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The Kindred Bonds of Mentally Ill Homeless Persons

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While the unraveling of the kinship bond has long been suspected to play a role in the epidemiology of homelessness, the connection between kinship and homelessness has been little studied. Based on a normative analysis of the role of family structure in response to adversity, this article explores the impact of the amount and quality of kinship ties on episodes of homelessness experienced by discharged psychiatric patients in Ohio. Survey data derived from personal interviews with both former patients and their kin indicate more strain in relations with kin of the homeless than the nonhomeless. The strain in the kinship bond appears to emanate from a greater prevalence of chronic disabilities that undermine independent functioning and tax the resources of relatives who choose to remain involved. Consistent with this interpretation, patients with histories of homelessness reported more psychiatric symptoms, more deficits in daily living skills, and more contact with the criminal justice system. In general, patient variables were better able than family variables to differentiate the homeless from the nonhomeless. Nonetheless, the formulation of public policies for reducing the incidence and prevalence of homelessness will surely need to take account of the kinship bond and how it can be strengthened.

All through its history, the United States has had homeless persons, the number and composition varying from period to period. Contemporary homelessness has special characteristics that reflect current social trends. First, homeless persons are currently more visible because there are more of them and present police practices do not confine the homeless to skid row. Although there

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were many homeless in the Great Depression, in the prosperous post World War II decades the number of homeless declined to the point that observers predicted the demise of skid rows by the middle 1970s. However, contrary to expectations, homelessness increased dramatically in the 1980s. Encountering the homeless on the streets and in public places became a commonplace event in everyday urban experiences. Second, the characteristics of homeless individuals of the current period are different from those of the past. The post-World War II homeless population was dominated by old men — average age in the fifties — living in single-room-occupancy and flophouse hotels and showing high rates of alcoholism.¹ In the nineties, the average age of homeless persons is in the middle thirties, half or more are from nonwhite ethnic groups, a quarter or more are women, and a third to a half command at least a high school education.²

Most observers agree that contemporary homelessness is largely the outcome of three major, mutually amplifying social trends: the diminishing supply of low-cost housing, especially in inner cities; changes in the economy lowering demand for employment of unskilled persons; and a sharp decline in the real value of entitlement benefits.³ The end result in the 1980s was a drastic increase in the number of Americans in extreme poverty, some of whom became homeless.

Not all the extremely poor become homeless; only a small minority do. The majority manage to obtain shelter and subsistence through the material help given to them by their kin and friends. Indeed, homelessness is a sign that our kinship ties sometimes fail either to exist or to function. First, several observers note that larger-than-expected proportions of the homeless received out-of-home placement in foster care or group homes.⁴ For these, there were no kinship ties to fall back on. Second, as adults, many others have posed greater burdens than their primary kin could sustain: kinship obligations are strong but not indestructible.⁵ It is especially significant that the homeless manifest high levels of disabilities that are likely burdensome to their kin.

This article is concerned particularly with the relationship of chronic mental illness and homelessness. Virtually all researchers find that serious mental illness affects a minority, albeit sizable, among the homeless.⁶ By the same token, there is also much indication that the homeless are overrepresented among the mentally ill. For example, one recent study of patients admitted to a New York State mental hospital reported a rate of prevalence of homelessness of 19 percent in the three months preceding admission.⁷

Serious chronic mental illness is a disability that is an obstacle to achieving independent living. Employment opportunities are reduced. Self-care may be impeded. The capacity for social relationships may be severely diminished. Although income maintenance and human services programs can compensate for these problems to some extent, for many adults with serious mental disorders, their families of origin continue to represent a crucial social resource whose importance extends well past the transition to young adulthood. Without mental hospitals to take continuing responsibility for patient management, it is inevitable that former patients as well as community mental health workers turn to primary kin — parents, spouses, and children — during times of crisis. Whether primary kin are identifiable and accessible, and how they respond to requests for assistance, is often pivotal to whether a vulnerable and dependent adult joins the ranks of the homeless.

Strain in relations to primary kin is problematic as such (nobody wants to see family bonds unravel) but especially for vulnerable groups such as the severely men-

tally ill to whom the family may be the first line of defense against adversity. Linda Stoneall observed that deinstitutionalized mentally ill persons and their families oscillate between periods of closeness typified by assistance and periods of separation in which estrangement is the norm.⁸ Separation may occur when a mentally ill person rejects the demands and conditions of support imposed by family members or when family members can no longer tolerate the mentally ill person's failure to comply with these demands. Thus, one logical end point may be abandonment of the patient by the family, or conversely, abandonment of the family by the patient.

