the scope of potential change should be realistic and process-level changes should be included, rather than solely measuring symptom-level reductions.

Limitations

Several limitations of the current review should be acknowledged. The evidence base is characterised by mostly small sample sizes, frequent use of quasi-experimental designs, and inconsistent reporting of intervention fidelity and follow-up outcomes. In addition, the predominance of US-based studies, consistent with previous reviews (Bodley-Scott et al., 2024; Hyun et al., 2020), may limit the generalisability of findings to services operating within other welfare, housing and healthcare contexts.

The literature was heavily weighted towards mindfulness-based interventions, limiting comparison across different third-wave modalities. Methodological heterogeneity across the included studies precluded meta-analysis, and as such, a pooled effects estimates could not be calculated, which limits the ability to draw conclusions regarding effectiveness.

The exclusion of second-wave CBT may be considered a limitation, given its status as a well-established intervention. However, this exclusion was necessary to address the review's specific question about third-wave modalities; particularly given their inclusion within psychologically informed frameworks for homelessness services (Keats et al., 2012). Moreover, CBT has been reviewed in recent reviews (Bodley-Scott et al., 2024).

Finally, given that the majority of included studies were rated as moderate or high risk of bias, the conclusions drawn here should be interpreted with caution.

Conclusion

This mixed-methods systematic review synthesised quantitative and qualitative evidence on third-wave psychological interventions for unhoused people. Overall, this review indicates that third-wave psychological interventions show promise for supporting unhoused people, particularly in addressing emotional regulation, coping with distress, and engagement with internal experiences. However, the evidence base remains limited and methodologically heterogeneous, with mostly moderate-high rates of bias, mixed findings regarding symptom change and a predominance of mindfulness-based approaches. Importantly, the findings suggest that intervention effectiveness cannot be understood independently of the contexts in which they are delivered. Taken together, the review highlights the need to move beyond narrow evaluations of effectiveness based solely on symptom reduction and retention. Greater emphasis is required on process-level change, relational factors, and the broader structural conditions that shape engagement with care. Future research should adopt more context-sensitive approaches, while clinical practice should prioritise flexibility, trauma-informed delivery, and relational continuity. Within this framework, third-wave interventions may offer a valuable contribution as part of integrated, responsive systems of care for unhoused people.

Conflict of Interest Statement

The authors declare that this research was conducted in the absence of any commercial or financial relationships that could be interpreted as a potential conflict of interest.

Data Availability Statement

All data analysed in this review is derived from published studies. Extracted data supporting the findings of this study are available from the corresponding author upon reasonable request.

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Chapter Three: Empirical Study

Article Title

“They’re intertwined really... They make each other worse”: An interpretative phenomenological analysis of living with epilepsy in the context of homelessness

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Guidelines available (Appendix F).

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Abstract

People experiencing homelessness, or “unhoused people”, are eight times more likely to have a diagnosis of epilepsy compared to the general population. However, little is known about how epilepsy is experienced and understood within the context of

homelessness. This study used Interpretative Phenomenological Analysis to explore the lived experience of epilepsy among six unhoused men in Ireland. Four group experiential themes were developed: Diagnosis as an Explanation with No Way Out, Dual Loss of Autonomy, Public Seizures and Social Devaluation, and Living Within Constrained Survival Pathways. Findings illustrate a dynamically reinforcing relationship between epilepsy and homelessness. Seizures undermined bodily reliability, while environmental instability associated with homelessness intensified unpredictability in managing safety and medical needs. This dual vulnerability meant participants navigated simultaneous bodily and environmental threats. The absence of private space made seizures public incidents, creating a double bind in which individuals depended on visibility and bystanders for assistance, yet were exposed to stigma and misrecognition. Services were often experienced as fragmented and cyclical, disrupting recovery and requiring individuals to prioritise survival over health through harmful trade-offs. Repeated exposure to these conditions contributed to a gradual erosion of agency and ongoing reconstruction of identity. These findings suggest that the burden of epilepsy in homelessness is compounding, with each condition significantly exacerbating the impact of the other. Epilepsy care for unhoused people should therefore incorporate trauma-informed approaches that address psychosocial needs and peer support, reduce stigma, improve staff awareness, and support integrated inclusion health pathways.

1. Introduction

Epilepsy is a neurological disorder characterised by unprovoked, recurrent, and frequently unpredictable seizures [1]. Misconceptions and enduring stigma surrounding epilepsy contribute to social exclusion [2]. Social exclusion is a process whereby certain individuals — most often those experiencing poverty, discrimination, and/or limited life

opportunities and skills — are pushed to society's margins; depriving them of power and autonomy over their own lives, and creating barriers to education, employment, and social connection [3]. Similar patterns of stigma and social exclusion characterise homelessness, which is widely understood as a complex social phenomenon shaped by structural inequality, poverty, and exclusion from stable housing, healthcare, and wider systems of support.

Unhoused people are individuals who lack stable and safe housing including those sleeping outside in open air and living in emergency or temporary accommodation. The definition of 'unhoused' is understood in line with the European Typology of Homelessness and Housing Exclusion (ETHOS) [4], which conceptualises homelessness as encompassing a range of diverse living situations rather than a single condition. "Unhoused people" is the preferred term of reference in this paper, which is consistent with person-centred language to shift the framing of the issue from individual responsibility to the structural conditions that shape the absence of adequate housing. This term has been increasingly used in recent literature [5, 6].

Unhoused people are estimated to be eight times more likely to be diagnosed with epilepsy compared with housed populations [7, 8, 9]. Seizures represent one of the most common neurological reasons for emergency department presentation among unhoused individuals. Seizure frequency has been found to increase with the duration of homelessness. Seizure-related morbidity and mortality rates are disproportionately high compared to housed groups [9].

Health inequalities across socio-economic groups are often conceptualised as a gradient, though the disparity between even the most disadvantaged housed populations and unhoused people has been described as more akin to a "cliff" [10]. Access to consistent and effective healthcare presents a further challenge for unhoused people. Unhoused populations frequently encounter barriers including fragmented care pathways across geographically dispersed services, inflexible appointment systems, and previous experiences of stigma or prejudicial treatment that contribute to mistrust of healthcare providers [8].

When epilepsy and homelessness co-occur, these forms of disadvantage appear to intersect in ways that are mutually compounding. Factors associated with homelessness often exacerbate seizure frequency through disrupted sleep, chronic stress, lack of safe storage for medication, heightened anxiety overall, and for some individuals, substance use, where withdrawal may further elevate seizure risk [7, 9]. In addition, uncontrolled seizures with frequent breakthrough seizures may simultaneously limit an individual's capability to secure or sustain housing. This suggests a bidirectional relationship in which epilepsy and homelessness operate in a reciprocal and compounding manner [7]. Epilepsy in unhoused people must therefore be understood within a broader social and structural context that actively shapes both risk and capacity for management.

The existing literature relating to epilepsy among unhoused groups has largely focused on prevalence, hospitalisation patterns, mortality, and treatment adherence [7, 9, 10]. A case report outlines the wounds sustained from unwitnessed seizures on the streets [11], and recent studies have begun to examine the psychosocial impact of epilepsy among unhoused groups [12]. These findings suggest felt stigma negatively affects social outcomes, increases distress, and negatively impacts the individual's confidence needed to manage epilepsy, prompting recommendations that epilepsy care explicitly address psychosocial and stigma-related concerns alongside medical treatment of epilepsy in the context of homelessness [12, 13, 14].

Specialised models of care have been developed to improve epilepsy management among unhoused groups [8, 12]. One such example is an Inclusion Health Epilepsy Service in an Irish, hospital-based urban setting, which was specifically designed to meet the needs of individuals experiencing forms of social exclusion, including unhoused people [12]. Findings from a mixed-methods study on epilepsy and homelessness conducted in this context indicate higher rates of depression, anxiety and epilepsy-related stigma, with mental health difficulties playing a central role in shaping quality of life for unhoused people [12]. The study included a written open-ended question to understand informational needs, lived challenges, resource awareness and perspectives on care. The results described stigma, mental distress and perceived loss of

life opportunities as closely intertwined, which led the authors to call for more in-depth investigation of the lived experience of epilepsy in the context of homelessness.

These intersecting experiences may be understood through the concept of “*double jeopardy*”, which proposes that holding multiple stigmatised identities results in greater disadvantage to health and wellbeing, in comparison to a single marginalised status [15]. This may also be conceptualised through a syndemic lens, whereby two or more conditions co-occur and mutually compound the severity and consequences of the other, driven by shared structural determinants such as poverty, exclusion and limited access to care [16]. Individuals living with both homelessness and epilepsy may therefore be at heightened risk of cumulative stigma, exclusion, and psychosocial harm. To date, however, no qualitative research to our knowledge has explored how unhoused people themselves understand and give meaning to living with epilepsy within the context of their everyday lives.

The present study therefore aims to qualitatively explore the lived experience of epilepsy among unhoused people, with a particular focus on how individuals understand, interpret, and ascribe meaning to their condition within the context of housing instability, stigma, healthcare engagement, and everyday survival. Accordingly, the study asks: How do unhoused people experience living with epilepsy?

Interpretative Phenomenological Analysis (IPA) is a qualitative approach interested in exploring how individuals make sense of significant life experiences within specific social and relational contexts [17]. IPA recognises how lived experience is context-dependent and therefore focuses on in-depth, case-by-case analysis before looking at patterns across participants and allows for both convergence and divergence across accounts. Given the complexity, sensitivity, and deeply personal nature of these experiences, an IPA approach was deemed most appropriate. By focusing on participants’ subjective perspectives, this research aims to understand the psychosocial dimensions of epilepsy as lived under conditions of homelessness and to inform the development of more responsive and socially attuned models of epilepsy care for this underrepresented group.

2. Method

2.1 Participants

Participants were recruited across settings representing varying levels of housing stability, aligning with the diverse categories outlined in the ETHOS classification of homelessness [4]: hospital inpatient services in a large urban setting during periods of living outside and temporary accommodation ($n = 2$); temporary accommodation within a community homelessness service in a second urban setting ($n = 2$); and independent tenancies with ongoing key-worker support following long-term homelessness, also in the second urban setting ($n = 2$).

2.2 Recruitment

Inclusion criteria included (1) adults over the age of 18 years old, (2) with a diagnosis of epilepsy (3) experiences of homelessness, and (4) sufficient fluency in the English language to engage with the research process. Exclusion criteria included (1) adults with an acute psychotic illness at the time of recruitment where this precluded capacity to provide informed consent, (2) those visibly under the influence of substances at the time of providing consent and/or interview, as determined via clinical judgement, and (3) those unable to provide informed consent due to cognitive impairment.

Purposive sampling was used. Recruitment was supported through a hospital-based inclusion health epilepsy service in a large urban setting and across homelessness community services in a second urban setting from June 2024 – December 2025. Clinicians, managers and key workers provided eligible individuals with information outlining the purpose of the study (Appendix J) with an easy-read leaflet (Appendix I). Individuals who expressed interest had their contact details passed, with consent, to the researcher and were contacted directly by the researcher. Where phone contact was not possible, the researcher visited the participant in-person in community services to discuss the study prior to engagement, when needed.

The consent form was discussed and signed before each interview (Appendix K), where participants were made fully aware of their right to withdraw, anonymity and confidentiality limits, the recording of the interview and how the data will be used in future publications.

2.3 Ethical Considerations

This project was informed by institutional guidelines, and ethical approval was granted from research ethics committees of an Irish university in October 2024, and an affiliated teaching hospital in July 2024 [details blinded for review] (Appendix G - H). Ethical considerations were central to the recruitment and data collection process, particularly given the power differentials when working with unhoused people. Participation was voluntary, with no incentives offered, and all individuals were provided with clear information regarding the study, including the right to withdraw at any time.

The primary researcher had appropriate clinical training and supervision to manage participant distress, and a risk management protocol was in place. Participants were debriefed following the interview, and all data were stored securely in accordance with data protection regulations.

2.4 Data Collection

Semi-structured interviews were conducted by the lead researcher. Smith et al. [17] outline that a small, homogenous sample is best suited for IPA studies, which informed the sample size. An interview schedule was developed in line with IPA guidance and was trialled with an initial interview (Appendix L), this prompted refinement of language used to ensure accessibility and relevance. These refinements included rephrasing questions to be more open and experiential, shifting from general questions about impact to inviting participants to describe specific moments and sense-making. Interviews focused on domains exploring participant experiences of epilepsy, experiences of homelessness, and the intersecting experiences of homelessness and epilepsy.

Interviews were conducted in private rooms within service settings or other agreed appropriate locations. Interviews were audio-recorded using a Dictaphone and pseudonymised at the point of transcription. Pseudonyms were given to participants and are used throughout the results to protect participant anonymity while preserving the sense of each individual, consistent with IPA's idiographic commitment to the lived

experience of the individual [17]. Supervision was a central process which supported discussion around the process and reactions following interviews, and to follow-up on any participant needs identified following the interview process.

2.5 Data Analysis

The IPA analysis was conducted using Microsoft Word by the lead researcher in accordance with the description of IPA provided by Smith et al. [17]. Each transcript was read several times to support familiarity, which was further supported by the manual transcription of interviews. Initial noting involved detailed line-by-line analysis, noting linguistic, descriptive and conceptual comments (Appendix N). These notes were interpretatively developed into personal experiential themes (PETs). These steps were conducted for each individual transcript which allowed for an idiographic focus of each participant's experiences. Patterns across cases were then examined to identify shared group experiential themes (GETs) while also considering points of difference between participants' accounts [17, 18].

Responses to the direct interview question concerning recommendations for governments and services were summarised descriptively and presented separately from the experiential analysis.

2.6 Reflexivity and Positionality

The primary researcher (RC) who conducted the recruitment and main analysis approached this study as a trainee clinical psychologist, with no professional or lived experience of epilepsy or homelessness, and remained mindful of how professional training and societal assumptions could shape interpretation. The other authors included two clinical psychologists (JR, FOK), psychologist and researcher (SL), a specialist registrar in neurology (GR) and consultant physician (CNC); all of whom had professional experience working directly and/or conducting research with unhoused groups.

Reflexivity was an ongoing and active process throughout data collection and analysis. The primary researcher engaged in regular reflective journalling (Appendix M) and supervision to critically examine preconceptions, emotional responses, and

interpretative decisions, while maintaining a commitment to grounding analysis in participants' accounts. Attention was paid to issues of power, representation, and the risk of homogenising experiences within a diverse and marginalised group. The analysis was conducted with attention to established qualitative quality markers including sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance [19]. Moreover, Nizza et al.' [20] guidance regarding the four qualities of high-standard IPA informed the approach.

3. Results

Six adult men ($n = 6$) who identified as White Irish, with lived experience of homelessness and a diagnosis of epilepsy took part. Mean age of participants was 39.7 years, ranging from 32– 47 years. Mean time spent in homelessness was 13.83 years, ranging from 2 – 28 years. The timeframe of epilepsy diagnosis varied. One participant was born with epilepsy, two were diagnosed in adolescence or adulthood before homelessness, and three developed epilepsy during homelessness. Interviews ranged from 45 minutes – 90 minutes (average = 65 minutes)

From the analysis, four Group Experiential Themes (GETs) were developed: (1) Diagnosis As An Explanation With No Way Out, (2) Dual Loss of Autonomy - When Both the Body and Environment Become Unreliable, (3) Public Seizures and Social Devaluation, and (4) Living Within Constrained Survival Pathways.

