1991

An analysis of family social support differences between the recent and the long-term homeless

Judith A. Sherman
San Jose State University

Order Number 1345822

An analysis of family social support differences between the recent and the long-term homeless

Sherman, Judith Ann, M.S.

San Jose State University, 1991

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

AN ANALYSIS OF FAMILY SOCIAL SUPPORT DIFFERENCES BETWEEN THE RECENT AND THE LONG-TERM HOMELESS

A Thesis

Presented to

The Faculty of the Department of Nursing

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Judith A. Sherman

August, 1991

APPROVED FOR THE DEPARTMENT OF NURSING

Emilie C. Musci
Emilie C. Musci, DNSc, RN

Jean M Sullivan EdD, RN
Jean Sullivan, EdD, RN

Sharon Hogan
Sharon Hogan, MS, RN

APPROVED FOR THE UNIVERSITY

Serena M. Stanford

ABSTRACT

AN ANALYSIS OF FAMILY SOCIAL SUPPORT DIFFERENCES BETWEEN THE RECENT AND THE LONG-TERM HOMELESS

by Judith A. Sherman

This study was a secondary analysis of the Stanford Homeless Survey (1989-1990) and focused on the social support differences between the recent and long-term homeless male population (N = 1,009). Four family social support questions were selected from the larger survey in order to explore the length of time factor of homelessness. The social support model of Kaplan, Cassel, and Gore (1977) served as the conceptual framework. Analysis of three factors (marital status, foster care, and family ending) indicated no significant difference in family social support between recent and the long-term homeless. Family conflict did demonstrate a statistically significant difference $X^2(1, N = 1,009)$ which was equal to 8.98, $p < .003$, between the recent (n =867) and long-term (n = 142) homeless. Results indicated that both groups of recent and long-term homeless men live with diminished or non-existent family social support. Further research is needed to evaluate causes, programs, and strategies to prevent and/or reduce the increasing problems of homelessness.

ACKNOWLEDGEMENTS

With deep gratitude I acknowledge these special people:

My husband, Fred, whose support, smile, and faith have warmed my heart and cheered me on.

The wind beneath my wings . . . my special friends, Kevin, Maureen, Linda, Lorraine, Judy, Diane, Marilyn, and Marge whose persistent faith and encouragement has seen me safely through.

TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

INTRODUCTION

Within the last 10 years, homelessness has emerged as one of the leading social problems in this country. Poverty and deprivation have forced increasing numbers of persons into sleeping in public buildings and the streets. Hoch and Slayton (1989) estimated that homelessness may affect 250,000 to 2.2 million persons in the United States (p. 202).

The homeless are particularly vulnerable to isolation due to their difficulty in developing or maintaining social support from family members. In a study of the homeless on skid rows in major cities in the United States, Bahr and Caplow (1974) found that most homeless persons had absent or weak ties to their families. Social support that is available from the family may contribute positively to the psychological and physical well-being of those living in poverty and may help them avoid homelessness (Rossi, 1989).

Statement of the Problem

The number of homeless persons in this country is increasing, and the problem has reached epidemic proportions. Public health professionals (Jahiel, 1986; Ropers, 1984b) view homelessness as one of the most significant problems confronting this country. Homelessness affects a growing percentage of those who are poor, and may

reflect a growing disintegration of family structure and support.

Inadequate social support from family members may be a contributing factor in the incidence of both recent and long-term homelessness (Rossi, 1989). The previously cited Rossi study found those living in poverty with inadequate family social support were more vulnerable to homelessness. Without family strength and support, the poor may find problems and burdens of life overwhelming. Depressed, coping ability then becomes weakened and the poor may become homeless and unable to survive living on the street (Rossi, 1989).

Support from family members has been found to be a crucial element in the survival formula of the homeless (Cohen & Sokolorsky, 1989). Adequate family social support may also protect the person in a crisis, such as homelessness, from a myriad of physical and mental problems. Cobb (1976) postulated that social support has a protective function from a wide variety of pathological states: from arthritis through tuberculosis to depression, alcoholism, and other psychiatric illness.

Weak or non-existent family social support is only one of the many complex reasons a person becomes and remains homeless. New insights are needed in order to reduce both the incidence and length of homelessness. The numbers of

homeless are growing, and homelessness is one of the major issues challenging nursing today (Abdellah, 1985). The importance of family social support needs to be considered when planning nursing interventions in the growing homeless population.

Purpose and Need

The purpose of this study was to compare a group of recent homeless with those persons who were homeless over 5 years to determine if informal social support differences existed between these two groups. The dynamics of the homeless person's family support system were explored to identify factors that may have contributed to the homelessness.

There are many reasons a person becomes homeless. The marginal and working poor find themselves constantly on the brink of economic disaster (Maurin, Russell, & Memmott, 1989, p. 320). The previously cited study found that even a minor economic event such as a small rent increase may result in homelessness. These vulnerable homeless need insight to facilitate the development of new support systems. These homeless also need assistance to develop social skills and networks that will offer them an opportunity to improve their lives. This study seeks information about the homeless person's informal social

support system, so successful nursing strategies and programs may be designed and implemented.