While the kinship relations of the severely mentally ill may be strained, most patients are able to keep ties unbroken to at least some family members to whom they can turn during difficult times. What factors differentiate such kin ties from others that are broken or in the process of unraveling? To consider this problem, it is instructive to think about the normative contingencies that govern kindred relations in general.

Contemporary Kin Ties

Of all the social supports available to persons in any society, kinship ties are the most enduring. The mutual-support obligations existing between spouses are among the strongest, upheld both in law and custom. Accordingly, married couples share common residence, the same standard of living, and provide mutual support in many ways. The ties between parents and children, perhaps the strongest, are asymmetrical, at least as long as the child is a minor: In all fifty states, parents are obligated under law to provide support for children under the age of eighteen. Parents provide the basic necessities for their minor children and typically provide support well into early adulthood. Of course, an important difference between the marital and parental bonds is that the former can be terminated whereas the latter, in most cases, "is forever."⁹

Other kin relationships carry weaker obligations for support. Obligations to affinal kin — "in-laws" — derivative of the spousal bond, are weaker than for corresponding consanguinal kin and wither away after divorce. For Americans, the kindred sharing significant obligation levels excludes cousins of any degree or more remote kin. For all practical purposes, the kinship-support system includes spouses, parents, and children at its core, with minor ties to in-laws, siblings, grandparents and grandchildren, and uncles and aunts.

A kinship-support system works normally when members carry out the roles of their age and gender positions. Marriages become fragile when spouses cannot carry out their marital roles. Despite the recent changes in the common definitions of husband and wife roles, husbands who are unemployed and wives who cannot "keep house" often find themselves in the divorce courts.

Similarly, parents do not begrudge providing room and board to their minor children but may find an unemployed thirty-year-old living at home to be a burden. An adult might offer a sibling some temporary shelter during an episode of unemployment but balk at sharing a home indefinitely. In essence, adult kin are expected to be self-supporting financially and to form their own support kin networks through marriage and parenthood. Although this does not mean that adults cannot count at all on their kindred, it does mean that support is limited in duration and quantity. Primary kin may be those to whom an adult can turn for psychological support and temporary financial help, but long-term extensive care is problematic.

These characteristics of our kinship system have important implications for the care of adults with serious mental disorders. Typically, a person who is discharged from a mental hospital or other twenty-four-hour psychiatric setting is someone who has not been able to fulfill expectations concerning normal adult functioning. Many have never married. For those who did marry, the marriages typically were dissolved. Employment patterns before hospitalization were intermittent and precarious. After discharge, employment prospects may be even dimmer. Furthermore, these problems are not likely to go away in the near term. The major implication of these characteristics is that the obligations of primary kin toward severely mentally ill adults are limited. Surely every parent feels some responsibility toward his or her adult child, but that obligation is not all inclusive.

Further complicating matters may be the nature of the mental condition of the afflicted individual. Kinship obligations may be stated as a categorical imperative, but they are sustained to some degree by reciprocity. A withdrawn, self-centered person may need psychological support but may appear to the donor as an unresponsive recipient. If bizarre and erratic behavior is involved, continued contact may be unpleasant and possibly even risky. In short, seriously mentally ill persons often make unresponsive, unpredictable, and even unpleasant visitors, let alone housemates, a consequence that may further weaken an already tenuous kinship.

Generosity is also conditioned by capacity. The relatively affluent with their great discretionary income and large homes may have the greater capacity to extend aid to their kin, while those whose income is closer to subsistence and consequently living in closer quarters may not have as much capacity. As a consequence, the kinship-support systems of the poor are a fragile reed to count on for many adults with severe psychiatric problems. Under such conditions, we can anticipate that only the closest primary consanguinal kin will offer to incorporate a discharged mental patient into their households.

Maintaining social relationships of any depth can be expected to be problematic, and the more severe the mental disorder, the more fragile the relationship. This fragility is one of the main connections between chronic mental illness and the homeless. It is the generosity of those kin, largely parents, who act upon obligations going beyond the prescribed that makes it possible for many persons with serious mental disorders to live through episodes of adversity. When such episodes show promise of becoming long term and when the recipient is not a grateful recipient, the obligation can wither, throwing a mentally ill person on his or her own resources, a capacity too meager to sustain independent living.