Table 3

Overview of GETs and Supporting Quotes

Group Experiential Themes (GET)	Subthemes	Example of illustrative quote
GET 1: Diagnosis as an Explanation with No Way Out	Explaining the Missing Pieces No Escape from the Next Seizure	<i>“and everyone’s like “you had a seizure” and i say oh did i, did i... And you know, then you know, it's the blood, but you don't even pay attention to it because you can't remember it.” (Ciaran)</i>

“At least then when I got diagnosed, I knew what was fucking happening. I knew then what was causing them time outs.” (Joe)

“Kind of waiting for another seizure, but hoping I didn't get another seizure (...) And it wasn't until after I got a diagnosis that they said stress can cause seizures too, so I went there a little bit down wondering whether the stress of wondering if I'm going to have another seizure would cause me to have another seizure.” (Declan)

GET 2: Dual Loss of Autonomy - When Both the Body & Environment Become Unreliable	Living in an Unpredictable Body Living within Environmental Instability	<i>“I'd be walking down the road and I just collapse. And I wake up in hospital or something” (Neil)</i> <i>“It's cold, you don't know who's going to walk by, you don't know if someone could urinate on you, do whatever. It's very dangerous. So that obviously could keep me up (...) then I can't go to sleep and I might get a seizure. And that stresses me out. And then that in turn, then, because stress and lack of sleep, they're literally intertwined” (Billy)</i>
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“So you have to learn how to start your life all over again, how to work with epilepsy. To me, before that, my seizures were really rare at the time. I had one every month, maybe one every fuckin four or five months. So then it went from that to, as I said, homeless and your

stress and, so the stress was always there. And it was building up all the time. So I was having a lot more seizures.” (Cian)

“Then I’ve been robbed several times because I’ve had seizures by other homeless people, you know? And taking whatever it is you have, what very little you have, you know, running away with it. There’s no security with it, you know... There’s even less security when you have epilepsy and your homeless, you know, because you can’t trust anybody” (Declan)

**GET 3: Public
Seizures and
Social
Devaluation**

Public Visibility as
Survival and
Spectacle

Seizures as Social
Devaluation

“I’d want to be somewhere that if I had a seizure that someone can ring because I’d be thinking if I go off down here to sleep, say if I didn’t pay my rent and I was out on the street, I’d be thinking oh I don’t want to be too far away because if I had a seizure, no one would find me til tomorrow. I could end up in the water. So I’d be thinking “I can’t do that anymore what if I get a seizure. What if I fall into water”.” (Ciaran)

“Some people wouldn’t even bother their arse ringing an ambulance for you. Yeah, it’s happened to me once or twice, and it’s happened to a friend of mine that she had epilepsy and she took the worst seizure I’ve ever had seen anyone take and I had to scream at people and I had to fucking roar for them to call for an ambulance. And then there

was this lad who was videotaping her and then he just went and walked off.” (Joe)

“They’ll think you’re out of your head. You come out of your seizure and you’re on the floor, and people are seeing you roll around and they’re thinking “what’s wrong with him?”. And you might go up to them for help or else run away. And they’re just thinking “what’s wrong with him” (Cian)

**GET 4: Living
Within
Constrained
Survival
Pathways**

Caught in the
Revolving Doors of
Services

Inevitable Harm and
Impossible Trade-
Offs

Fractured and
Reconstructed
Selfhood

“Like if you have a seizure on your way to getting food, you know, and you come out of it, for me it would be an hour, an hour and a half, afterwards I’ll come out of it properly ... And I might be, an hour away from where the food is, and by the time we get there, it’s gone. Exactly what you need to help recover from a seizure is food, something to get that energy back, but you’ve missed that because of that. And, you say to them, well I had a seizure and they’re like, “well, show up on time next time”.” (Declan)

“But I have an alcohol problem now.
And that’s really from the hostels and the streets. They combine together and then there’s the depression ‘cos I’ve no where to go. And I’ve no one to talk to. You know, so you feel alone. So I go out and I have a few drinks. And then I probably take an epileptic fit and end up in

hospital. And it's not like it's a choice, it's from the life I've had to live." (Neil)

"But when you're homeless and you don't do drugs, it's the most loneliest place on the planet ... So I used to, I started drinking.. I wasn't really taking my tablets. So I wasn't taking my tablets, so I was at a bigger risk, very big risk of having a seizure because I didn't really have access to my tablets, where to put them or whatever... And then if you take your tablets and drink, that's even fucking worse. Do you know, so what do they say? Sorry for the language, but you're fucked if you do, you're fucked if you don't (...) I had to do with it, what I needed to do to survive, but at the same time, I was putting my own life in danger at the same time" (Cian)

"They'll ask you if you're using.. So they put it down that "It's because he was using". So we will just do this and we'll do that and send him back out. That's the scale they'll use. For how much they'll deal with someone. Run some tests and say he's fine yeah yeah, he's grand, send him back out (...) They think you don't value your life as much." (Ciaran)

"I went up and I came out of the hospital one day. And this will tell you how battered my doctor was. He was going through them and things. He goes, "oh, you were in seizure and had this." He goes,

“you didn't have a brain injury before, did you?”
And I goes, yeah, I had a fucking stroke, man.
Because you should have known this. Like, never
knew nothing about it.” (Cian)

3.1. Group Experiential Theme: Diagnosis As An Explanation With No Way Out

For participants who received a diagnosis of epilepsy later in life, diagnosis provided a framework for understanding past seizure events that were previously characterised by confusion. While the label helped to fill in these gaps in the memory, it rarely brought reassurance and offered minimal relief. Instead, it often incurred a permanent burden and uncertainty about future possibilities, and at times, a significant sense of hopelessness.

3.1.1. Subtheme: Explaining the Missing Pieces

For participants who were not born with epilepsy, diagnosis provided a framework through which previously ambiguous or misinterpreted seizure experiences could be re-interpreted. Loss of consciousness dominated many accounts. As Neil described, “I wouldn’t even know you know, I’d just hit the ground... Ending up in hospital. I never knew it was this bad you know, to get the diagnosis.” Diagnosis arrived not at the point of seizure, but for all, after months or years of inexplicable events. It formally named what had previously been unknowable, inferred only from memory gaps, injuries, blood, or waking to find incontinence.

Joe similarly reflected on the shift from confusion to recognition: “I’d wake up and I know something has happened but I wouldn’t know what it was back then, but now I know that it’s epilepsy.” Here, diagnosis provided an understanding of past events, allowing him to fill in the missing pieces. The seizure itself remained outside conscious awareness, though the fragments surrounding it, such as hospital admissions, injuries, or disorientation, began to make sense.

Ciaran highlighted how the amnesic quality of seizures prevented the consolidation of threat, making it difficult to fully grasp and internalise the danger

seizures posed: “It’s very hard to be afraid of something that you can’t remember – it’s sort of like the boogeyman is going to get you.” Epilepsy was therefore known indirectly, through seizure aftermath and through others. Where family members witnessed seizures, understanding was supported through repeated co-construction. As Ciaran noted, “The only thing that’s scary is seeing the look on my mam’s face... That’s only when the penny drops.” Here, meaning emerged relationally, facilitated by others’ fear and concern.

In contrast, the absence of medical guidance following diagnosis left some participants dissatisfied. Declan summarised this succinctly: “Not enough information. Not enough care given.” For Declan, diagnosis provided a label without containment and understanding was framed not only as informational, but dependent on interpersonal support. When both were absent, the sense of relief that might have come from finally explaining the memory gaps was largely lost.

3.1.2. Subtheme: No Escape from the Next Seizure

While the diagnosis provided some explanation, participants described coming to terms with epilepsy as chronic, unpredictable, and without cure. For Joe, the diagnosis provided consistent frustration regarding the unpredictable nature of seizures: “I’d find it annoying because you can’t tell when it’s gonna hit”. Declan repeatedly contrasted it with other illnesses: “A lot of other diseases or sick illnesses are curable, and there’s an endpoint to whatever the negatives are, whereas with the epilepsy there isn’t, it’s just a constant hoping things will be good. But that doesn’t necessarily mean that things are going to be good”. This comparison functioned to demonstrate the permanence attached to the diagnosis, which limited hope of recovery, highlighting the lack of closure it provided, and the continued uncertainty that permeates the experience.

For some, diagnosis also meant disrupting former identities, which were described as stable and strong. Life became increasingly restricted, where epilepsy limited opportunities and dismantled aspects of the self that were previously valued. Loss of employment, independence, and previously valued roles contributed to diminished self-worth. Declan described feeling “weak and worthless... not as entitled to life as other people,” a sentiment echoed by Billy, who stated simply, “I felt less

than.” Diagnosis marked not only medical recognition but enforced restrictions on individual autonomy. Notably, where epilepsy was shared within families, this erosion of self appeared less pronounced, suggesting that relational containment and normalisation buffered against these threats to identity.

For Declan, his accounts reflected intense distress associated with the diagnosis, which for him, signalled the beginning of a trajectory that culminated in homelessness: “Eventually I ended up... drugs and alcohol... That led to being homeless.” The diagnosis was seen as a pivotal event that shaped future pathways rather than merely explaining past events. While a diagnosis of epilepsy clarified aspects of the past, it did not restore control over the present or future, where explanation and burden coexisted.

3.2. Group Experiential Theme: Dual Loss of Autonomy - When Both Body and Environment Become Unreliable

Across accounts, participants described a profound erosion of autonomy that unfolded across both bodily and environmental domains. Seizures disrupted the reliability of the body itself, while homelessness and unstable living environments intensified unpredictability in managing medical needs and general safety. The body’s loss of reliability carried heightened consequences within street environments, where the absence of shelter, protection or support left participants navigating both bodily and environmental threats simultaneously.

3.2.1. Subtheme: Living in an Unpredictable Body

Participants frequently described seizures as events that undermined their sense of ownership over their bodies. The body appeared to operate outside conscious awareness in the build-up to and aftermath of a seizure, leaving individuals unable to anticipate or fully understand what had occurred. Neil described the disorientating nature of seizure episodes: “The mind isn’t working properly. You can’t really remember. You don’t remember what you were doing before you took the seizure, or when you took it, or what happened afterwards. Everything’s buzzin’. Everything is just confusing.”

Here, the seizure was experienced not simply as a medical event but as a rupture in consciousness. Memory fragments and confusion replace awareness, leaving participants unable to access their own bodily experience. In this way, the body became a site where events unfold beyond the individual's knowledge rather than something that could be monitored or controlled. At times, the disconnect between mind and body was particularly stark. Ciaran described regaining consciousness to find injuries without remembering the event itself: "You don't feel what happened, even though there's blood gushing from my face sometimes and blood everywhere all over my hands." While the body had undergone a violent physical event, the mind could not access it. This experience of waking into the aftermath of an unknown event left participants reconstructing seizures indirectly, which contributed to a persistent sense that the body could not be fully known or trusted to remain stable.

For some participants, warning signs gradually became recognisable over time. Ciaran described seeing "Dots ... Like the fuzzy black screen on the telly", acting as a brief warning signal for seizure onset. For others, waking moments acted as a period of heightened susceptibility for seizure; turning ordinary bodily states into sources of threat and fear. For Joe, seizures arrived without warning, as he expressed the threat enmeshed in this unpredictability: "And you dunno if you're gonna fuckin fall and crack your head or worse".

Daily life was shaped by the potential of sudden bodily collapse, where this loss of control was experienced as unpredictable, frightening and inevitable. Seizures were not the sole concern, but the threat extended beyond the event itself to include potential injuries that might be sustained in the aftermath. It created a pervasive sense of uncertainty around when the next seizure might occur, producing a hypervigilance to potential bodily betrayal.

3.2.2. Subtheme: Living within Environmental Instability

While seizures were experienced to undermine bodily autonomy, the environments in which participants lived intensified this vulnerability both physically and psychologically. Participants described navigating public spaces, temporary shelters, or unsafe sleeping arrangements where seizures could occur without support, protection,

privacy or routine. For Cian, who was born with epilepsy, homelessness altered the burden of the disease:

“When I became homeless, I just, things change fast, so I, when I first became homeless, I'm stressed. I didn't know what I was going, I didn't know what's going to happen. I'm not going to, I even, I used to stay in a tent. I stayed in a tent for six months on the street. My seizures started to get worse.”

The environment was not a neutral backdrop but actively contributed to seizure vulnerability through its associated stressors. Participants repeatedly identified stress as a risk factor, as Joe described: “my stress levels have been going up and down. So that's a warning sign to watch. Because out of anywhere now it could just hit me.” Stress therefore became something that had to be monitored, managed and reduced. However, within the parameters of homelessness, participants often felt unable to control the conditions that produced this stress, quickly eroding any sense of autonomy in their environment.

Environmental instability disrupts the routines that were previously found helpful in managing epilepsy. Irregular sleep, substance use, and the absence of secure spaces to store medication made seizure management difficult to maintain. Ciaran described the cumulative pressures associated with homelessness: “It's just a circle (...) being homeless and weariness, worry, lack of sleep a lot of the time, stress, you know, and drug taking and just a lot of like stuff. And then you're filling up forms that you have to do if you want to get a gaff. The stress of that.”

Billy described the street environment as an inherently unsafe space in which threat is constant: “It's cold, you don't know who's going to walk by you don't know if someone could urinate on you, do whatever. It's very dangerous.” In such contexts, the possibility of having a seizure introduced an additional layer of exposure. Declan similarly described the vigilance required when living on the streets, particularly the fear of losing consciousness in public spaces: “what if I have a seizure in the doorway in the middle of the night?”. This fear was not hypothetical as he explained that he had “been robbed several times... because I've had seizures”.

This illustrated how moments of bodily vulnerability can quickly become opportunities for exploitation. The unpredictability of seizures intersected with an environment where risk of threat is constant, amplifying participants' sense of vulnerability. Others described sleeping in tents or isolated areas where seizures might occur unnoticed. These conditions amplified the risks already posed by epilepsy, creating a feedback loop where environmental stress intensified seizure risk, bodily harm and emotional strain. Billy explicitly reflected on the reciprocal relationship between epilepsy and the environmental instability of homelessness: "They're intertwined really. The epilepsy will make it harder to be homeless because I'll be worried about the epilepsy and what will bring on a seizure (...) Homelessness then makes that worse because I have less control. They make each other worse."

What emerged was a mutually reinforcing dynamic between bodily unpredictability and environmental instability, where each amplified the burden of the other. As the body became harder to trust and the environment harder to control, the possibility of seizure management and life stability declined. Participants therefore navigated daily life with a diminished sense of control across both internal and external domains.

3.3. Group Experiential Theme: Public Seizures and Social Devaluation

A central experience across participants related to the inevitable collapse of the body in public spaces. For participants, seizures were not events that could be managed privately; they unfolded in streets, town centres, or hostel common areas, where the absence of private space meant the seizure was certainly a public event. These moments created a double bind where participants depended on members of the public to recognise the seizure and intervene, yet these same encounters were often shaped by stigma. As a result, seizures unfolded not only as medical emergencies but also as socially mediated experiences where vulnerability was both exposed and evaluated.

3.3.1. Subtheme: Public Visibility as Survival and Spectacle

Participants described waking from seizures to find themselves surrounded by strangers in highly exposed circumstances. For many, the unavoidable loss of privacy

during these moments was one of the most distressing aspects of living with epilepsy while homeless. As Cian explained: “The worst thing about having a seizure is when you... come out of that, like sometimes you wake up on the floor in the middle of town, people around you and you see a luminous jacket or something.”

Here, seizures were experienced less as private health events, and more as publicly visible occurrences. Participants regained consciousness not only into physical disorientation, but into the immediate awareness of being seen and interpreted by others, often provoking intense emotional reactions. Cian described experiencing “paranoia” and a sense of “fight or flight” when waking to find himself surrounded by strangers. Similarly, Ciaran reflected on the cumulative visibility of his seizures in public, questioning “how many people is after seeing me having seizures and probably thinking “that’s the fella over there” (...) Some people would know it’s a seizure but others...”. His trailing off indicated a hesitation in fully articulating how he is perceived, while also pointing to the development of a socially constructed identity shaped by public seizure episodes.

For Cian, this exposure extended into settings that might otherwise provide privacy, with even the bedroom disrupted, at times waking in bed to ambulance medics surrounding him. In this way, the seizure itself was compounded by the psychological shock of exposure, as participants had to navigate confusion and vulnerability, while simultaneously being subject to the gaze and interpretation of others, often without any opportunity for privacy.

These encounters also exposed a stark imbalance of power. Participants described lying disoriented on the ground while passer-bys stood over them, who determined whether help would be sought. Although intervention from bystanders was often necessary to access medical assistance, it meant participants were forced to depend on strangers. This frequently influenced how participants made decisions during their day, such as choosing somewhere public for sleep. Many described avoiding secluded areas despite the desire for privacy, recognising that being out of sight could prove life-threatening should a seizure occur. Therefore, not only did participants have to endure

seizures in public spaces, but depended on bystanders for intervention, thus made public visibility an essential need for survival.

3.3.2. Subtheme: Seizures as Social Devaluation

At times, public exposure was accompanied by experiences that participants interpreted as voyeuristic. Joe described an incident in which his friend had a seizure while others watched: “I had to fucking roar for them to call for an ambulance. And then there was this lad who was videotaping her and then he just went and walked off.”

This moment highlighted a troubling juxtaposition between visibility and neglect. Receiving public attention did not necessarily translate into care or protection. Instead, the event became something to observe or record, where suffering individuals were not deemed worthy of care and intervention. Such experiences left participants feeling exposed, dehumanised and outraged, reinforcing uncertainty that their needs might be witnessed without meaningful support.