Recent Research

Without firm knowledge of what are "normal" levels of contact with kin, it is difficult to interpret the findings of studies of the homeless or the mentally ill. The majority of homeless persons in recent studies report that they have been in contact with a family member or friend,¹⁰ but the extent or depth of these contacts is unclear. We do know that family involvement is largely restricted to consanguinal primary kin, since one to two thirds of all homeless persons have never married. Although contact is limited, kin appear to be more frequently utilized as sources of social support than friends. Homeless persons in Baltimore¹¹ and Detroit¹² were more likely to remain in contact with family members than to have friends with whom they were in

contact. Unfortunately, researchers typically do not offer detail on which kin are covered in the rubric "family," although we can venture that mainly primary kin are involved.

The study of family relationships is therefore important in and of itself, because kin are integral to the social networks of many homeless mentally ill persons. As such, the number and quality of these relationships, and the patterns of assistance that they provide, contribute — positively or negatively — to the quality of a former patient's life. For homeless mentally ill persons, relations to primary kin seem to be particularly strained. Researchers in Los Angeles¹³ found that homeless mentally ill individuals had more impoverished social supports (low contact with family/friends, poor relations with family, more negative early family experiences, and fewer feelings of attachment to kin) than the non-mentally ill homeless. Studies in Boston¹⁴ and Milwaukee¹⁵ found that mentally disabled homeless persons were less likely than non-mentally ill homeless persons to be in contact with relatives.

Peter Rossi's analysis of homelessness in Chicago led him to conclude that the unraveling of the kinship bond may take a number of years, hence is a gradual process ending with the exhaustion of the patience and tolerance of family and friends.¹⁶ He estimates that the average life of tolerance and help is about four years, that is, the average period of unemployment experienced before becoming homeless, a period during which family and friends provided housing, food, and other amenities.

The Approach

We examine the impact of the amount and quality of kinship ties on episodes of homelessness experienced by former patients. The data derive from interviews with both former patients and their kin. Although a number of previous studies of the mentally ill included "family involvement" as a variable, none actually conducted interviews with these family members. This is hardly surprising; interviewing family members of the homeless is difficult, because the subject matter is especially sensitive when kin ties have deteriorated. Furthermore, many former patients either do not have any living relatives or do not acknowledge their existence.

This article compares the kin ties of mentally ill persons who report recent episodes of homelessness with others who report no such history. Because family relationships are reciprocal and interactive, perceptions of the kinship bond are viewed from the perspectives of both the mentally ill person and their kin. From each of these perspectives, we examine whether the kin ties of the homeless are in fact more strained, and whether deterioration of the kinship bond can be explained in terms of general characteristics of mentally ill persons and their kin.

Methods

In mid-1988, as part of the National Evaluation of the Robert Wood Johnson Program on Chronic Mental Illness,¹⁷ a total of 283 patients from Cincinnati, Columbus, and Toledo, Ohio, were identified in Ohio state psychiatric hospitals or twenty-four-hour crisis care facilities using selection criteria that emphasized the acute nature of the patient's condition. Patients were interviewed shortly after discharge, at which time they were asked to name up to four members of their immediate family. If patients gave fewer than four names (most did), they were asked to name other rela-

tives or particularly close friends. Approximately 7 percent gave no names or addresses, stating that they had no family or friends. Another 10 percent declined to provide names and addresses, thereby refusing permission to interview any family or close friends. At the patient level, the analysis includes the former patients for whom at least one family/friend interview was completed as well as those who had no one to name. Those who refused to identify family or friends are excluded ($n = 31$).¹⁸ These criteria for inclusion and exclusion resulted in a total patient sample of 252. The patients were 51.6 percent male, 51 percent were under thirty-two years of age, 46.4 percent were black, 53.6 percent had twelve or more years of education, 15.9 percent were living with a spouse or partner, and 91.7 percent identified family or friends to be interviewed.

A total kin sample of 365 persons was interviewed (largely in person) between October 1989 and March 1990. The response rate for the kin study was 79 percent. The major categories of kinship were mother (30%), father (11%), sister (18%), and brother (12%). A variety of other kin relations were also represented (29%), including small numbers of daughters and sons, wives and husbands, aunts and uncles, grandmothers and grandfathers, nieces and nephews, cousins, in-laws, and the step and half relations of blended families.

The average age of the kin respondents was forty nine (48.58) years. More than two-thirds (68%) were female. As many as 39 percent had less than a high school education. Slightly more than half the kin respondents were black. The proportion of kin respondents currently living with a patient was 16.4 percent. Nearly a third (30.6%) reported 1988 household income as less than \$10,000.