Alongside exposure, participants frequently encountered stigma and misrecognition in the aftermath of seizures. Across accounts, seizures were often interpreted by others as signs of intoxication or drug use rather than medical emergencies. Participants described repeatedly being treated as though they were “out of your head” or as if there was something “wrong with him” (Ciaran). Such assumptions positioned participants within socially stigmatised identities.

These assumptions were also evident within healthcare settings. Cian described the line of questioning he frequently encountered upon arrival at hospital: “When was the last time you used? When was the last time you shot up? Never done drugs like that. I’ve done drugs, but not like that” There was a sense of exasperation here in defending the self against assumptions tied to his housing status.

For some, instances of stigma carried serious and dangerous consequences. Declan described being physically assaulted while living on the streets in the United Kingdom, attributing the violence to intersecting stigma of homelessness, epilepsy and his nationality: “I was being assaulted because I was Irish, but half the time it was because of my epilepsy and I was on the streets with nowhere safe to go”. Here epilepsy

intersected with homelessness and nationality to produce compounded forms of marginalisation, where seizures became moments where existing social prejudices are activated and intensified.

Participants therefore described becoming acutely aware of how their behaviour might be perceived following a seizure. Emerging consciousness was accompanied not only by physical recovery, but by the need to prove legitimacy as a patient, rather than a suspect. In this way, seizures produced a social bind where participants were required to manage both their medical condition and the interpretations imposed by others.

3.4. Group Experiential Theme: Living Within Constrained Survival Pathways

A pervasive sense of constrained agency underpinned participant accounts, as individuals described navigating survival within structural conditions that limited choice and opportunity to effectively manage epilepsy. Homelessness and healthcare services were often experienced as producing a revolving-door dynamic in which recovery was repeatedly disrupted, while attempts to cope required participants to accept harmful trade-offs. Within these conditions, participants described how prolonged exposure to constraint and instability gradually reshaped their sense of identity and the efforts they employed to rebuild their self-concept.

3.4.1. Subtheme: Caught in the Revolving Doors of Services

Across most accounts, healthcare services and homeless services were experienced as simultaneous sources of protection and harm. Participants described services as perpetuating cycles in which recovery from seizures was undermined and autonomy constrained. Rather than creating pathways out of crises, services often returned individuals to the same conditions that precipitated their difficulties, regularly ascribing blame to the individual in the process. Living with epilepsy incurred an additional system of medical services to navigate lasting resolution.

Several participants described how seizures had become normalised within homelessness contexts, reducing the urgency of responses. Ciaran reflected on how

seizures are often interpreted as routine, often attributed to presumed substance use: “Because like it’s nearly becoming normal now. The fact ‘oh he had a seizure from tablets’ (...) So they don’t get the ambulance.” Here, seizures became part of the everyday landscape of homelessness, rather than being recognised as events requiring medical assessment, diminishing their perceived seriousness and leaving participants without appropriate consideration of their clinical need.

Both Joe and Cian found that extreme presentations, such as physical collapse or severe aggression, were sometimes necessary to obtain legitimacy and secure support. Hospital admissions were described as brief and rarely altered broader circumstances for recovery. Some experienced premature discharge, while Neil explained how treatment frequently ended with rapid discharge back to the streets: “Then get brought into hospital where they keep me then kick me back out of the streets again. And I do be half broken up when I’m on the streets, while I’m still unwell.”

These experiences created a revolving-door dynamic, where homelessness, addiction, emergency healthcare, and hospital services, intersected to temporarily stabilise crises without addressing underlying conditions. Structural inflexibility further constrained participants’ capacity to manage their health. Requirements to attend appointments or food services at fixed times often conflicted with the physical aftermath of seizures, making engagement difficult. These systemic difficulties also shaped how participants imagined their future possibilities. Some expressed uncertainty about exiting homelessness, fearing that living independently without consistent support would leave them unable to safely manage seizures and return them to the same systems of care.

In this context, systems appeared less as pathways to stability and more as lanes that both contained and reproduced vulnerability, reinforcing participants’ sense of dismissal within systems meant to provide care; echoing broader social devaluation during public seizures. Epilepsy thus added another layer of systemic navigation, increasing the likelihood that individuals would be cycled between systems rather than exiting them.

3.4.2. Subtheme: Inevitable Harm and Impossible Trade-Offs

Participants described navigating survival within conditions where agency was severely constrained by the structural realities of homelessness. The choices available to them rarely offered a safe resolution and instead, nearly all options carried some form of unavoidable harm that was recognised and anticipated.

Coping strategies therefore involved navigating impossible trade-offs, where decisions were driven by immediate survival needs rather than personal values or long-term wellbeing. For example, Cian described selling prescribed medication to obtain food “you’d sell a few of your tablets just to get by. Sometimes you’re going to get a bit of grub”, or choosing private spaces to avoid the humiliation of public seizures despite the risk of unmanaged medical emergencies. For many, drugs and alcohol became a means of managing the profound loneliness associated with homelessness, despite the recognised risk of worsening seizures. As Neil reflected, “It’s not like it’s a choice, it’s from the life I’ve had to live.”

Others described different forms of calculated risk-taking. For Declan, survival involved turning to theft after repeated barriers to employment and a lack of protection when reporting assaults. Joe explained that “lashing out” at others in a physical and often aggressive manner, believing this reduced overwhelming stress and therefore the likelihood of a seizure, while also acknowledging “the outbursts help the stress, but it could make me damage someone else”.

Across accounts, these survival strategies garnered additional judgement from others, but were framed as pragmatic responses to constrained circumstances, rather than choices, where survival often required accepting harm in one domain to avoid greater harm in another.

3.4.3. Subtheme: Fractured and Reconstructed Selfhood

Amid repeated experiences of marginalisation, dismissal, and the physical and psychological burden of navigating epilepsy within homelessness, participants described a gradual erosion of self. These experiences were not understood as singular traumatic events but as a slow accumulation of strain that altered how participants saw themselves. As Cian reflected, “Somewhere along the way it takes your dignity out of you. It

changes you and sometimes it changes the good bits.” In this sense, homelessness and epilepsy together appeared to undo previously held beliefs of competence, dignity, and personal worth.

For some, this erosion culminated in profound hopelessness. For Billy, homelessness was “the straw that broke the camel’s back,” confirming a long-standing sense of feeling “less than” following his epilepsy diagnosis. Three of the six participants described thoughts or attempts of suicide, reflecting the overwhelming nature of living within conditions where pathways for change felt severely constrained. Neil described continuing to endure life largely out of obligation to his children following the death by suicide of his wife, who also lived with epilepsy. His account conveyed the heavy emotional burden of loss and the perceived futility of escaping his circumstances shaped by homelessness and a fragile body.

At the same time, participants described efforts to preserve aspects of identity in the face of these pressures. Billy’s withdrawal from chaotic service environments that provided too much “traffic for the mind”, became a way of protecting his sense of self. By adopting a nocturnal sleep pattern, he developed a routine that allowed him to avoid the disorder of hostel life and reduce exposure to situations and substances that he perceived as increasing his risk of seizures. Others described maintaining dignity through humour, routines, close relationships, or focusing on internal validation. For Cian, completing a college course became less about external success, and more about proving something to himself: “I just wanted to see if I could do it. And I did.” These efforts illustrated how participants worked to preserve and reassert a sense of self within conditions that continually threatened to erode it.

3.5 Participants’ Priorities for Government and Service Responses

At the end of each interview, participants were asked what governments and services could do to better support unhoused people with epilepsy. As these responses arose from a direct recommendation question rather than the experiential analysis, these recommendations were summarised descriptively and are presented separately from the Group Experiential Themes in Table 4.

Participants' priorities included access to stable and epilepsy-informed accommodation, receiving epilepsy-specific support from a knowledgeable professional, simplified service pathways with reduced bureaucratic burden, safe spaces for seizure recovery and medication storage, improved recognition of and responses to epilepsy, and earlier identification and support.

However, not all participants considered service recommendations straightforward or likely to produce change. One participant expressed scepticism that guidance could alter how individuals or services responded, potentially reflecting a broader sense of limited influence over systems of care.

Table 4

Participants' Priorities for Government and Service Responses

Participant priority	What this involved
Stable and epilepsy-informed accommodation	Access to safe accommodation with staff who understood epilepsy and could provide practical support.
A consistent point of support	An identifiable person or service available for advice, advocacy and assistance for epilepsy-related needs, rather than navigating multiple disconnected services.
Reduced administrative and service burden	Fewer appointments within a centralised system of care to prevent multiple journeys and navigation, alongside reduced bureaucratic demands of paperwork; particularly noting how this additional stress and exhaustion could increase seizure vulnerability.
Safe spaces for seizure recovery	Somewhere to rest and eat following seizures, receive support, and securely store medication.

**and medication
management**

**Improved epilepsy
recognition and
response** Greater epilepsy awareness among homelessness,
healthcare staff and the general population to
reduce assumptions that all seizures are substance-
related, and better public knowledge of seizure
first-aid.

**Earlier
identification and
prevention** Improved assessment of possible epilepsy on entry
to homelessness services, greater research
investments, and earlier support to prevent
escalating health needs.

Participants' responses therefore emphasised both practical and relational priorities. Although priorities varied across participants, they broadly reflected a need for services that could respond flexibly to the intersecting challenges of epilepsy and homelessness.

4. Discussion

The purpose of this study was to understand the lived experiences of unhoused individuals who have a diagnosis of epilepsy. To our knowledge, this is the first in-depth qualitative study examining the intersection of these experiences using an interpretative phenomenological approach.

The current study builds on existing literature on elevated rates of epilepsy in homelessness [7, 12] by offering an in-depth account of how these conditions are experienced at their intersection. It extends recent findings from open-ended survey data, which identified stigma, mental distress, and perceived loss of life opportunities as closely connected for this group [12]. Four Group Experiential Themes (GETs) were identified: (1) Diagnosis As An Explanation With No Way Out (2) Dual Loss of Autonomy - When Both the Body and Environment Become Unreliable, (3) Public Seizures and Social Devaluation, and (4) Living Within Constrained Survival Pathways.

Pontes & Marques [7] proposed a bidirectional relationship between epilepsy and homelessness, in which each exacerbates the other. The present findings support and extend this by showing a dynamically reinforcing interaction. While previous research in housed populations found epilepsy to undermine individual bodily trust [22], the present findings show how this loss of bodily control is compounded by environmental instability. This aligns with research on other complex health conditions among unhoused populations, including heart failure [23], diabetes [24] and acquired brain injury (ABI) [25], where environmental instability is consistently identified as undermining effective illness management. In the context of epilepsy, this instability, coupled with loss of bodily control, renders seizures into moments of heightened exposure, leaving individuals vulnerable to theft, exploitation or harm while unconscious or disorientated. In this way, individuals are unable to rely on either their bodies or their surroundings, positioning epilepsy not only as a neurological condition, but as one embedded within relational and structural contexts.

In the current findings, the diagnosis of epilepsy provided clarity on past experiences that were previously confusing or unexplained, but provided little relief or resolution. This contrasts findings in housed cohorts, where diagnosis commonly provides relief and initiates an adjustment process typically supported through the acquisition of information, joining support groups and maintaining regular contact with services and other supportive, stable relationships; all of which serve to support acceptance of the diagnosis [26]. However, this stabilising function of diagnosis was not shared by participants in the current study as they lacked access to many of the supports that enable this acceptance. For one participant, the diagnosis of epilepsy was viewed as a pivotal event that preceded and contributed to trajectories into homelessness, though this pattern was not consistent across accounts. Where epilepsy was diagnosed prior to homelessness and accompanied by strong familial support, participants appeared better able to interpret and manage seizures, consistent with literature highlighting the role of the family in adjustment to diagnosis [27]. In contrast, where epilepsy developed during homelessness, or where supportive relationships were absent or disrupted, it appeared more destabilising, compounding uncertainty and disrupting participants' sense of self and capacity to manage their condition. For one participant who had been born with

epilepsy, the condition had been long integrated into identity, yet homelessness undermined previously established coping structures, illustrating how environmental instability can erode even well-established adjustment. While caution is warranted given the small number of cases, these findings suggest that both the timing of diagnosis and access to relational and informational resources shape how epilepsy is integrated into the self, influencing whether it is experienced as manageable, destabilising, or a source of ongoing vulnerability.

Beyond shaping how epilepsy is integrated into the self, these findings also highlight the importance of relational containment. Charyton et al. [28] also described the role of supportive relationships in improving quality of life for housed individuals with epilepsy by providing emotional and practical support, alongside companionship. The current findings show that within homelessness, the absence of consistent supportive relationships fundamentally shapes how seizures are experienced. Participants with strong familial support described these events as more manageable, suggesting these networks acted as a protective factor. In contrast, where these relationships were absent or lost, the burden of managing seizures appeared to intensify. Merdsoy et al. [29] similarly found that the emotional impact of chronic illness in homelessness is mediated by interpersonal relationships; which can be facilitative or act as a barrier [24]. In the current study, distress was heightened, and for three out of six participants, extended to suicidal thoughts and/or behaviours. As homelessness [30] and epilepsy [31] are independently associated with increased suicide risk, these findings suggest that individuals navigating both may be at even further elevated risk.

Participants described moments of care and protection as often inconsistent or undermined by broader service structures. As a result, relational containment was frequently absent and not adequately compensated for by services that lacked continuity. This suggests that isolation actively exacerbates disease burden by eroding perceived coping capacity and contributing to hopelessness. These dynamics appear further compounded by repeated cycles of engagement and discharge across services, disrupting the continuity required to support both the psychological and physical impact of seizures. These patterns reflect wider evidence that health systems may exclude

unhoused people through fragmented, rigid service structures [32]. A qualitative study of homelessness and ABI, which is 2.5–4 times more prevalent than in the general population, identified similar challenges, including fragmented systems and stigma [25]. For unhoused people with epilepsy, such discontinuity may be particularly detrimental, placing additional strain on individuals already managing the cognitive, emotional, and practical demands of recurrent seizures.

Stigma and social support are established predictors of quality of life for housed individuals with epilepsy [33, 34]. Although participants did not explicitly name stigma, their accounts of the line of questioning they received following a seizure, “*When was the last time you used? When was the last time you shot up?*” (Cian), illustrated how it operated implicitly in shaping how they were perceived and responded to by others. Repeated encounters of this kind appeared to foster a sense of social devaluation that became internalised over time, transforming seizures from private medical events into public spectacles, as Cian noted how these encounters leave him feeling, “*I do be mortified*”. A central feature of participants’ accounts was the routine misattribution of seizures to substance use. Similar stigmatising assumptions have been reported among unhoused individuals self-managing diabetes, where insulin use is misinterpreted [24]. In the present study, such assumptions undermined participants’ status as patients, requiring them to manage the physical consequences of seizures alongside the social interpretations imposed upon them. Ciaran reflected on how these assumptions shape the level of care that is provided: “So they put it down that “it’s because he was usin’. You know. So we will just do this and we’ll do that and send him back out. That’s the scale they’ll use for how much they’ll deal with someone”. These patterns reflect previous findings, which outline how stigma towards unhoused people often manifests through diagnostic overshadowing and presumptions of substance use, with significant consequences for access to care [35]. Here, such dynamics added a distinct layer of additional burden, contributing to disengagement from services and reinforcing marginalisation.

Mula and Kaufman [36] describe how the co-occurrence of epilepsy and mental health difficulties generates a form of double stigma, in which two already stigmatised

conditions combine to produce a mutually reinforcing cycle of discrimination and psychological vulnerability. The current findings extend this concept by demonstrating how epilepsy and homelessness operate in an intensifying loop, where each condition magnifies the severity and social consequences of the other; creating a compounded burden of distress for participants. Encounters with bystanders, healthcare professionals, and service staff were often marked by suspicion, judgement, or doubt, intensifying the sense of exposure: “They make each other worse” (Billy). The bidirectional relationship is consistent with the syndemic framework [16], whereby homelessness and epilepsy are not merely co-occurring, but actively sustained and worsened by the shared structural conditions of poverty and exclusion participants navigated on a daily basis.

In response to these challenges, participants’ coping strategies were embedded within conditions of limited containment, public exposure, and ongoing misrecognition. Their actions reflected what Carver et al. [37] describe as disengagement coping, which include strategies adopted when direct action feels impossible. Coping was shaped less by preference and more by the constraints of homelessness, bodily instability, and relational insecurity. All participants reported substance use at some point during homelessness and emphasised that this was not recreational, but one of the few available means of managing distress, uncertainty, and the profound lack of control. These strategies offered momentary relief yet carried longer term consequences for physical health, seizure management, and at times, interpersonal relationships. Similar trade-offs have been described by unhoused people with heart failure, where immediate survival must be prioritised over long-term health [23]. This reflects constrained agency, in which coping both responds to and reinforces structural conditions, contributing to the series of no-win scenarios and narrowing possibilities for managing distress.