While the profile of patients is similar to that of prior studies, the profile of kin differs from those of many prior studies of family members with mentally ill relatives in having a greater variety of kinship ties, less education, lower income, and a higher proportion of blacks.

Measuring Homelessness

To measure homelessness, the former patients were read a list of "places where people sometimes sleep when they have nowhere to stay," including "outside without shelter," "inside an empty building," "in a public shelter," and "in a church." Patients were asked whether they had slept in any of the four types of places in the year prior to hospitalization. A summary measure was constructed by combining answers to the four items, resulting in three categories: (1) never, or zero episodes of homelessness; (2) less than thirty nights in the previous year spent in a homeless condition; and (3) more than thirty nights homeless in the year prior to hospitalization.

Measuring Patient Characteristics

In addition to conventional demographic characteristics, the patient interviews obtained measures of the quality of relations with kin. "Satisfaction with family"¹⁹ was based on the following items: How do you feel about: (a) your family in general; (b) how often you have contact with your family; (c) the way you and your family act toward each other; (d) the way things are in general between you and your family? A seven-point scale with end points labeled "terrible" and "delighted" was used to record responses. The latter were averaged to create a summary index. The internal consistency (coefficient alpha) of the index was .903.

We also constructed a measure of each patient's "faith in their families," based on answers to "If you were in trouble, such as needing money, something to eat, or needing someone to talk to, who, if anybody, could you usually count on to help you out?" If a patient mentioned spontaneously a spouse/partner, parent, brother/sister, or another relative, the response was coded as 1 (0 otherwise).

Measures were also obtained to use as indicators of the seriousness of the patients' disabilities and of unemployment. An index of "deficits in living skills" was constructed by adding up affirmative responses to the following questions: In the month before you were admitted to the hospital did you need help: (a) with things like grooming, bathing, or dressing; (b) taking medicine; (c) with housework and laundry; (d) with things like shopping for groceries; (e) with cooking or preparing your meals; (f) with traveling to places you needed to go, like the doctor or to do errands; (g) managing your money; and (h) deciding how to spend your free time? The internal consistency (coefficient alpha) is .716.

The severity of the patients' conditions was further assessed using a measure of "psychiatric symptoms" constructed from thirty items from the Hopkins Symptom Checklist 90.²⁰ Patients were asked how much discomfort each problem had caused them during the past week. The problems represented in the thirty-item version of the SCL-90 cover psychotic thinking, paranoia, and depression. Some examples are "hearing voices that other people do not hear," "crying easily," "feeling that you are watched or talked about by others," and "feeling others do not understand you or are unsympathetic." Response categories were 1 = not at all; 2 = a little bit; 3 = moderately; 4 = quite a bit; and 5 = extremely. The reliability (alpha) of the summary index constructed by averaging all thirty responses is .936, indicating a high degree of internal consistency despite the variations in types of symptoms.

Contact with the criminal justice system was measured by self-reported "arrests," coded 1 (0 otherwise) if the patient reported being arrested or picked up by the police for any crimes during the past year, and "nights in jail" coded 1 (0 otherwise) if the patient reported spending at least one night in jail during the past year.

Patients' employability was measured by asking each patient whether he or she had "earned income" in 1988 or worked or been involved in a "work or training" program or any other work activities, whether paid or unpaid, during the past year. In both cases, responses were coded 1 if yes (0 otherwise).

Measuring Characteristics of Kin

To measure kin perception of their "involvement" with the patient, family members were asked, How deeply are you involved with [name of patient]? The response categories were 1 = not involved; 2 = slightly involved; 3 = somewhat involved; and 4 = very involved. To further define the content and extent of kin involvement in assisting former patients, kin were asked how often in the past thirty days they had helped by providing transportation, helping with shopping, preparing meals, helping with household chores, and offering advice. The index of "help provision" is an average of help given (alpha = .804).

Family members were also asked whether during the past thirty days they had personally paid for or given money to pay for each of a list of items ranging from typical everyday necessities, such as shelter and transportation, to personal needs, such as cigarettes and pocket money, and medical expenses. For each affirmative

response, the family member was asked to estimate the amount given. The sums involved were then added to create a summary measure of "money given" to the mentally ill relative.

To measure "positive attitudes" toward the patient, family members stated their agreement (1 = strongly disagree; 2 = disagree; 3 = ambivalent; 4 = agree; 5 = strongly agree) with the following items: (a) I enjoy being with [name of patient]; (b) I'm very proud of [name]; (c) [Name] makes me happy; (d) [Name] is pretty easy to get along with. Responses were averaged to construct a summary measure of attitudes toward the patient. The internal consistency (coefficient alpha) is .81.

A measure of "network support" was constructed from items, patterned after the General Social Survey, asking kin to identify up to five persons with whom they had discussed important matters over the last six months. For each relationship, we asked: During the past thirty days, did you and [discussion partner] discuss problems concerning [name of patient]? Affirmative responses were coded 1 (0 otherwise) and averaged across network relationships. The result can be interpreted as the percentage of personal network members with whom the respondent discussed the patient. The higher the percentage, the more it may be inferred that the respondent was sufficiently involved with the patient to share such concerns with others.

"Worry about the patient" summarizes responses to five items ($\alpha = .818$), reporting how much they worried (1 = not at all; 2 = a little; or 3 = a lot) about (a) the patient's safety, (b) not getting needed services, (c) having little or no social life, (d) poor physical health, and (e) current living arrangements.

To measure resources available to the family which may set limits on their generosity, kin respondents were asked to report total 1988 "household income" from all sources before taxes. "Household size," an indicator of physical resources, was a count of the total number of people, including the respondent, who were living in the respondent's household at the time of the interview. Social resources was indicated by "network size," which was a count of the number of discussion partners reported in the network inventory.

Results

Table 1 shows the prevalence of homelessness as reported by patients in interviews that took place shortly after discharge. The first column summarizes patients' combined homelessness experience. As shown, 78.2 percent said they had never been in a situation in which they had nowhere to stay. Just over 14 percent said they had in fact been in this situation, but not for more than a cumulative total of one month. The remaining 7.5 percent stated that they had been in this situation for at least one cumulative month or more in the preceding year. Thus, a total of 21.8 percent reported between one and 365 nights of homelessness in the year prior to admission. The median number of nights homeless was ten.

Table 1 also shows the places where homeless persons slept for at least one night. A total of 12.3 percent reported having slept outside without shelter, 5.2 percent said they had slept in an empty building, 15.1 percent said they had slept in a public shelter, and 1.6 percent said they had slept in a church. These are not mutually exclusive sleeping arrangements. For example, nearly one half (47.4 percent) of those patients who reported sleeping outside also reported use of a public shelter.

Table 1

**Place Slept by Frequency in Year Prior to Hospitalization
(n = 252)**

Frequency in Past Year	Combined Homelessness Experience (%)	Slept Outside Without Shelter (%)	Slept in an Empty Building (%)	Slept in a Public Shelter (%)	Slept in a Church (%)
Never	78.2	87.7	94.8	84.9	98.4
Less than one Month	14.3	10.3	5.2	9.9	1.6
At least one Month	7.5	2.0	0.00	5.2	0.00
Total	252	252	252	252	252

Table 2 treats homelessness as a binary state, with patients who reported any experience of homelessness in the past year (21.8 percent) contrasted with those who reported none. The typical profile of those characterized as homeless is predominantly that of a young male not living with a spouse (or a partner, if married). Of those who were able to identify family or friends who could be interviewed, 20.4 percent reported at least one homeless condition, while 38.1 percent of those who were unable to identify any kin or close friends reported a homeless condition. This, in itself, supports the idea of a link between familial ties and homelessness.

As in other studies of the homeless, the average age was in the early to mid-thirties, and almost one half were drawn from nonwhite ethnic groups (see Table 2). Of the

Table 2

Background Characteristics of Homeless Mentally Ill Persons in Year Preceding Hospitalization (n = 252)

	Homeless in Past Year (%)	N of Cases	Significance of Difference
A. Gender			
Male	30.0	130	p < .001
Female	13.1	122	
B. Age			
Under 32	24.2	128	NS
32 & over	18.7	123	
C. Race			
Black	20.5	117	NS
White	23.0	135	
D. Education			
12 or more years	18.5	135	NS
Less than 12 years	25.6	117	
E. Lives with spouse/partner			
Yes	7.5	40	p < .02
No	24.2	211	
F. Has family or friends			
Yes	20.4	231	p < .06
No	38.1	21	

patients who were high school graduates, slightly fewer than one-fifth were homeless. Of those who were not high school graduates, the proportion of homeless was just over one-quarter. While the relationship between educational attainment and homelessness was not statistically significant, it is in the direction observed in previous studies of the homeless. Similarly, although not significant, we find that younger patients are overrepresented among the homeless. Blacks were over-represented among the homeless relative to their proportion in the Ohio population, but were not more likely than whites to be found in the homeless condition. In fact, there was a slight underrepresentation of blacks reporting homelessness relative to their numbers in the total sample.