Overall, these findings suggest that epilepsy within homelessness is transformed from a discrete neurological condition into a relationally mediated and structurally intensified experience of vulnerability. Epilepsy within homelessness requires consideration of the environments, relationships, and systems within which seizures unfold. Without addressing these relational and structural conditions, efforts to improve clinical management alone may be insufficient to reduce distress or risk.

4.1. Clinical Implications

These findings have several implications for clinical practice. First, they highlight the importance of relationally sensitive approaches to care when working with individuals navigating both homelessness and chronic health conditions. Trauma-informed care emphasises respect, transparency, and collaboration to foster trust and engagement; and has shown promise within homelessness services [38]. As such, these approaches may hold particular relevance for unhoused people with epilepsy, whose experiences include repeated stigma, judgement and marginalisation, particularly during moments of medical vulnerability.

The findings highlight the need for greater awareness and education regarding epilepsy within homelessness services and frontline healthcare settings. Given that unhoused people are eight times more likely to have a diagnosis of epilepsy than housed populations [7, 8, 9], the current findings point to a lack of condition-specific understanding of epilepsy within homelessness services. Participants emphasised the need for improved staff training and broader public and governmental awareness. Training for staff and healthcare professionals may include practical guidance on recognising different seizure presentations, responding safely during and after a seizure, and identifying when emergency medical intervention is required. Individualised seizure action plans could further support consistent responses across hotels, outreach services and healthcare settings. Peer education within homeless services may also enable residents to respond safely.

Peer support has been found to be an effective form of support provision in housed people living with epilepsy [39], and is increasingly recognised as a valuable approach within homeless services when done effectively and sensitively [40]. In the current study, participants described significant loneliness and isolation, alongside a lack of contact with others who shared their experience of epilepsy, suggesting that this remains an unspoken and unsupported aspect of their lives. As such, peer support initiatives and inclusion of service user perspectives in shaping interventions may offer a meaningful opportunity to reduce isolation and improve supports.

Lastly, the findings highlight the need for more integrated pathways of care for individuals experiencing both epilepsy and homelessness. Unhoused people consistently report difficulty in navigating fragmented systems that do not address intersecting needs and often lack appropriate training [41], alongside the internal and external barriers to care [42, 43]. Participants similarly described services as difficult to navigate, rigid, and at times stigmatising, leaving them to manage complex medical needs alongside unstable living conditions and prioritise survival over healthcare. These challenges, alongside the levels of distress evident in participants' accounts, including suicidality, underscore the need for more comprehensive and coordinated care.

Integrated care models have been recommended for unhoused people or those at risk of being unhoused with complex health needs, including acquired brain injury [44]. Inclusion health approaches offer a particularly useful way of addressing these challenges, as they are designed to counter service fragmentation through integrated, trauma-informed, and relational models of care that are responsive to the needs of marginalised groups and informed by lived experience [45, 46]. For example, the Inclusion Health Epilepsy Service at St James's Hospital, Dublin, enhances access to care by strengthening pathways between specialist and community services, thereby supporting continuity of care [8]. As such, Inclusion Health pathways are essential for improving health and psychosocial outcomes among unhoused individuals with complex conditions, such as epilepsy.

4.2 Clinical Psychology Implications

Findings indicate several implications for clinical psychology practice. The combined experience of epilepsy and homelessness appears to significantly impact identity; as such, interventions should be sensitive to potential identity disruption and support reconstruction in the context of unpredictability and social devaluation. Clinicians can support anticipatory coping for seizures, including recognising early warning signs, preparing for public seizures, and developing practical strategies that preserve dignity.

Assessment and formulation should account for the timing and impact of recent seizures, integrating both neurological and environmental sources of threat, while

supporting individuals to contextualise difficulties within structural constraints rather than internalising blame or shame. Elevated suicide risk should be actively monitored through ongoing risk assessment and collaborative safety planning. Adaptations to intervention delivery are required to accommodate potential memory, attention and executive function difficulties associated with epilepsy [47], including simplified materials, repetition, and flexible, shorter sessions. Given accounts of identity disruption following diagnosis and the loss of previously valued roles, approaches supporting adjustment to chronic illness are likely to be effective. Acceptance and Commitment Therapy has demonstrated utility for individuals with epilepsy [48] and its emphasis on values-based action in the presence of uncontrollable internal and external events maps closely onto the unpredictability participants described. Moreover, accounts dominated by shame, self-blame and social devaluation suggest that compassion-focused approaches [49] may be well-suited to address the self-critical processes involved.

Relational safety should be prioritised as a core clinical task, particularly given repeated experiences of stigma and negative service encounters. Trauma-informed and seizure-informed approaches are indicated, with clinical psychologists well positioned to support training and consultation for frontline staff. Finally, clinical psychologists should play an active role within multidisciplinary and inclusion health models, contributing to coordinated care through flexible delivery formats, including outreach and drop-in provision where possible

4.3. Limitations

Several limitations should be considered when interpreting the findings of this study. The sample consisted exclusively of men. Although this was not an intentional aspect of the study design, it raises questions regarding the recruitment and representation of women experiencing both epilepsy and homelessness. The absence of female participants highlights the importance of future research exploring whether gender shapes experiences of epilepsy within homelessness in different ways.

Moreover, all participants were White Irish from previously settled backgrounds. As such, the findings may not capture the experiences of individuals from more diverse cultural or ethnic backgrounds who may encounter additional barriers within healthcare

and homelessness systems. Future research would benefit from exploring these experiences within more culturally diverse samples.

Lastly, as the study was conducted within the Irish context, the findings are therefore shaped by the particular healthcare, social protection, and homelessness systems operating within Ireland. Experiences of epilepsy within homelessness may differ in other national contexts where access to healthcare, housing policy, and social supports are structured differently; and further research to explore experiences in these systems would be useful to understand whether similar or divergent themes are found.

4.4. Conclusion

In conclusion, this study provides novel insight into the lived experiences of individuals navigating epilepsy while experiencing homelessness. The findings highlight how seizures are experienced not only as neurological events but as embedded within broader social, relational, and structural contexts. Managing epilepsy within homelessness involved navigating uncertainty, stigma, and dependence within environments often characterised by instability and limited safety. The intersection of these experiences appeared to create a compounding burden in which health vulnerabilities and structural disadvantage became closely intertwined. These findings underscore the importance of integrated, relationally sensitive approaches to care that recognise the complex realities faced by individuals managing chronic health conditions within the context of homelessness.

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Declaration of Competing Interests

Three co-authors hold clinical positions within services involved in participant recruitment. All authors declare that this had no bearing on data collection, analysis, or interpretation. No other conflicts of interest are declared.

Data Statement

Due to the sensitive nature of participant disclosures, including experiences of homelessness and epilepsy, interview data are not publicly available in order to protect participant confidentiality and anonymity.

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Chapter Four

Integrated Discussion

Introduction

The following chapter provides an overview and outline of the aims and key findings from the current thesis. This thesis had two aims. The first aim was to systematically review the evidence relating to the effectiveness and acceptability of third-wave psychological interventions with unhoused people. The second was to explore the lived experience of having a diagnosis of epilepsy while being unhoused.

This chapter also integrates findings across studies by reflecting on (1) how engagement is conceptualised and constrained, and (2) the relational conditions under which engagement becomes possible. The value of these overall findings in contributing to the evidence base and subsequent implications for clinical practice, education, policy and research are discussed.

The chapter is concluded by reflections from the researcher on the process of conducting research with a marginalised group, such as unhoused people, and offers learnings based on recruitment with a population traditionally framed as “hard to reach” in research by outlining an alternative viewpoint.

Summary of Key Findings

Study 1

The first study was a mixed-methods systematic review examining quantitative and qualitative outcomes associated with third-wave psychological interventions for unhoused people. Eighteen studies, represented across nineteen publications, were included. A range of interventions were included, such as Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), mindfulness-based approaches, Compassion Focused Therapy (CFT) and Behavioural Activation.

Overall, a narrative synthesis on quantitative data suggests that third-wave interventions show promise in improving psychological outcomes, including emotional distress, substance use, and psychological flexibility. Quantitative findings were mixed

but generally positive, though the strength of this evidence is constrained by heterogeneity in intervention type, delivery, and outcome measurement. Mindfulness-based interventions dominated the evidence base, limiting comparability across modalities. While the evidence base requires further evaluation of underrepresented modalities, findings suggest a cautious interpretation that third-wave therapies are both feasible and acceptable in homelessness contexts.

A thematic analysis on qualitative findings provided important insight into participants' experiences of change and resulted in four themes: (1) Cultivating inner steadiness amid instability, (2) Growing through connection, (3) Meeting people where they are at, and (4) "My head is lifted higher": Regaining a sense of confidence and capability. These themes highlighted increased awareness of internal states, improved emotional regulation, and strengthened interpersonal connections. These process-level shifts were often central to participants' accounts but not always reflected in standardised outcome measures, where perceived benefit was evident in qualitative accounts, in the absence of quantitative change. This discrepancy suggests that experiential and relational aspects of change are not reliably captured by standardised, symptom-focused measures within the literature.

The overall evidence base is limited by methodological challenges, including high attrition, small sample sizes, and reliance on quasi-experimental designs. These constraints reflect the practical realities of conducting research in homelessness contexts and support the need for cautious, contextually informed interpretation of the current findings, which provide evidence of feasibility, acceptability and process-based benefits associated with third-wave psychology interventions in homelessness contexts.

Study 2

The second study explored the lived experiences of unhoused people with a diagnosis of epilepsy, using semi-structured interviews and IPA analysis. Six adult men with a diagnosis of epilepsy and current or recent experiences of homelessness were recruited across hospital and community homelessness services in Ireland.

The analysis generated four group experiential themes and nine subthemes: (1) Diagnosis as an Explanation with No Way Out (including Explaining the Missing Pieces, No Escape from the Next Seizure), (2) Dual Loss of Autonomy (including Living in an Unpredictable Body, Living within Environmental Instability), (3) Public Seizures and Social Devaluation (including Public Visibility as Survival and Spectacle, Seizures as Social Devaluation), and (4) Living Within Constrained Survival Pathways (including Caught in the Revolving Doors of Services, Inevitable Harm and Impossible Trade-Offs).

Together, findings demonstrated a dynamically reinforcing relationship between epilepsy and homelessness, in which both conditions compound instability and undermine an individuals' capacity to maintain safety, predictability, autonomy and control. Seizures were often experienced as public and socially exposing events, creating a tension between reliance on others for assistance and exposure to stigma and misrecognition related to presumed substance use. Across accounts, participants navigated constrained survival contexts, where choices were shaped by structural pressures and competing demands, and where epilepsy diagnosis provided explanation without meaningful resolution.

Critique & Reconceptualization of Engagement in Practice

Existing literature has established that unhoused people face significant barriers to engaging with care (O'Carroll & Wainwright, 2019; Omerov et al., 2020; Reilly et al., 2022) and the present findings of Study 1 and Study 2 further illustrate this point. Taken together, they point to a need to reconsider how engagement itself is conceptualised and evaluated within homelessness contexts.

Engagement is typically operationalised through behavioural indicators such as attendance, retention, and adherence (Bijkerk et al., 2023; Holdsworth et al., 2014). Across the studies included in Study 1, high rates of attrition, inconsistent attendance, and variable completion of intervention components were frequently reported (Grabbe et al., 2012; Held & Owens, 2015; Maddock et al., 2017). Interpreted through this

behavioural lens, these patterns are typically interpreted as indicators of poor engagement or limited feasibility (Bijkerk et al., 2023). Commonly used terms such as “non-compliance,” “dropout,” and “non-adherence” (Hird et al., 2024) implicitly locate responsibility at the level of the individual and overlook the structural conditions that shape engagement. This individualising framing reflects a broader tendency within policy and research to attribute homelessness to personal or behavioural deficits, such as mental health difficulties or substance use (O’Regan et al., 2021). In contexts characterised by transience and instability, attrition may instead reflect the “natural flow of service use,” (Amico, 2009); patterns of contact that are simply incompatible with traditional expectations of sustained participation.

Findings from Study 2 further contextualise engagement by situating it within participants’ lived realities. Daily life was characterised by instability and prioritisation of immediate needs such as safety, shelter, and managing unpredictable health events, patterns consistent with prior research on managing health conditions in homelessness contexts (Manser et al., 2024; Pendyal et al., 2021). Therefore, what is often labelled as ‘disengagement’ in these circumstances may more accurately reflect adaptive ‘survival’ responses under significant structural constraint.

This framing is supported by a broader body of evidence. A meta-synthesis of youth homelessness interventions found that disengagement often resulted from rigid programme requirements, unsafe environments, or stigmatising interactions, rather than a lack of motivation; and that engagement was better understood as a relational, non-linear process, grounded in connection and respect (Curry et al., 2021). De Bruin et al. (2015) similarly argue for engagement to be understood as a multi-dimensional process incorporating motivation, attention, emotional involvement, relational aspects, responsiveness, and fidelity, all of which are domains that traditional behavioural measures fail to capture.

Study 1 offers direct empirical support for this multi-dimensional framing. While outcome measures across studies were often mixed, qualitative findings consistently pointed to meaningful forms of engagement that would have otherwise been overlooked, including shifts in self-perception, emotional regulation, and interpersonal connection.

Engagement, in this sense, may occur even in the absence of sustained attendance or measurable clinical change, indicating that prevailing evaluative frameworks may not only inadequately capture engagement, but may also distort judgements of intervention, particularly where relational processes are central.

Inclusion health literature further extends this argument to the service level. Luchenski et al. (2026) highlight how service fragmentation, inflexible delivery models, and cumulative disadvantage constrain access to and continuity of care. Guidance from the National Institute for Health and Care Excellence (NICE, 2022) similarly emphasises the need for flexible, integrated, and outreach-oriented approaches that account for instability in living circumstances. Services such as the Inclusion Health Pathway in St James's Hospital (Carroll et al., 2021; Ní Cheallaigh et al., 2018), illustrate how such principles can be operationalised in practice. Together, these perspectives reinforce the view that engagement is shaped not only by individual willingness, but by the degree to which services are accessible, adaptable, and responsive to the realities of those they aim to serve.

In conclusion, while attendance and retention offer practical utility in service evaluation, reliance on these metrics in isolation, specifically in the context of homelessness, risks obscuring other meaningful forms of engagement. The qualitative findings from Study 1, combined with lived experience from Study 2, point to more nuanced understanding of engagement. Engagement may therefore be more usefully understood as a contextually produced and relationally negotiated process, shaped under conditions of constraint.

Relational Care as a Core Mechanism of Engagement

While the previous section reconceptualises engagement as contextually and structurally produced, the current theme focuses on the mechanism of relational care through which engagement becomes possible in practice. In Study 1, qualitative findings demonstrated internal shifts such as increased awareness, improved relational functioning, and enhanced perceived capability, alongside the role of peer connection and facilitator relationships in shaping them. Study 2 further extended this by showing how interactions can be experienced as either affirming and transformative, or

undermining and dehumanising. Collectively, these findings suggest that engagement is shaped not only by structural conditions, but by how individuals experience being seen, understood and responded to within them.

The importance of the therapeutic relationship, or working alliance, is a well-recognised mechanism of change (Ardito & Rabellino, 2011; Rogers, 2007). Within homelessness services, trauma-informed approaches that prioritise collaboration, transparency, and emotional safety are widely recommended given the high prevalence of trauma and adverse experiences in this population (Dobischok et al., 2024; Hopper et al., 2010; Reeves, 2015). Despite this recognition, relational factors are frequently positioned as facilitators of engagement, rather than as active mechanisms of change. Across several studies included in Study 1 (Bender et al., 2015; Cervantes, 2023; Santa Maria et al., 2019), the primary focus remained on intervention content and delivery, with relational processes treated as secondary or implicit.

Findings from Study 2 bring this mechanism into sharper focus. Participants described stigma, misrecognition, and social devaluation across healthcare and public settings, consistent with evidence that stigmatising interactions deter care-seeking among unhoused individuals (O'Carroll & Wainwright, 2019). This was intensified by the public nature of seizures, which both necessitated reliance on others and exposed participants to judgement or dismissal. Relationships thus functioned as both sites of harm and potential support, shaping how individuals understood themselves and their place in the social world. Within this framing, disengagement may not reflect resistance to care, but a rational response to relational environments experienced as unsafe, invalidating, or stigmatising.