Chronic Disabilities and Poor Prospects

Family members are less likely to want to stay involved with persons with chronic disabilities, especially if the disabilities lead to disruptions in the household and the community. The potential for withdrawal is greater to the degree that the disorder is severe, the social consequences are salient, and the existing relationship is fragile. Table 3 contrasts the homeless and nonhomeless mentally ill with respect to the prevalence of deficits in daily living, psychiatric symptoms, and trouble with the law.

Table 3

**Clinical and Social Characteristics of Mentally Ill Persons
(n = 252)**

	Total (n = 252)	Homeless	Nonhomeless	Significance of Difference
Psychiatric symptoms (mean)	2.35	2.59	2.28	p < .03
Deficits in daily living (mean)	1.77	2.44	1.60	p < .01
Arrested in past year (%)	28.6	32.7	27.4	NS
In jail in past year (%)	22.2	34.6	18.8	p < .02
Earned income in past year (%)	35.9	43.6	33.7	NS
Work or training in past year (%)	46.4	60.0	42.6	p < .03

Examination of Table 3 reveals considerable support for the chronic disabilities hypothesis. Persons with recent histories of homelessness report more deficits in daily living as well as more psychiatric symptoms. They are also more likely to have been in jail during the past year. Homeless persons were also somewhat, although not significantly, more likely to have been arrested. While the observed pattern of greater disability and trouble with the law among the homeless is not surprising, it is still noteworthy, because most prior studies of the homeless mentally ill have not included a nonhomeless comparison on these factors.

Table 3 also compares the homeless and nonhomeless in terms of the potential for economic self-sufficiency that may be associated with psychiatric disability. Surprisingly, there is no evidence that the prospects of the homeless for becoming self-supporting are poorer than in the comparison group of nonhomeless persons. In fact, the homeless persons under study were *more likely* than those without episodes of homelessness to report that they worked or were involved in a work or training program during the past year. There was also a nonsignificant tendency for the homeless to be more likely to earn income during the past year.²¹

Family Roles and Resources

Analyses of the distribution of family characteristics, shown in Table 4, revealed that similar proportions of primary kin (e.g. parents, siblings) were interviewed in both groups. This is somewhat surprising because of the tendency already reported for homeless persons in the sample to be more likely to state that they had no family or friends who could be interviewed. Evidently, the latter were a small group and the remainder were as able and willing as the nonhomeless to identify kin to be interviewed. The fact that the interviewers probed for multiple nominations (up to 4) may also account for the large numbers of primary kin in both groups. An alternative possibility is that the homeless in the present study had been in that condition for a short time only, and that relations with kin had not yet deteriorated to the point which observers commonly associate with persons for whom homelessness has become a chronic condition. Whatever the reason, the comparability of kinship between groups produces a methodological benefit since it is possible to link homelessness to family resources without the confounding effect of family role.

Table 4

Characteristics of the Kin Respondents (n = 365)

Characteristic	Total (n = 365)	Kin of Homeless (n = 77)	Kin of Nonhomeless (n = 288)	Significance of Difference
Parent (%)	40.8	41.6	40.6	NS
Child (%)	7.7	5.2	8.3	NS
Spouse (%)	3.6	0.00	4.5	NS
Sibling (%)	29.9	31.2	29.5	NS
Other kin (%)	18.1	22.1	17.0	NS
Low income (% <\$10,000)	28.5	31.2	27.8	NS
Household size (mean)	3.2	2.9	3.3	p < .08
Network size (mean)	3.3	3.1	3.4	NS

Table 4 switches the unit of analysis from the patient to the kin interviewed and focuses on the resources that the patients' families possess. The critical contrast is between the 77 kin of patients who reported homelessness and the 288 kin of patients who reported no such episodes. We expected that the kin of the homeless would be poorer, live in more crowded circumstances, and have more limited social support networks. Meager monetary, physical, and social resources may make it more difficult for kin to extend hospitality to dependent adults, and in this way help to explain why these particular kin were not the safety net of last resort between the patient and homelessness.

However, examination of Table 4 reveals little support for the meager resources hypothesis. The proportion reporting family income of less than \$10,000 (an indication of poverty) was 31.2 percent among the kin of the homeless as compared to 27.8 percent among the kin of the nonhomeless. Neither this difference nor that associated with network size is statistically significant, contrary to expectation. Household size, an indicator of limited physical resources, was actually higher in the kin of the nonhomeless ($p < .08$).