The concept of epistemic trust (Fonagy & Allison, 2014) provides a useful theoretical frame for understanding why these relational dynamics have such influence on engagement. Epistemic trust refers to an individual's willingness to view information from others as reliable, trustworthy and personally relevant, and this openness is thought to initially develop through early caregiving relationships and shaped by wider social experiences (Fonagy & Allison, 2014). Dismissal and marginalisation can undermine epistemic trust and limit openness to care, whereas interactions characterised by respect

and understanding can help to restore it (Li et al., 2023). The experiences of prejudice and stigma reported in Study 2's 'Public Seizures and Social Devaluation' theme illustrate this erosion directly and provide an account of why participants were often reluctant to subsequently seek care.

This is further supported by broader evidence. In a meta-analysis of engagement facilitators for unhoused young people, Curry et al. (2021) found that supportive relationships were referenced in nearly all 47 included studies and were identified as a core mechanism of engagement. These findings suggest that relational care is not simply an adjunct to service delivery, but a core component.

The importance of relational care can not only be seen in intervention and service delivery but extends to research practices. Hodgetts et al. (2022) extend this beyond intervention delivery, arguing in their "*relationships first and research second*" approach, that trust, reciprocity, and recognition are foundational to effective practice with unhoused people; reflections on how these principles shaped recruitment for Study 2 are discussed in subsequent sections. Across intervention, service, and research contexts, relational care is thus better understood as a core component of the work itself rather than an adjunct to it.

Overall, this theme further expands on engagement by demonstrating how it cannot be understood without attending to the relational context in which care is delivered. While structural constraints shape the conditions of engagement, relational dynamics shape how those conditions are experienced. Relationships may either reinforce or buffer against stigma, and where relational care is absent, disengagement may represent a rational or protective response. This suggests that effective care must attend not only to what is delivered, but to how individuals are seen, understood, and responded to, and that these relational processes warrant more explicit evaluation within service design and research.

Researcher Reflections

This section is written in the first person, as it centres on reflections related to my personal experience of conducting this research. I chose this thesis topic due to a

longstanding interest in working with people who are marginalised in society, and I quickly learned the importance of reflexivity as a central component of the research process. In line with the principles of Smith et al. (2022), I engaged in regular supervision and reflexive journalling throughout, noting my assumptions, internal reactions, and how my understanding of the data evolved over time. These processes helped me to remain aware of how my own perspective was shaping the research, rather than assuming neutrality.

I am a white, cisgender woman with a high level of education and significant structural privilege. I have stable housing, financial security, and a level of choice and freedom that was not afforded to participants. Becoming more aware of this throughout the research process was at times uncomfortable, but necessary. This was brought into sharp focus during moments in interviews, for example when one participant asked, *“You ever been punched in the face before? No?”*. Another suggested: *“if you want to write a good paper, you just need to spend about a week on the streets.”*

These moments highlighted the limits of my understanding and the distance between my position and that of participants; and the uncomfortable reality that researchers are always implicated in power relations (Camara, 2025; Hodgetts et al., 2022). I was mindful that I have not shared these experiences described by the participants and do not know what it is like to live them, regardless of the level of empathy I could engage with.

This was further illustrated in an interview when a participant asked, *“If you were homeless now, what would you do?”*. I responded, *“I have no idea,”* which appeared to shift the interaction, with the participant leaning in and replying, *“Exactly.”* This exchange underscored the limits of my experiential knowledge and the importance of acknowledging this explicitly, rather than attempting to bridge it through assumed understanding. It also highlighted how moments of openness about not knowing can redistribute the interactional dynamic, allowing participants’ expertise to come to the fore. This moment can also be understood as an instance in which epistemic authority shifted, with the participant positioned as the knower, and my role as one of openness rather than interpretation.

Embodied and Emotional Responses in the Field

Entering homelessness services and hospital settings, I often noticed an immediate sense of alertness in myself. There were times where I felt on edge, particularly in environments where individuals were visibly distressed in common areas and where the atmosphere felt unpredictable. What stood out to me was that I was only entering these environments for short periods of time, and I could and would leave afterwards and return home. This prompted reflection on what it might feel like to live in these environments on an ongoing basis.

These embodied responses became an important part of my understanding of the context in which participants were living. Rather than viewing them as separate from the research, they offered some insight into the instability and unpredictability that appeared to characterise participants' experiences. This aligns with a reflexive approach as described by Linda Finlay (2005), where the researcher's emotional and physical responses can inform understanding of the research setting.

Similarly, the experience of conducting interviews grounded me in the realities of participants' lives, particularly in relation to time. The challenges participants faced in attending interviews, or in maintaining engagement, reflected not a lack of interest, but the competing demands and chronic stress inherent in homelessness. Notably, some participants were navigating busy homelessness services and were often concurrently engaged with addiction supports, while managing chronic stress that were further compounded by seizure-related cognitive deficits (Novak et al., 2022). Again, noticing my own internal reactions to non-attendance, alongside the pressures of academic timelines, offered insight into how easily such instances can be interpreted negatively within service contexts. These experiences highlighted a tension between the structured timelines of research and the fluid, often unpredictable nature of context that participants navigated on a daily basis.

Recruitment as a Relational and Structural Process

Recruitment was initially conducted through the Inclusion Health Service in St James's Hospital, as the study emerged from existing collaborative work between my

academic supervisor and this team, who were already engaged in homelessness-focused research. Recruitment through this pathway was slow and logistically complex, as my attendance at the service was limited to one day per week due to travel constraints to Dublin alongside competing clinical training demands. This restricted flexibility, as potential participants were often unavailable on that day or requested alternative times that could not be accommodated. These experiences highlighted the complexity of engaging individuals within acute and often unstable contexts, particularly the time required to effectively support this engagement. Over time, recruitment was expanded to include community homelessness services, which provided multiple avenues for engagement.

Engagement was significantly supported through collaboration with keyworkers, managers, and staff who had established, trusted relationships with potential participants; elements of relational ethics that have been noted by researchers in homeless contexts (Hodgetts et al., 2022). Coordinating participation therefore relied heavily on liaison with key workers, whose input was essential in supporting engagement, particularly where cognitive or memory difficulties, including brain injury, affected participants' ability to attend. Even with these supports, reminders, and coordination in place, attendance often remained unpredictable, with plans frequently falling through on the day and requiring additional follow-up and re-engagement.

Recruitment and obtaining consent were therefore not procedural or transactional tasks, but a relational process requiring time, consistency, trust and flexibility; principles aligned with trauma-informed research practices (Richard et al., 2026). This often required several communication efforts to foster a relationship, and allowing space for participants to make informed decisions without pressure. I was committed to ensuring that participants did not feel rushed or coerced, and offered re-schedules where needed to suit the schedules of the participants, which often posed tension with the pressures of academic timelines. Flexibility was essential in how and when interviews were conducted, as well as recognising that non-attendance or withdrawal were understandable within the context of participants' lives.

The term “hard-to-reach groups” is commonly used within research for individuals in marginalised groups in society, such as unhoused individuals (Green, 2021; Richard et al., 2026), yet over the course of this study, I found this framing increasingly difficult to resonate with. It risks implying that the challenge lies within the individuals themselves, rather than within the structures and systems attempting to engage them. In practice, rather, traditional research approaches, with fixed timelines and often rigid procedures, were incompatible with the realities of homelessness. In this sense, it may be more accurate to consider such populations as “hardly reached”, reflecting limitations within research systems rather than within the individuals themselves.

This perspective aligns with broader critiques of exclusion in research processes (Câmara, 2025; Ellis, 2021), and resonates with my observation that relatively little research of this kind is conducted within the Doctorate of Clinical Psychology programme, UCC. There is therefore a risk that existing research practices may inadvertently replicate the very exclusions they seek to address.

Relational Dynamics in the Interview Process

The importance of relationship became very apparent throughout the research process. There were moments of mistrust, ambivalence, and suspicion, including being questioned about my motivations for conducting the research. Being asked whether I was “*just here to get an A,*” required me to sit with the reality that I was, in fact, gaining something from this process.

This highlighted the inherently relational and unequal nature of the research process, where I was positioned to benefit academically, while participants were sharing deeply personal experiences, without formal compensation or direct benefit. Throughout the research process, I was aware of occupying multiple roles, including researcher, clinician-in-training, and an individual with personal connections to experiences of homelessness. Listening to participants’ accounts while holding these different positions at times felt complex. Relationship-building was therefore not an optional aspect of the research, but central to it. It also involved being willing to sit with discomfort, including

moments where my presence or intentions were questioned, without becoming defensive or withdrawing.

Alongside these complexities, participants frequently described the interview process as beneficial in itself. Several noted that the opportunity to speak about living with epilepsy in the context of homelessness was rare, even among peers with shared experiences such as seizures. Engagement was often framed not only in personal terms, but as motivated by a desire to improve circumstances for others in similar situations. Many expressed that it was ‘about time’ this topic was being examined. These accounts positioned the interview as a relational space that could enable expression, validation, and meaning-making, while also highlighting participants’ active investment in the research aims.

This further emphasised the importance of reflexivity in managing these dynamics and ensuring that personal experiences did not override or obscure participants’ perspectives. At the same time, these positions have unavoidably shaped my sensitivity to aspects of participants’ accounts, including themes of marginalisation, identity, and systemic barriers.

Overall, these reflections suggest that traditional research models may be insufficient when working with marginalised populations, such as unhoused people. This mirrors principles within inclusion health and trauma-informed care (Richard et al., 2026), where the focus is on adapting systems to meet the needs of individuals, rather than expecting individuals to fit within rigid systems. If integrated approaches are considered essential within healthcare for this population, it follows that similar principles should be applied within research. Without adaptation, there is a risk that research processes may inadvertently reinforce exclusion. Therefore, a shift towards more relational and flexible approaches is necessary to ensure that the voices of those most marginalised are meaningfully included.

Clinical Practice Implications

The findings underscore the need to centre relational care as a core mechanism of change within services for unhoused people. In the context of high rates of trauma

(Mayock & Neary, 2025; Woodhall-Melnik et al., 2018), further reflected across both Study 1 and Study 2, relationally attuned service provision holds particular importance. Such approaches may facilitate the development of epistemic trust (Fonagy & Allison, 2014) and, in turn, support sustained engagement with care. Accordingly, relational care should be conceptualised not as an adjunct to intervention delivery, but as a primary clinical task.

However, the capacity to provide relational care is not only shaped by staff knowledge and skill, but also by the organisational conditions within care is delivered. High caseloads, insufficient staffing, limited time and staff turnover may constrain opportunities to establish trust; while the emotionally demanding nature of frontline work may affect staff capacity to remain relationally available (Peters et al., 2021). Training must therefore be accompanied by adequate staffing, manageable workloads, continuity of care where possible, and access to regular supervision, reflective practice, and support following challenging or distressing incidents. Without such support, responsibility for relational care risks being placed on individual practitioners, as opposed to the systemic constraints that create barriers for such care.

This highlights the potential role of clinical psychologists within multidisciplinary teams in offering formulation-led understandings of presenting difficulties that situate behaviour in context; providing consultation and reflective practice to frontline staff whose work is emotionally demanding; supporting trauma-informed adaptation of intervention protocols; and contributing to service level evaluation in ways that capture process and relational outcomes rather than attendance alone. Services should also play an active role in supporting the engagement of unhoused people, including advocacy and outreach approaches by meeting individuals in community settings with more flexible timeframes, and including service users in decision-making processes (Luchenski et al., 2018).

Reconceptualising engagement also requires practical changes to intervention delivery. Services should preserve the core therapeutic components of interventions while allowing flexibility in session timing, duration, location, pacing and format. This may include outreach or drop-in provision, reminders, practical support with transport

where feasible, and continuity of facilitator where possible. Developing open and re-enterable intervention pathways may further support episodic attendance. Moreover, episodic attendance should prompt exploration of the contextual, relational and intervention-related barriers involved, rather than automatic discharge or assumptions of limited motivation.

This also requires a shift towards designing services capable of engaging individuals within unstable contexts to ensure burden is not placed on individuals whose capacity to navigate services is already constrained. Integrated care pathways are therefore essential (Luchenski et al., 2026), particularly for many unhoused individuals who are navigating co-occurring physical health, mental health, and social needs.

Education and Training Implications

The findings indicate several implications for education, particularly in the Doctoral training of Clinical Psychologists, and the ongoing training of frontline staff working in healthcare and homelessness services.

Clinical psychology training programmes in Ireland already identify relational competence (Constantino et al., 2017), and the Psychological Society of Ireland (2021), draws specific attention to diversity and cultural competence as core accreditation elements. However, in current training programmes, there appears to be less explicit attention to the structural and contextual conditions of marginalisation and homelessness. As the World Health Organisation (2025) has recently called for a fundamental shift in policy and practice pertaining to mental health, with a specific focus on targeting the determinants of health, providing dedicated teaching on power differentials, biases, inclusion health, and on psychological practice within non-traditional settings would add significant value to the teaching curriculum.

There is support across health guidance (Luchenski et al., 2018; NICE, 2022) for regular training and upskilling of frontline staff in the relational and contextual competencies central to this work. Skills such as attunement, validation, and collaborative engagement (Ardito & Rabellino, 2011; Rogers, 2007) should be prioritised as explicit training content for frontline staff, including healthcare

professionals likely to encounter unhoused people in emergency, acute, and primary care settings, rather than assumed as implicit. Given that such skills are emphasised within clinical psychology training, clinical psychologists are well placed to support frontline staff in understanding their importance and embedding them in practice.

Training should also address how engagement itself is conceptualised. Supporting staff to recognise that behaviours commonly interpreted as "non-compliance" or disengagement may reflect responses to unstable living conditions, rather than individual resistance or lack of motivation, may reduce the risk of pathologising service users and support more compassionate, context-sensitive responses (Curry et al., 2021). Targeted training for emergency-department and acute-medicine staff on these dynamics, and on the consequences of stigmatising encounters, would also be a direct and actionable response to the current findings.

Inclusion health training offers a useful framework for structuring such content. Postgraduate training resources developed for medical professionals in Ireland (Royal College of Physicians of Ireland, 2026) provide a helpful starting point, and the continued development of resources across psychology, nursing, social work, allied health, and homelessness-service workforces would help establish a consistent, evidence-based knowledge base across the multidisciplinary teams that unhoused people most often encounter.

Lastly, incorporating peer-led approaches and lived experience perspectives into training may enhance staff understanding of the relational and structural barriers faced by unhoused people, highlight professional blind-spots, and support the development of more responsive care practices (Carver et al., 2025; Green, 2021; Mangan et al., 2024). Peer roles may be particularly valuable in bridging relational gaps, offering forms of credibility, trust, and shared understanding that are not always accessible within traditional professional roles (Green, 2021). Importantly, including lived experience in training would also serve to recognise lived experience as epistemically equal to professional knowledge.

Policy Implications

At a policy level, the findings reinforce the need for integrated, inclusion health-oriented models of care that address both clinical and social determinants of health (Luchenski et al., 2026). Policies that support flexible access pathways, cross-sector collaboration, and continuity of care are therefore critical; and already recognised in Irish policy (Department of Health, 2020). This includes recognising continuity and relational consistency as indicators of service quality (Bijkerk et al., 2023; Curry et al., 2021; De Bruin, 2015), rather than relying solely on metrics such as retention, attendance, symptom reduction, and completion as indicators of success.

Policy frameworks should therefore support the development and adoption of more context-sensitive evaluation criteria. Without such shifts, there is a risk that services may inadvertently reproduce patterns of exclusion by withdrawing support from those least able to meet conventional expectations of engagement.

Research Implications

This thesis highlights priorities for broader future research. First, there is a need to move from retention-based models of engagement towards more nuanced and contextually grounded conceptualisations that incorporate other domains. Engagement should be understood as a dynamic, non-linear process, encompassing traditional attendance metrics, in addition to episodic, cognitive, affective and relational processes of participation (Bijkerk et al., 2023; Curry et al., 2021). Practically, feasibility and acceptability should be assessed as related but distinct constructs using mixed-methods evaluations (Bowen et al., 2010). Feasibility may be evaluated through recruitment and consent rates, intervention reach, patterns and reasons for non-attendance, exposure to core intervention components, fidelity to intended therapeutic processes, delivery adaptations, and the staffing, time, training and resources required for implementation (Bowen et al., 2010). Acceptability may be assessed through participants' experiences of intervention relevance, willingness to return and the development of epistemic trust, burden of participation, felt safety and choice, facilitator alliance and peer connection, using brief accessible measures, alongside qualitative feedback (Sekhon et al., 2017). In this way, acceptability may be best assessed through brief post-session feedback, exit

interviews with those who choose to disengage, and co-produced evaluation with people with lived experience.