Perceptions of the Kinship Bond

Table 5 presents perceptions of the kinship bond from both patient and kin perspectives. The patients' views are shown in Panel A, and those of the kin in Panel B. It is

Table 5

Perceptions of the Kinship Bond

	Total (n = 252)	Homeless (n = 55)	Nonhomeless (n = 197)	Significance of Difference
A. Patient-Reported				
Satisfaction with kin (mean)	4.45	3.88	4.61	p < .01
Faith in family (%)	61.1	40.0	67.0	p < .001
B. Kin-Reported				
	Total (n = 365)	Homeless (n = 77)	Nonhomeless (n = 288)	Significance of Difference
Involvement (mean)	3.18	2.86	3.26	p < .01
Gives Care (mean)	.77	.55	.83	p < .02
Gives Money (mean)	44.15	42.64	44.55	NS
Positive Attitudes (mean)	3.59	3.39	3.64	p < .05
Network support (%)	57.9	48.2	60.5	p < .02
Worry (mean)	2.10	2.07	2.11	NS

important to note that the sample sizes (n = 252 patients; n = 365 kin) associated with the relevant comparisons vary depending on the unit of analysis employed.

Panel A contrasts the homeless and nonhomeless patients in terms of how satisfied they are with their family and whether they feel they can count on their relatives during a crisis. Examination of these data strongly suggests that patients with histories of homelessness have more strained relations with their families. They are less satisfied with their family relationships and report less faith that they can turn to kin during hard times.

Mirroring differences reported by the patients, family members of the homeless also reported more relationship strain (see Panel B). Specifically, they reported less involvement with the patient, less caregiving, fewer positive attitudes toward him or her, and they were also less likely to discuss the patient with members of their social network. Although the families of the homeless appear in these ways to be more withdrawn from the patient, there is no significant difference between their level of worry and the worry of the families of the nonhomeless. Nor is there a significant difference in the amount of money given as assistance to patients.

Summary Model for Predicting Homelessness

The preceding analyses of homelessness were conducted at the bivariate level. While they accurately describe relationships between individual variables and homelessness, they ignore whatever may be the relationships among the independent variables and can be usefully supplemented by a multivariate approach that allows for effects to be estimated *ceteris paribus*. Table 6 uses a logistic regression procedure that is appropriate to a binary dependent variable.

Table 6 shows the logit results where homelessness is analyzed as the probability of occurrence within the past year (1 = yes, 0 = no). This probability was predicted using the variables from the preceding bivariate analyses that were significant at the .05 level. Variables derive from both kin and patient reports. Since there may be more family members than one per patient, such patient variables as gender and symptomatology are repeated within families.

The results reveal that the probability of homelessness is linked to being male, having deficits in daily living skills, and having spent time in jail during the past year.

Table 6

**Logit Coefficients for Predictors of Homelessness
(n = 335)**

Independent Variable	Logit Coefficient	Significance
Patient is female	-.746	p = .037
Patient lives with spouse/partner	-.707	p = .191
Patient psychiatric symptoms	.327	p = .157
Patient deficits in daily living	.351	p = .000
Patient in jail in past year	.709	p = .048
Patient worked or in training in past year	1.046	p = .002
Patient satisfaction with kin	.042	p = .725
Patient faith in family	-.688	p = .081
Kin involvement	-.072	p = .726
Kin gives care	-.352	p = .148
Kin attitude toward patient	.007	p = .971
Kin network support	-.002	p = .685
Constant	-2.507	p = .024

The unexpected result that working or receiving vocational training is associated with an increased probability of homelessness is also obtained in the logit model. In addition, there is a tendency among those patients who report little faith in their kin to have a higher probability of being homeless.

While the logistic results showed that a number of patient variables were statistically significant, it is noteworthy that none of the family measures were significant even though each had been at the bivariate level. This indicates that family characteristics do not differentiate the homeless from the nonhomeless when patient characteristics are statistically controlled. The effects of those family attitudes that were significant at the bivariate level appear to have been mediated by patient variables.

Discussion

Homelessness needs to be viewed in the context of extreme poverty in America and of the failure of societal institutions to provide minimally decent levels of care and support to its most vulnerable members. The failure of the society to provide support to families with dependent adults is a significant part of this larger problem. While much research indicates that families can and do make considerable sacrifices to support dependent adults for short periods, we predicted that their generosity is apt to reach its limits when their own resources are exhausted, when the behavior of the patient is extremely disruptive, or when psychiatrically disabled kin show no ability or willingness to seek employment or present much prospect of becoming employed in the near term.