Second, the findings critique the continued prioritisation of randomised controlled trials as the gold standard for evaluating interventions in homelessness contexts. In complex social interventions, issues such as high attrition, variable engagement, reliance on self-report, and inconsistent fidelity are often structural rather than methodological limitations (De Bruin, 2015). While RCTs offer methodological rigour, they may systematically misrepresent effectiveness in populations characterised by instability, where the conditions required for methodological rigour are themselves absent. As such, alternative designs, including mixed-methods and qualitative approaches may provide helpful ecologically valid insights into intervention effectiveness.

Finally, incorporating peer-led and co-produced research approaches may also enhance the relevance and applicability of findings, particularly in capturing forms of engagement that are meaningful to service users (Green, 2021). Accordingly, reconceptualization engagement requires restructuring both delivery and evaluation of interventions. Services must adapt the conditions where participation occurs, while broadening how engagement intervention success are understood and measured.

Conclusion

Through examining both the effectiveness of third-wave psychological interventions for unhoused people and the lived experience of navigating epilepsy within this context, this thesis offers insight into how engagement with care is understood and enacted under conditions of instability, particularly where intersecting health needs and social marginalisation compound uncertainty, autonomy and access to care. The findings highlight the importance of considering engagement as shaped not only by individual behaviour, but by structural constraints and relational experiences.

While behavioural indicators such as attendance and retention remain important for evaluating intervention and service delivery, the findings suggest that meaningful

engagement would be strengthened by incorporating relational, cognitive, and emotional processes. Across both studies, relational interactions emerged as a central feature to whether services were experienced as safe, relevant, and worth engaging with.

These findings have important implications for clinical practice, education, policy, and research, particularly in supporting approaches that are both structurally responsive and relationally attuned within homelessness contexts.

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Appendix A:

Publication Guide for Clinical Psychology & Psychotherapy Journal

Note: Below are the relevant author guidelines for the target journal. Please also find a permanent link to the journal instructions as of April 2026, should you need to access:

<https://web.archive.org/web/20260426093807/https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html>

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

Free Format submission

CPP now offers Free Format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract (which does need to be correctly styled), introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. [OPTIONAL TEXT, if the journal is running image checks: If the figures are not of sufficiently high quality your manuscript may be delayed.]

References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.

- An ORCID ID, freely available at <https://orcid.org>. (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)
- The title page of the manuscript, including:
 - Your co-author details, including affiliation and email address. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)
 - Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication):
 - data availability statement
 - funding statement
 - conflict of interest disclosure
 - ethics approval statement
 - patient consent statement
 - permission to reproduce material from other sources
 - clinical trial registration [OPTIONAL TEXT, if the journal has a double-blind peer review policy: Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and supply a separate title page file.]

To submit, login at <https://authors.wiley.com/journal/CPP> and create a new submission. Follow the submission steps as required and submit the manuscript.

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: main text file; figures.

File types

Submissions via the new Research Exchange portal can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTeX (.tex) formats.

If submitting your manuscript file in LaTeX format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a Latex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the Latex Main Document should be uploaded as a “LaTeX Supplementary File.”

Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the “Acknowledgements” section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](#));
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;

11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship

On initial submission, the submitting author will be prompted to provide the email address and country for all contributing authors.

Please refer to the journal's [Authorship](#) policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the [Conflict of Interest](#) section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords (see [Wiley's best practice SEO tips](#)).

Main Text

1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.

2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the [APA FAQ](#).

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486. doi: [10.1176/appi.ajp.159.3.483](https://doi.org/10.1176/appi.ajp.159.3.483)

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from <http://www.youtube.com/watch?v=Vja83KLQXZs>

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be

understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click [here](#) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Appendix B

Search String

Table 4

Search Strategy

Database	Search Strategy	Results
CINAHL	S1: TI (homeless* OR unhoused OR roofless OR “rough sleeping” OR “Ill-housed persons” OR “People experiencing homelessness”) OR AB (homeless* OR unhoused OR roofless OR “rough sleeping” OR “Ill-housed persons” OR “People experiencing homelessness”) S2: TI (“3rd wave” OR third-wave OR “third wave” OR ACT OR “acceptance and commitment therapy” OR mindful* OR “mindfulness based cognitive therapy” OR MBCT OR “mindfulness based stress reduction” OR MBSR OR “compassionate mind training” OR “compassion focused therapy” OR CFT OR “behav* activation” OR “meta-cognitive therapy” OR “metacognitive therapy” OR DBT OR “dialectical behav* therapy” OR “schema therapy” OR “Functional analytic” OR “Integrative Behav* Couple Therapy” OR IBCT OR “Cognitive Behav* Analysis System of Psychotherapy” OR CBASP) OR AB (“3rd wave” OR third-wave OR “third wave” OR “ACT” OR “acceptance and commitment therapy” OR mindful* OR “mindfulness based cognitive therapy” OR MBCT OR “mindfulness based stress reduction” OR MBSR OR “compassionate mind training” OR “compassion focused therapy” OR CFT OR “behav* activation” OR “meta-cognitive therapy” OR “metacognitive therapy” OR DBT OR “dialectical behav* therapy” OR “schema therapy” OR “Functional analytic” OR “Integrative Behav* Couple Therapy” OR IBCT OR “Cognitive Behav* Analysis System of Psychotherapy” OR CBASP) S3: S1 AND S2	Search: 24/01/2025 Results: 264
PsychINFO	S1: TI (homeless* OR unhoused OR roofless OR “rough sleeping” OR “Ill-housed persons” OR “People experiencing homelessness”) OR AB (homeless* OR unhoused OR roofless OR “rough sleeping” OR “Ill-	Search: 24/01/2025

housed persons” OR “People experiencing homelessness”)

Results:
530

S2: TI (“3rd wave” OR third-wave OR “third wave” OR ACT OR “acceptance and commitment therapy” OR mindful* OR “mindfulness based cognitive therapy” OR MBCT OR “mindfulness based stress reduction” OR MBSR OR “compassionate mind training” OR “compassion focused therapy” OR CFT OR “behav* activation” OR “meta-cognitive therapy” OR “metacognitive therapy” OR DBT OR “dialectical behav* therapy” OR “schema therapy” OR “Functional analytic” OR “Integrative Behav* Couple Therapy” OR IBCT OR “Cognitive Behav* Analysis System of Psychotherapy” OR CBASP) OR **AB** (“3rd wave” OR third-wave OR “third wave” OR “ACT” OR “acceptance and commitment therapy” OR mindful* OR “mindfulness based cognitive therapy” OR MBCT OR “mindfulness based stress reduction” OR MBSR OR “compassionate mind training” OR “compassion focused therapy” OR CFT OR “behav* activation” OR “meta-cognitive therapy” OR “metacognitive therapy” OR DBT OR “dialectical behav* therapy” OR “schema therapy” OR “Functional analytic” OR “Integrative Behav* Couple Therapy” OR IBCT OR “Cognitive Behav* Analysis System of Psychotherapy” OR CBASP)

S3: S1 AND S2

PubMed

#1: “homeless*”[Title/Abstract] OR “unhoused”[Title/Abstract] OR “roofless”[Title/Abstract] OR “rough sleeping”[Title/Abstract] OR “Ill-housed persons” OR “People experiencing homelessness”[Title/Abstract]

Search:
24/01/2025

#2: “3rd wave” [Title/Abstract] OR “third-wave”[Title/Abstract] OR “third wave” [Title/Abstract] OR “ACT”[Title/Abstract] OR “acceptance and commitment therapy” [Title/Abstract] OR “mindful*”[Title/Abstract] OR “mindfulness based cognitive therapy” [Title/Abstract] OR “MBCT”[Title/Abstract] OR “mindfulness based stress reduction”[Title/Abstract] OR “MBSR”[Title/Abstract] OR “compassionate mind

Results:
332

training"[Title/Abstract] OR "compassion focused therapy"[Title/Abstract] OR "CFT"[Title/Abstract] OR "behav* activation" [Title/Abstract] OR "meta-cognitive therapy"[Title/Abstract] OR "metacognitive therapy"[Title/Abstract] OR "DBT"[Title/Abstract] OR "dialectical behav* therapy"[Title/Abstract] OR "schema therapy"[Title/Abstract] OR "Functional analytic"[Title/Abstract] OR "Integrative Behav* Couple Therapy"[Title/Abstract] OR "IBCT"[Title/Abstract] OR "Cognitive Behav* Analysis System of Psychotherapy"[Title/Abstract] OR "CBASP"[Title/Abstract]

#3: #1 AND #2

Scopus

TITLE-ABS (homeless* OR unhoused OR roofless OR "rough sleeping" OR "Ill-housed persons" OR "People experiencing homelessness") AND TITLE-ABS ("3rd wave" OR "third-wave" OR "third wave" OR ACT OR "acceptance and commitment therapy" OR mindful* OR "mindfulness based cognitive therapy" OR MBCT OR "mindfulness based stress reduction" OR MBSR OR "compassionate mind training" OR "compassion focused therapy" OR CFT OR "behavio?r activation" OR "meta-cognitive therapy" OR "metacognitive therapy" OR DBT OR "dialectical behavio?r therapy" OR "schema therapy" OR "Functional analytic" OR "Integrative Behav* Couple Therapy" OR IBCT OR "Cognitive behavio?r Analysis System of Psychotherapy" OR CBASP)

Search:
24/01/2025

Results:
1,033

Note. Searches were limited to English-language publications. No date restrictions were applied. Grey literature was included; therefore, searches were not restricted to peer-reviewed sources.

Appendix C

PROSPERO Registration

Registration Number: CRD42025603217

Title: A systematic review of the effectiveness of third-wave psychological interventions with unhoused people

Authors: Corscadden, R., O’Keeffe, F., Buckley, K., Rolfe, J., Lambert, S.

Year: 2024

Link: <https://www.crd.york.ac.uk/PROSPERO/view/CRD42025603217>

NIHR | National Institute for
Health and Care Research

PROSPERO
International prospective register of systematic reviews

A systematic review of the effectiveness of third-wave psychological interventions with unhoused people.

Rebekah Corscadden, Fiadhnaí O’Keeffe, Kelly Buckley, Joanne Rolfe

To enable PROSPERO to focus on COVID-19 submissions, this registration record has undergone basic automated checks for eligibility and is published exactly as submitted. PROSPERO has never provided peer review, and usual checking by the PROSPERO team does not endorse content. Therefore, automatically published records should be treated as any other PROSPERO registration. Further detail is provided [here](#).

Citation

Rebekah Corscadden, Fiadhnaí O’Keeffe, Kelly Buckley, Joanne Rolfe. A systematic review of the effectiveness of third-wave psychological interventions with unhoused people.. PROSPERO 2024 Available from <https://www.crd.york.ac.uk/PROSPERO/view/CRD42025603217>

REVIEW TITLE AND BASIC DETAILS

Review title

A systematic review of the effectiveness of third-wave psychological interventions with unhoused people.

Original language title

English

Review objectives

Are third-wave psychological interventions effective with unhoused people?

Keywords

Acceptance and Commitment Therapy, ACT, Behavioural Activation, CBASP, CFT, Compassion Focused Therapy, DBT, Dialectical Behaviour Therapy, homeless, homelessness, IBCT, MBCT, MBSR, Metacognitive Therapy, Mindfulness, Mindfulness Based Stress Reduction, Mindfulness-Based Cognitive Therapy, people experiencing homelessness, psychological intervention, Schema Therapy, therapies, therapy, third wave interventions, third wave therapies, unhoused people

Appendix D

Table 5

JBIC Critical Appraisal Checklist

Author(s)	Year	Checklist Item	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Overall Risk
Barr, N., Petering, R.	2021	Quasi-experimental	✓	X	✓	✓	✓	✓	U	U	✓					Moderate risk
Petering R Barr, N., Clark et al	2021	Quasi-experimental	✓	X	✓	✓	X	✓	✓	U	✓					Moderate risk
Viafora et al	2024	Quasi-experimental	✓	X	✓	✓	X	✓	✓	U	✓					Moderate risk
Grabbe et al	2015	Quasi-experimental	✓	✓	X	✓	X	✓	✓	✓	✓					Moderate risk
Varsha Eswara	2012	Quasi-experimental	✓	X	✓	✓	X	✓	✓	✓	✓					Moderate risk
santa Maria, D	2020	Quasi-experimental	✓	N/A	✓	N/A	✓	✓	U	X	✓					Moderate risk
Cervantes	2025	Quasi-experimental	✓	✓	✓	✓	✓	✓	✓	U	✓					Low risk
Alhusen et al	2023	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	U	✓				Low risk
Little et al	2017	Qualitative	U	✓	✓	U	✓	X	X	✓	✓	✓				Moderate risk
Held, P., Owen	2014	Qualitative	✓	✓	✓	✓	✓	✓	✓	✓	X	✓				Low risk
Chavez et al	2015	RCT	U	U	U	N/A	N/A	U	U	✓	✓	✓	X	X	✓	HIGH RISK
Nyamathi et al	2020	RCT	✓	U	✓	N/A	N/A	✓	U	✓	✓	✓	X	✓	✓	Moderate risk
Vickery, K et al	2017	RCT	✓	U	✓	N/A	N/A	✓	U	✓	✓	✓	X	✓	✓	Moderate risk
Santa Maria et al	2024	RCT	✓	U	✓	N/A	N/A	✓	✓	✓	✓	✓	✓	✓	✓	Low risk
Vickery, K et al	2019	asi-experimental	✓	X	✓	✓	✓	✓	X	X	✓					HIGH RISK
Maddock, A et al		Qualitative	U	✓	✓	✓	✓	✓	X	X	✓	✓				
Bender, K. et al	2023	asi-experimental	✓	X	✓	U	X	✓	✓	X	✓					HIGH RISK
McCay et al		Qualitative	U	✓	✓	✓	✓	✓	X	X	✓	✓				
	2016	asi-experimental	✓	X	✓	✓	X	✓	✓	X	✓					MODERATE RISK
		Qualitative	✓	✓	✓	✓	✓	X	X	✓	✓	✓				
	2015	RCT	✓	U	✓	N/A	N/A	✓	X	✓	✓	U	X	✓	✓	HIGH RISK
		Qualitative	U	✓	✓	✓	✓	✓	X	X	✓	✓				
	2015	asi-experimental	✓	✓	X	✓	✓	✓	X	✓	✓					MODERATE RISK
		Qualitative	U	✓	✓	✓	✓	✓	X	X	✓	✓				

Appendix E

Example Audit Trail for Qualitative Synthesis

Theme 1: Cultivating Inner Steadiness Amid Instability

Responding Rather than Reacting reflects how this cognitive regulation supported more considered responses to stressors. Eight studies (54 coded extracts) reported that developing awareness enabled participants to notice their emotional reactions and choose how to respond.

Alhusen et al., (2017), example codes:

- "The way I handle stress is different. I don't let it consume me";
- "Instead of reacting right away when [child] does something wrong, I take a minute to myself"
- "More self-control"

Little (2014)

- Where I could just calm down instead of yelling. {Talk. You know. Instead of reacting or overreacting} Just you know {react to whatever the situation was} and not overreact." [Inanna]

Maddock et al., (2016)

- felt calmer and less stressed by their lives in general through the regular use of mindfulness exercises such as the mindful breathing exercise
- All reported feeling less emotionally reactive
- "I don't react to them cause we're in the same boat"
- "I can recover myself a lot quicker, I know the thoughts are only temporary"

McCay et al., (2015)

- "It just really shows that you can actually calm yourself down, you can actually make relationships, you can actually respect yourself and self-soothe yourself"
- "I can now take time to realize what I'm going through and like thinkabout it and like calm myself down. ... You know when you're standing in front of someone you just like wonder what it would be like to just punch you in the fucking face. You don't say it to them but you think it. DBT helps me not punch them in the face "

Santa Maria et al., (2019)

- "It made me think of my feelings and day in a different way"

Viafora et al., (2014)

- "Using mindfulness to manage anger"
- Feeling less stressed, calmer, more relaxed
- "Mindfulness meditation is something good cause like for me it help me to take the tension and the bolts I have inside my head cause then I wont be mean and strike people with my lighting bolts"
- "When I am angry I breath and I calm down before I do something crazy. Without meditation I would always be angry"

Appendix F

Publication Guide for Epilepsy & Behavior Journal

Note: Below are the relevant author guidelines for the target journal. Please also find a permanent link to the journal instructions as of April 2026, should you need to access: [/web/20260426094040/https://www.sciencedirect.com/journal/epilepsy-and-behavior/publish/guide-for-authors](https://www.sciencedirect.com/journal/epilepsy-and-behavior/publish/guide-for-authors)

Article types

Epilepsy & Behavior publishes the following types of articles:

- Original research articles (both clinical and laboratory research)
- Reviews
- Editorials
- Brief communications
- Letters
- Book reviews
- Calendar of events

Reviews: Please note that only unsolicited systematic reviews will be considered for publication. Authors are required to register the protocol for the systematic review before data extraction on an accessible, searchable site such as PROSPERO and include registration number.

Editorials: Please note that Editorials are only commissioned and they comment on articles published in *Epilepsy & Behavior*.

Letters: Please note that only letters to the Editor commenting on papers published in *Epilepsy & Behavior* will be considered for publication.

Ethics and policies

Ethics in publishing

Authors must follow ethical guidelines stated in [Elsevier's Publishing Ethics Policy](#).

Submission declaration

When authors submit an article to an Elsevier journal it is implied that:

- the work described has not been published previously except in the form of a preprint, an abstract, a published lecture, academic thesis or registered report. See our policy on [multiple, redundant or concurrent publication](#).
- the article is not under consideration for publication elsewhere.
- the article's publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out.
- if accepted, the article will not be published elsewhere in the same form, in English or in any other language, including electronically, without the written consent of the copyright-holder.

To verify compliance with our journal publishing policies, we may check your manuscript with our screening tools.

Authorship

All authors should have made substantial contributions to all of the following:

1. The conception and design of the study, or acquisition of data, or analysis and interpretation of data.
2. Drafting the article or revising it critically for important intellectual content.
3. Final approval of the version to be submitted.

Authors should appoint a corresponding author to communicate with the journal during the editorial process. All authors should agree to be accountable for all aspects of the work to ensure that the questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Declaration of competing interests

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence or bias their work. Examples of potential competing interests include:

- Employment
- Consultancies
- Stock ownership
- Honoraria
- Paid expert testimony
- Patent applications or registrations
- Grants or any other funding

- Affiliation with the journal as an Editor or Advisory Board Member

The [declarations tool](#) should always be completed.

Writing and formatting

File format

We ask you to provide editable source files for your entire submission (including figures, tables and text graphics). Some guidelines:

- Save files in an editable format, using the extension .doc/.docx for Word files and .tex for LaTeX files. A PDF is not an acceptable source file.
- Format Word files in a single-column layout. Double-column formatting is only permitted for LaTeX submissions.
- Remove any strikethrough and underlined text from your manuscript, unless it has scientific significance related to your article.
- Use spell-check and grammar-check functions to avoid errors.

We advise you to read our [Step-by-step guide to publishing with Elsevier](#).

Title page

You are required to include the following details in the title page information:

- Article title. Article titles should be concise and informative. Please avoid abbreviations and formulae, where possible, unless they are established and widely understood, e.g. DNA.
- Author names. Provide the given name(s) and family name(s) of each author. The order of authors should match the order in the submission system. Carefully check that all names are accurately spelled. If needed, you can add your name between parentheses in your own script after the English transliteration.
- Affiliations. Add affiliation addresses, referring to where the work was carried out, below the author names. Indicate affiliations using a lower-case superscript letter immediately after the author's name and in front of the corresponding address. Ensure that you provide the full postal address of each affiliation, including the country name and, if available, the email address of each author.
- Corresponding author. Clearly indicate who will handle correspondence for your article at all stages of the refereeing and publication process and also post-publication. This responsibility includes answering any future queries about your results, data, methodology and materials. It is important that the email address and contact details of your corresponding author are kept up to date during the submission and publication process.
- Present/permanent address. If an author has moved since the work described in your article was carried out, or the author was visiting during that time, a "present address" (or "permanent address") can be indicated by a footnote to the

author's name. The address where the author carried out the work must be retained as their main affiliation address. Use superscript Arabic numerals for such footnotes.

Abstract

You are required to provide a concise and factual abstract which does not exceed 250 words. The abstract should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:

- Abstracts must be able to stand alone as abstracts are often presented separately from the article.
- Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
- Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

Keywords

You are required to provide 1 to 7 keywords for indexing purposes. Keywords should be written in English. Please try to avoid keywords consisting of multiple words (using "and" or "of").

We recommend that you only use abbreviations in keywords if they are firmly established in the field.

Highlights

You are encouraged to provide article highlights at submission.

Highlights are a short collection of bullet points that should capture the novel results of your research as well as any new methods used during your study. Highlights will help increase the discoverability of your article via search engines. Some guidelines:

- Submit highlights as a separate editable file in the online submission system with the word "highlights" included in the file name.
- Highlights should consist of 3 to 5 bullet points, each a maximum of 85 characters, including spaces.

We encourage you to view example [article highlights](#) and read about the benefits of their inclusion.

Graphical abstract

You are required to provide a graphical abstract at submission.

The graphical abstract summarizes the contents of your article in a concise, pictorial, professional form, highlighting important aspects of the research. It is designed to appeal to an interdisciplinary audience, and draw more attention to your online article. Some guidelines:

- Ensure you have obtained the necessary permission to include any third party owned material in a graphical abstract.
- Use of generative AI or AI-assisted tools in the production of graphical abstracts must align with Elsevier's [GenAI Policies for Journals](#).
- Submit your graphical abstract as a separate file in the online submission system.
- Ensure the image is 531 x 1328 pixels (h x w) or proportionally more, and is readable at a size of 5 x 13 cm.
- Preferred file types for graphical abstracts are TIFF, EPS, PDF or MS Office files.

More information, examples and a template can be found in the [graphical abstract guidelines](#).

Tables

Tables must be submitted as editable text, not as images. Some guidelines:

- Place tables next to the relevant text or on a separate page(s) at the end of your article.
- Cite all tables in the manuscript text.
- Number tables consecutively according to their appearance in the text.
- Please provide captions along with the tables.
- Place any table notes below the table body.
- Avoid vertical rules and shading within table cells.

We recommend that you use tables sparingly, ensuring that any data presented in tables is not duplicating results described elsewhere in the article.

Supplementary material

We encourage the use of supplementary materials such as applications, images and sound clips to enhance research. Some guidelines:

- Supplementary material should be accurate and relevant to the research.
- Cite all supplementary files in the manuscript text.
- Submit all supplementary materials at the same time as your manuscript.
- Include a concise, descriptive caption for each supplementary file, describing its content.
- After submission supplementary files can only be added or replaced in the revision stage of the editorial process.

- Be aware that all supplementary materials provided will appear online in the exact same way as received. These files will not be checked, formatted or typeset by the production team.

Data statement

To foster transparency, you are encouraged to state the availability of any data at submission.

Ensuring data is available may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you can state the reason why (e.g., your research data includes sensitive or confidential information such as patient data) during the submission process. This statement will appear with your published article on ScienceDirect.

Read more about the importance and benefits of providing a [data statement](#).

Article structure

Article sections

- Divide your article into clearly defined and numbered sections. Number subsections 1.1 (then 1.1.1, 1.1.2, ...), then 1.2, etc.
- Use the numbering format when cross-referencing within your article. Do not just refer to "the text."
- You may give subsections a brief heading. Headings should appear on a separate line.
- Do not include the article abstract within section numbering.

Footnotes

We advise you to use footnotes sparingly. If you include footnotes in your article, ensure that they are numbered consecutively.

You may use system features that automatically build footnotes into text. Alternatively, you can indicate the position of footnotes within the text and present them in a separate section at the end of your article.

Acknowledgements

Include any individuals who provided you with help during your research, such as help with language, writing or proof reading, in the acknowledgements section.

Acknowledgements should be placed in a separate section which appears directly before the reference list. Do not include acknowledgements on your title page, as a footnote to your title, or anywhere else in your article other than in the separate acknowledgements section.

Appendices

We ask you to use the following format for appendices:

- Identify individual appendices within your article using the format: A, B, etc.
- Give separate numbering to formulae and equations within appendices using formats such as Eq. (A.1), Eq. (A.2), etc. and in subsequent appendices, Eq. (B.1), Eq. (B. 2) etc. In a similar way, give separate numbering to tables and figures using formats such as Table A.1; Fig. A.1, etc.

References

References within text

Any references cited within your article should also be present in your reference list and vice versa. Some guidelines:

- References cited in your abstract must be given in full.
- We recommend that you do not include unpublished results and personal communications in your reference list, though you may mention them in the text of your article.
- Any unpublished results and personal communications included in your reference list must follow the standard reference style of the journal. In substitution of the publication date add "unpublished results" or "personal communication."
- References cited as "in press" imply that the item has been accepted for publication.

Linking to cited sources will increase the discoverability of your research.

Before submission, check that all data provided in your reference list are correct, including any references which have been copied. Providing correct reference data allows us to link to abstracting and indexing services such as Scopus, Crossref and PubMed. Any incorrect surnames, journal or book titles, publication years or pagination within your references may prevent link creation.

We encourage the use of Digital Object Identifiers (DOIs) as reference links as they provide a permanent link to the electronic article referenced.

Reference style

Indicate references by number(s) in square brackets in line in the text. You can refer to author names within your text, but you must always give the reference number, e.g., "as demonstrated [3,6]. Barnaby and Jones [8] obtained a different result".

Number the references in the reference list in the order in which they appear in the text.

Please note the shortened form for last page number. e.g., 51-9, and that for more than 6 authors the first 6 should be listed followed by 'et al.'.

For further details you are referred to 'Uniform Requirements for Manuscripts submitted to Biomedical Journals' (J Am Med Assoc 1997;277:927-34) and [more samples of formatted references](#).

Abbreviate journal names according to the [List of Title Word Abbreviations](#) (LTWA).

Examples:

Reference to a journal publication:

[1] Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific article. J Sci Commun 2020;163:51-9. <https://doi.org/10.1016/j.sc.2020.00372>.

Reference to a journal publication with an article number:

[2] Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific article. Heliyon. 2022;19:e00205. <https://doi.org/10.1016/j.heliyon.2022.e00205>.

Reference to a book:

[3] Strunk Jr W, White EB. The elements of style. 4th ed. New York: Longman; 2000.

Reference to a chapter in a book:

[4] Mettam GR, Adams LB. How to prepare an electronic version of your article. In: Jones BS, Smith RZ, editors. Introduction to the electronic age, New York: E-Publishing Inc; 2023, p. 281-304.

Reference to a website:

[5] Cancer Research UK. Cancer statistics reports for the UK, <http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/>; 2023 [accessed 13 March 2023].

Reference to a dataset:

[6] Oguro M, Imahiro S, Saito S, Nakashizuka T. Mortality data for Japanese oak wilt disease and surrounding forest compositions [dataset]. Mendeley Data. 2015. <https://doi.org/10.17632/xwj98nb39r.1>.

Reference to software:

[7] Coon E, Berndt M, Jan A, Svyatsky D, Atchley A, Kikinzon E, et al. Advanced Terrestrial Simulator (ATS). Version 0.88 [software]. Zenodo; 2020 Mar 25. <https://doi.org/10.5281/zenodo.3727209>.

Web references

When listing web references, as a minimum you should provide the full URL and the date when the reference was last accessed. Additional information (e.g. DOI, author names, dates or reference to a source publication) should also be provided, if known.

You can list web references separately under a new heading directly after your reference list or include them in your reference list.

Data references

We encourage you to cite underlying or relevant datasets within article text and to list data references in the reference list.

When citing data references, you should include:

- author name(s)
- dataset title
- data repository
- version (where available)
- year
- global persistent identifier

Add [dataset] immediately before your reference. This will help us to properly identify the dataset. The [dataset] identifier will not appear in your published article.

Preprint references

We ask you to mark preprints clearly. You should include the word "preprint" or the name of the preprint server as part of your reference and provide the preprint DOI.

Where a preprint has subsequently become available as a peer-reviewed publication, use the formal publication as your reference.

If there are preprints that are central to your work or that cover crucial developments in the topic, but they are not yet formally published, you may reference the preprint.

Appendix G

Ethical Approval



Research Office

Project ID: 4002

Dr Georgia Richard,
St James's Hospital

Approval Date: 1 July 2024

Submission Number: 3566

Submission Title: Quality of life, Unmet needs, Awareness and Stigma in Homeless people with Epilepsy (QUASH-Epilepsy)

Submission Date: 20.May.2024 21:29

Dear Dr Richard,

On behalf of the Chair and members of the SJH/TUH Joint Research Ethics Committee I wish to inform you that your study has received **FULL APPROVAL**. Your study can now proceed.

The following documents were reviewed and approved:

Document Type	File Name	Date	Version
Participant Information Leaflet	PIL QUASH Patient RC 14.5.24	14.May.2024	2
Participant Consent Form	Consent RC 14.5.24	14.May.2024	2

Please note that ethical approval for this study is only active under the following conditions:

1. Applicants must submit an annual report for ongoing projects.
2. Applicants must submit an end of study declaration/end of study report upon completion of the study.
3. All adverse events must be reported to the JREC.
4. All changes (minor and substantial) to documentation/study must be submitted to the JREC using the amendment request form and the changes must be tracked/highlighted clearly. Approval from the JREC is required before implementation of the changes.

It is the responsibility of the researcher/research team to ensure all aspects of the study are executed in compliance with the General Data Protection

regulation (GDPR), Health Research Regulations and the Data Protection Act 2018.

Yours sincerely,

Dr Sadhbh O'Neill

Research Ethics & Clinical Trials Manager,

SJH/TUH Joint Research Ethics Committee

The SJH/TUH Joint Research and Ethics Committee operates in compliance with and is constituted in accordance with the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 & ICH GCP guidelines.

Appendix H

Ethical Approval Received from UCC



10 September 2025

Coláiste na nEalaíon, an Léinn Cheiltigh
agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies
and Social Sciences

Scoil an Síceolaíochta Feidhmi
School of Applied Psychology

University College Cork,
Cork, Ireland.

T +353 (0)21 490 4551 / 4552
E infoapsych@ucc.ie
<http://www.ucc.ie/en/apsych/>

Dear Rebekah,

Your application for an approval of an amendment to the protocol for interviewing participants for your research project (approved by Tallaght University Hospital 3566) has been reviewed and is approved.

With best wishes for the next stage of your research,

A handwritten signature in blue ink, appearing to read 'S. Dockray', is written over a light blue circular stamp.

Dr Samantha Dockray

Chair of CP-REC

Appendix I

Easy Read Participant Leaflet

RESEARCH STUDY

ARE YOU IMPACTED BY HOMELESSNESS? AND DO YOU HAVE A DIAGNOSIS OF EPILEPSY?

IF YES....

- We want to learn about **your** experience with homelessness and epilepsy.
- This will help us understand what is important to you and how services might help in the future.



WHAT DO I HAVE TO DO?

- We are looking for people who might talk about their experiences via interview with one of our researchers.
- The interview can happen at a time and place that suits you.
- You can choose to not answer specific questions and/or leave the interview at any time.



INTERESTED?

- Contact Rebekah Corscadden, Trainee Psychologist & Primary Researcher: **087-6610359**
- Or please tell a member of staff at your service and they will let the researcher know.



Appendix J
Participant Information Leaflet (aligned with St James's Hospital PIL)

QUASH-Epilepsy.v10



Patient Information Leaflet

STUDY TITLE: Quality of life, Unmet needs, Awareness and Stigma in Homeless adults with Epilepsy (QUASH-Epilepsy)

NAME OF PRINCIPAL INVESTIGATORS:

Ms Rebekah Corscadden (Psychologist in Clinical Training, UCC)

Dr. Fiadhnaít O'Keeffe (Senior Lecturer, UCC & Principal Specialist Neuropsychologist)

Prof. Clíona Ní Cheallaigh (Consultant in Inclusion Health, St James's Hospital, 014103000)

Dr Georgia Richard (Neurology Specialist Registrar, St James's Hospital, 014103000)

What is this leaflet about?

You are being asked to participate in a research study. To decide if you should agree to be part of this research study, you should know enough about its risks and benefits to make a sound judgment. This process is known as informed consent.