We did not find support for all these hypotheses in the present study. The resources of the kin of the homeless were no more meager in financial, physical, and social terms than those of the kin of the nonhomeless. More support for the meager resources hypothesis may arise from more heterogeneous samples. The current sample, derived largely from kin of state hospital patients who were much too poor to seek services from the private sector, was drawn predominantly from the urban lower and working classes. We did find support for the chronic disabilities hypothesis on a number of dimensions. Compared to the nonhomeless, the homeless reported

more psychiatric symptoms after discharge, more deficits in daily living before going into the hospital, and they were more likely to have spent time in jail during the year prior to their hospital or crisis center admission. While the economic prospects of the persons reporting homelessness for becoming self-sufficient were no less than those of the nonhomeless, this may merely reflect the desperation that motivates homeless persons to find short-term work and earn money when they have no alternative social support to fall back on, or the assertiveness of case managers in getting these persons to accept vocational training.

There was far less ambiguity in the results surrounding the perceptions of the kinship bond. These data clearly document strain in the kinship bond from the perspectives of both the former patient and his or her family. Patients who acknowledge episodes of homelessness report less satisfaction with kin as well as less faith in them. For their part, kin of the homeless report less involvement with former patients, provide less informal care, acknowledge more negative attitudes, and are less likely to share feelings about their psychiatrically disabled relative with members of their personal network. The fact that they worry no less and give no less money is testimony to the fact that in most cases full disengagement has not (yet) occurred.

Future research is needed to test more clearly the assumption that the unraveling of the kinship bond is causally prior to homelessness. The problem is that cross-sectional surveys cannot disentangle cause from effect, nor distinguish homelessness that is episodic and tied to situational factors and temporary reversals from homelessness that continues for much longer periods. In view of the methodological difficulties involved, it might be prudent to begin with a sample of persons who are precariously housed and living with primary kin and to conduct follow-up interviews with the parties involved at some future date, for example, two years later. If sufficient numbers of dependent adults become homeless during the study period, comparisons could be made before and after episodes of homelessness. Longitudinal research patterned along these lines would allow examination of how the kinship bond may unravel in the face of unemployment, psychiatric disability, and homelessness. Ideally, it would also be possible in such a study to identify the place where interventions could most usefully be focused.

There is also a need for research to consider whether and to what extent formal support (services under professional auspices) is substitutable for informal support (family and friends). Although most homeless persons possess social networks of nontrivial size — Lovell reports an average network size of eleven persons²² — there is considerable dispersion around the mean in network size, and some homeless persons do in fact epitomize the stereotype of the individual who is alone and bereft of family and friends. The extent to which it is possible to shore up an impoverished social network, to renew family ties, or to substitute for such through relationships with professionals and paraprofessionals certainly deserves systematic inquiry.

In terms of public policy, our findings indicating significant strain in the kinship bond are most consistent with interventions emphasizing assertive case management and other related community support services.²³ The provision of supportive services to discharged patients may help preserve or improve their relationships with parents, siblings, and other relatives by reducing their dependence on kin. Relationships will of course be aided to the extent that treatment is successful in diminishing the signs and symptoms of chronic disability. With proper support and encouragement, some of these kin may also be willing to join with professionals in helping a former

patient look for work, find acceptable housing, and apply for welfare benefits, particularly if assistance given is viewed as steps to facilitate independence.

Another short-term consideration is relevant to hospital discharge policy. Patients with severe mental disorders should not be released to the streets. The process of community care should begin *before* release from a hospital or crisis care unit, and it is important that family support be mobilized to the extent possible around the transition represented by discharge. When kin are able and willing to be involved, professionals should support family members before the fragile bonds fray and the process of withdrawal begins. Interventions involving outreach to families, including financial stipends in exchange for providing shelter to a psychiatrically disabled relative, may also be useful as a means of shoring up kindred relationships and preventing homelessness.

Families cannot be expected to substitute for mental health professionals in twenty-four-hour shifts. While some families may be willing to act as the "safety net of last resort," at least for a time, they may require a variety of professional supports. Given that long-term structural issues are unlikely to be resolved in the current economic climate, it is necessary to utilize the existing social and mental health services. The failure of the present system to deal adequately with the disabling consequences of mental illness is in part responsible for the unraveling of kinship bonds, which, in turn, increases the relative risk of homelessness. ❧

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