The current study has received approval from Clinical Psychology Research Ethics Committee, University College Cork and from St James's Hospital Research Ethics Committee. This study forms part of a larger research project conducted in St James's Hospital that is trying to understand how people with epilepsy are affected by their condition, and if this is different for people impacted by homelessness. This information leaflet form gives you detailed information about one part of the research project.

Once you understand the study, its risks, and its benefits, you will be asked to sign the form if you wish to take part. You will be given a copy to keep.

Thank you for taking the time to read this.

QUASH-Epilepsy.v10



PART 1 – THE STUDY

WHY IS THIS STUDY BEING DONE?

- To understand what it is like to live with epilepsy as a person experiencing homelessness.

WHY HAVE I BEEN CHOSEN TO PARTICIPATE IN THIS STUDY?

You have been chosen to participate as you have a diagnosis of epilepsy and are impacted by homelessness.

WHAT HAPPENS IF I VOLUNTEER TO PARTICIPATE?

If you volunteer to participate, you will take part in an interview where we will talk about your personal experience of living with epilepsy while homeless. Understanding your experience will help us understand what psychological or social support might be helpful in making sure services can meet these needs.

This interview may be done in-person, or via telephone, depending on what suits your own availability and preference, and the availability of the researcher.

ARE THERE ANY RISKS INVOLVED IN PARTICIPATING?

You may be **upset** by some of the questions we ask about your past or your life now. You can skip any questions that you would prefer not to answer. If you feel upset during or after the interview, please let us or the organisation who referred you to us know and we will arrange for someone to contact you to offer support.

ARE THERE ANY BENEFITS INVOLVED IN PARTICIPATING?

There may not be any major direct benefits to you from participating or taking part in this study. **You may enjoy the opportunity to talk about your life.** On the basis of this study, we intend to share these findings widely so service providers can understand what might be helpful in supporting others impacted by homelessness and epilepsy.

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**WHAT HAPPENS IF I DO NOT AGREE TO PARTICIPATE?**

Participation in this study is on a **voluntary basis**. If you do not agree to participate this will not have any impact on your care in your hostel or with your keyworkers, doctors, or nurses.

CAN I STOP BEING IN THE STUDY?

You may withdraw or **quit this study at any time**, and this will have no impact on your care in your hostel or with your keyworkers, doctors, or nurses.

Taking part in this study will also not affect how your keyworkers, doctors and nurses look after you.

WILL MY PARTICIPATION BE CONFIDENTIAL?

Your identity will remain **confidential**. All personal information and data will be kept confidential. Your name will not be published and will not be disclosed to anyone outside the research team. Only the researcher you meet with for interview will know the identity of those who participate. Codes will be used to hide identities in all external communications. We will take care that there are no details which can be used to identify you in anything that we share outside the small team that is carrying out the study.

An exception to this is if anything related to **child safety** is raised, in which case the investigators have an obligation to report these to TUSLA. Similarly, if you give me information that indicates you are going to do something to hurt yourself or others, I may need to notify the proper authorities to make sure you and others are safe.

PART 2 – DATA PROTECTION**WHAT INFORMATION ABOUT ME WILL BE USED AS PART OF THIS STUDY?**

We plan to collect and use the following personal data from you:

- Your age
- Your sex

QUASH-Epilepsy.v10



- We will talk about your social circumstances including housing, your medical diagnoses, and your experience of these.

WHAT WILL HAPPEN TO MY PERSONAL DATA?

Only information that is needed to achieve the study goals will be collected. We will make sure that this is the case by using a standard consent form for all study participants.

If a data breach took place, it would be possible for a 3rd party access your personal information. We are taking multiple steps to ensure that this does not happen, by ensuring that study computers are password-protected and ensuring that all documents containing personal information are stored on secure platforms.

WHO WILL ACCESS AND USE MY PERSONAL DATA AS PART OF THIS STUDY?

If you agree to take part in the interview component of this study, Rebekah Corscadden and Dr Fiadhnaít O'Keeffe will access and use your personal data as described above.

The findings of this study will be shared with the wider research team, Dr Georgia Richard and Professor Clíona Ní Cheallaigh, who are medical professionals based in St James's Hospital. The findings from this study will be included in their research outcomes. Your identity will always remain anonymous.

WILL MY PERSONAL DATA BE KEPT CONFIDENTIAL? HOW WILL MY DATA BE KEPT SAFE?

A Data Protection Impact Assessment has been completed for this project and has been submitted to the St James's Data Protection Officer, and the level of risk assessed was low. A Data Protection Impact Assessment has also been completed and has been submitted to the Clinical Psychology Research Ethics Committee.

The results of this study will be published in relevant journals and presented at conferences. You will not be able to be identified on the basis of the results that are published or presented.

If you agree to take part in the interview, the following processes will take place to protect your personal data: interviews will be pseudonymised at the point of collection by Rebekah Corscadden, Trainee Clinical Psychologist UCC. The pseudonymisation key will be stored on a password-protected, Excel file on UCC OneDrive with restricted access by primary researcher, Rebekah Corscadden. Your

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name will not be recorded, and you will be identified by a specific study number. Other details including your age and gender will be recorded alongside this study number.

The interview will be recorded using a dictaphone. Recordings will be uploaded to UCC OneDrive and deleted from the dictaphone. Recordings will be deleted from UCC OneDrive once transcription is complete. This pseudoanonymised transcribed data will be stored on UCC OneDrive with restricted access to researchers, Ms Rebekah Corcadden and Dr Fiadhnaith O'Keeffe. In line with UCC Research Code of Conduct, this data will be stored for 10 years and subsequently deleted after this period.

WHAT IS THE LAWFUL BASIS TO USE MY PERSONAL DATA?

Your Personal Data will be processed under Article 6(1)(e) "processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller" and your Special Category Personal Information will be processed under Article 9(2)(j) "processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject." Of GDPR.

WHAT ARE MY RIGHTS?

- Right to access the data held and to obtain a copy of the data
- Right to restrict or object to processing
- Right to have any inaccurate information corrected or deleted
- Right to have data deleted
- Right to portability – right to move data from one controller to another in a readable format
- Right to withdraw consent
- Right to lodge a complaint with the Data Protection Commissioner

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PART 3 – COSTS, FUNDING & APPROVAL

WILL IT COST ME ANYTHING TO TAKE PART?

It will not cost you any money to take part in this study. There is no reimbursement available for your participation.

WHO IS FUNDING THIS RESEARCH?

There is no specific funding associated with this research project. Data collected for this study will not be used for commercial purposes.

HAS THIS STUDY BEEN REVIEWED BY AN ETHICS COMMITTEE?

This study has been approved by the St James's and AMNCH Research and Ethics board. This Research and Ethics board can be contacted at ResearchEthics@tuh.ie.

This study has also been approved by the Clinical Psychology Research & Ethics Committee, University College Cork for recruitment in non-governmental organisations providing services to people impacted by homelessness in Cork.

FUTURE RESEARCH

Your personal data will not be used for future research.

CONTACT DETAILS

If you have any further questions about the study, wish to make a complaint or express concerns about any aspect of this study, or if you want to opt out of the study, please contact **Rebekah Corscadden**:

Email: 121100544@umail.ucc.ie

Phone: 087 661 0359

**Appendix K
Participant Consent Form**

QUASH-Epilepsy.v10



Participant Informed Consent for Clinical Research

STUDY TITLE: Quality of life, Unmet needs, Awareness and Stigma in Homeless adults with Epilepsy (QUASH-Epilepsy)

NAME OF PRINCIPAL INVESTIGATORS:

Prof. Cliona Ní Cheallaigh (Consultant in Inclusion Health, 014103000)

Dr Georgia Richard (Neurology Specialist Registrar, 014103000)

Dr. Fiadhnaít O’Keeffe (Senior Lecturer, UCC & Principal Specialist Neuropsychologist)

Ms. Rebekah Corscadden (Psychologist in Clinical Training, UCC, HSE)

CONTACT DETAILS

Name: Rebekah Corscadden

Address: University College Cork, Distillery House, North Mall, Sunday’s Well, Cork

Email: 121100544@umail.ucc.ie

Name: Georgia Richard

Address: Office 1.02A Dept of Clinical Medicine, Trinity Centre for Health Sciences, St. James’s Hospital, Dublin 8

Email: cipher.study.ireland@gmail.com

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**PARTICIPANT CONSENT FORM****PLEASE TICK YOUR RESPONSE IN THE APPROPRIATE BOX**

I have read and understood the Participant Information Leaflet	☐ Yes	☐ No
I have had the opportunity to ask questions and discuss the study	☐ Yes	☐ No
I have received satisfactory answers to all my questions	☐ Yes	☐ No
I have received enough information about the study	☐ Yes	☐ No
I know how to contact the research team if I need to	☐ Yes	☐ No
I understand that I am free to withdraw from the study at any time without giving a reason.	☐ Yes	☐ No
I understand that there are no direct benefits to me from participating in this study.	☐ Yes	☐ No
I consent to take part in the study, having been fully informed of the risks, benefits and purpose of the study as set out in the information leaflet with which I have been provided.	☐ Yes	☐ No

I give explicit consent to have my personal data (only data necessary for this study) being processed for the purpose of this research study.	☐ Yes	☐ No
I agree to data collection, including personal data collection, using semi-structured interview as detailed in the PIL	☐ Yes	☐ No
I understand my data will kept for a maximum of 10 years then deleted, complying with strict data regulations.	☐ Yes	☐ No
I understand that if I disclose anything that raises serious concerns about child abuse or neglect, Tusla will be notified according to Children First Act.	☐ Yes	☐ No

I understand that if I indicate that I am going to do something to hurt myself or others, the proper authorities may need to be notified to make sure that I and others are safe.	☐ Yes	☐ No
I understand that I will not be paid for my time and/or the use of the data collected in this study.	☐ Yes	☐ No
I understand that the results from analysis of my personal data will contribute to the partial fulfilment of a Doctoral Thesis for the Doctorate in Clinical Psychology Programme, UCC.	☐ Yes	☐ No

Participant signature:

Date:

Participant's Name in print:

To be completed by the **RESEARCHER**:

I have fully explained the purpose and nature (including benefits and risks) of this study to the participant in a way that he/she could understand. I have invited him/her to ask questions on any aspect of the study.	YES Y	NO Y
I confirm that I have given a copy of the information leaflet and consent form to the participant.	YES Y	NO Y

Researcher's Name (Block Capitals):	
Researcher's Title & Qualifications:	
Researcher's Signature:	
Date:	

Appendix L

Interview Schedule

Introduction

Thank you for agreeing to take part in this research project. I am going to ask you some questions about your experiences of having epilepsy while managing homelessness. I would really like to understand what this has been like for you, though it is up to you how much you would like to tell me.

If there is anything you would prefer not to answer, then you do not have to, it's completely your choice. You can take your time answering, there is no rush. If at any point you feel uncomfortable or would like to stop, please let me know and we can take a break. You are also welcome to completely stop the interview and withdraw from the research study at any time during our conversation, and you also have the right to withdraw from the study within two weeks of the interview without giving a reason.

If I notice you becoming upset, I will ask you if you are alright and if you would like to take a break. The interview should take around 1 hour and at the end of the interview, I will spend some time talking to you about other things and ensure that you feel safe and happy to finish. Do you have any questions before we begin?

Topic 1: Lived Experience of Epilepsy

1. Can you tell me about when and how you came to get a diagnosis of epilepsy?

Possible prompts: How did you feel about it? Can you remember when you first noticed something was different about your health? How have you made sense of the diagnosis over time?

2. How does epilepsy affect you day-to-day?

Possible prompts: Can you walk me through what it is like for you to have a seizure? What sensations or thoughts do you have before or after? How do you make sense of what happens? How do you manage them?

3. How has getting a diagnosis of epilepsy changed the way you see yourself?

Possible prompts: Has it affected your mental or physical well-being?

5. Can you tell me about how epilepsy has affected your relationships with others?

Possible prompts: How do you feel other people act when you have a seizure? How do you feel about their reactions? What goes through your mind during these times?

Topic 2: Experiences of Homelessness

6. Can you tell me about your experience of homelessness?

Possible prompts: What does a typical day look like for you? What are the biggest challenges? What keeps you going?

7. How has the experience of homelessness shaped the way you see yourself?

Possible prompts: Has it changed the way you think or feel about yourself?

8. How do you think other people in society see you as a person experiencing homelessness?

Possible prompts: What do you think goes through their minds? How does that make you feel?

Topic 3: Intersection of Epilepsy and Homelessness

9. Can you describe how being homeless has shaped the way you live with epilepsy?

Prompt: How does it affect managing your health, going to appointments, or getting medication? What are some of the biggest challenges?

10. Has epilepsy impacted your experience of homelessness? If so, in what ways?

Prompt: What are the main differences in your life before and after developing epilepsy? Can you tell me about a time when having epilepsy made homelessness particularly difficult? What happened, how did you feel? How did you get through it?

11. What have you found helpful in managing epilepsy and homelessness? What has been particularly difficult in managing epilepsy and homelessness?

Possible prompts: Are there any strategies, services or people who have been particularly supportive? What do you think would make a difference?

12. How do you see your future while managing epilepsy and homelessness?

Possible prompts: Can you describe what you hope for? What worries you? What would need to change for things to improve?

13. If you could recommend things that government or services could do to make improvements for the homelessness community who have epilepsy, what would that look like?

Possible prompts: What do you wish professionals understood? What would make the biggest difference in your life? Is there anything that you would like people in the public to know about this experience?

14. Is there anything else you would like to tell me about that I might have missed?**Debrief and interview close**

Thank you for taking the time to take part in this research today. Over the coming months, I will be analysing all of the interviews to see shared experiences, as well as differences, in how people understand and manage epilepsy alongside homelessness. The findings will be written up and submitted for publication, with the aim of informing services and supporting more responsive and appropriate care.

I appreciate you sharing your experiences. How are you feeling after taking part today?

If anything discussed today has stayed with you or raised any concerns, you may find it helpful to speak with your GP or your key worker. I can also provide you with a debrief sheet that includes information about available supports.

Appendix M

Example Reflective Log

Reflective Journal – Research

Six recruitment attempts from Cork to St James's Hospital.

Interesting parallel as an external researcher coming into a busy medical environment, not knowing where to go, wandering around to find location, confusing directions etc– (on a much smaller and less significant scale) reflective of how people experiencing homelessness might feel when trying to access unfamiliar services.

When conducting the interview – the challenge in transitioning from a clinician to a researcher. Supporting the participant to tell their story without providing leading questions / exploring in ways that would be more common in a therapeutic encounter. Navigating boundaries of disclosures of past crimes and trying to respond appropriately (no risk of harm to vulnerable people identified) – ultimately acknowledging that this is part of their story, and their history led them to these experiences, the need to respect this.

The reality of what it means to conduct research with this population. Naivety thinking recruitment would be manageable, while the process demonstrated how many factors contribute to people's difficulty in attending services. When I think about the cognitive processes required to make appointments (the executive function, planning and organising, remembering, maintaining motivation, figuring out way to get to the hospital) and the challenges people experiencing homelessness are more likely to endure (e.g. brain injury, epilepsy, active addiction) that make all these things more difficult.

Difficulty navigating the multiple demands of conducting research within a medical setting – possibility of interruptions, noises, shared spaces in the ward. Challenge for me, the researcher, in maintaining calmness and attention on the participant amidst all of these distractions. Resisting internal urge to resist clinical intervention to help.

Realising during the first interview that the interview schedule needed to be revised. The language was not accessible enough and some questions were too abstract. Needed to be revised to support them to relay their psychological experience in a more comfortable way for participants.

Appendix N

Example of Analytic Memoing in Theme Development

The following excerpt provides an example of analytic memoing, capturing interpretative comments developed during the analysis during movement from descriptive observations to higher-order conceptualisations

In homelessness, when faced with risk, instability, threat - all you have is bad choices, and you have to choose the 'least bad' choice to try survive psychologically and physically. E.g. substances to manage the isolation

Refusal to participate in the expectations of institutions... You can be competent and not use your skill... You can have knowledge and refuse to be the educator

Sense of building self-worth from within, while still hedging around connection with others

Consistent attempts to re-assert boundaries within the interview, challenge the interviewer – left me feeling exposed ?

Violence only as situational, desire to avoid

Sensitive to having interpretation imposed on him – he is the owner of his narrative and resists anything that suggests otherwise

Finding some level of control and adaptation in understanding illness, unique triggers, listening to the body

The loneliness of homelessness without substances

Substances as an imperative if you want to survive the experience

Then these substances contributing to the worsening of epilepsy

Substances as coping and as threat