Research Questions

To determine the informal social support differences between the recent and long-term homeless populations, the following question was addressed:

Is there a difference in social support between the recent homeless and those homeless over 5 years?

Four items were selected from the Stanford Homeless Survey (1989-1990) in order to answer this question. They were: (a) marital status of the recent and long-term homeless; (b) foster care placements of recent and long-term homeless; (c) incident of a family conflict causing homelessness for the first time in the recent and long-term homeless; and (d) the incidence of a family ending by death, divorce, separation, or moving causing homelessness for the first time in the recent and long-term homeless. These variables were used to answer the following sub-questions:

1. Is there a significant difference between the marital status of the recent and long-term homeless?

2. Is there a significant difference in the number of foster care placements between the recent and long-term homeless?

3. Is there a significant difference in the incidence of a family conflict causing homelessness for the first time, between the recent, and long-term homeless?

4. Is there a significant difference in the incidence of a family ending by death, divorce, separation, or moving, causing homelessness for the first time, between the recent, and long-term homeless?

Definitions

The following definitions were used in this study:

1. Homelessness is absolute lack of housing or living in shelters expressly provided for homeless persons (Rossi, 1989).

2. Long-Term Homeless are those persons who are homeless over 5 years.

3. Recent Homeless are those persons who are homeless 5 years or less.

4. Social Support is the degree to which a person's basic social needs are gratified through interaction with the family. Basic social needs include affection, esteem, belonging, identity, and security (Kaplan, Cassel, & Gore, 1977).

5. Informal Social Support is the support a person receives from family members, as opposed to formal supports which are organized, publicly subsidized, or private pay services (Social Support and Health, 1985).

6. Family is a unit of interacting persons related by ties of marriage, birth, adoption, or other strong social bonds whose central purpose is to create, maintain, and promote the social, mental, physical, and emotional development of each of its members (University of California, San Francisco, Department of Family Health Care Nursing, 1981).

7. Foster Care Placement are homes in which a child or children are cared for by people other than their natural or adoptive parents (Webster's New World Dictionary, 1988, p. 532).

Summary

Homelessness has become one of the most significant social problems in this country; and the homeless are profoundly isolated from mainstream society. Social support is a basic need, and if family support is weak or non-existent, isolation of the homeless person may become overwhelming and may result in psychological and physical disorders (Rossi, 1989). It is important to examine the homeless person's family support network in order to identify differences in social support between the recent homeless and those homeless over 5 years. The insights gained from this information may be used to design and implement successful programs and strategies to reduce both

number of homeless persons and the length of time spent homeless.

Chapter 2

CONCEPTUAL FRAMEWORK AND RELATED LITERATURE

This chapter includes a discussion of the theoretical concepts of social support. Related literature on homelessness, social support, and stress and health studies is also reviewed.

Conceptual Framework

The conceptual framework used in the study is based on social support theory. Kaplan, Cassel, and Gore (1977) define social support as the gratification of a person's basic needs for: (a) affection, (b) esteem, (c) belonging, (d) identity, and (e) security provided by the psychosocial resources of the family. Social support by the family may also reduce stress and improve control of a person's life (Cassel, 1976). Gore (1977) postulated that a person who received approval and a sense of identity in a family support context may feel important to others. Supported by family, the person may be less likely to become emotionally or physically ill (Gore, 1977). Not only do such family support ties assist people to remain healthy, they also play an important role in helping them deal with the pressures and problems of living in society (Gore, 1977).

Cassel (1976) found that membership in a social network, composed of the family, may also result in an increased sense of predictability and control. Cassel

(1976) postulated that the family provides the opportunity for social interaction and feedback that allow adoption of appropriate roles and behavior in society. Those persons who become homeless lose stability, predictability, and regulatory control over all their social experiences as proposed by Cassel in 1976. The homeless lack role models and sources of appropriate behavior, and they may become alienated from mainstream society. Social support from the family may offer those homeless a resource for social interaction that may improve a sense of control over their existence, strengthen coping ability, and reduce stress (Cassel, 1976).

The homeless have slipped through the web of the existing social welfare system, and may suffer from the stress, fear, and loneliness of living on the street. Kaplan, Cassel, and Gore (1977) suggest that social support also offers protection from the social upheavals of mobility, social disorganization, and rapid social change. Family social support may offer those homeless an opportunity for reaffirmation in society, introduce a semblance of organization in their lives, and provide a safe haven from the mobility of the homeless life.

Homelessness is a stressful condition which leaves the affected person vulnerable to reduced emotional and physical well being, which, according to Kaplan, Cassel, and Gore

(1977), may lead to depression, disease, and death. Cassel (1976) and Gore (1985) both proposed that social support moderated or protected the person from the negative health effects of stress. Both felt without the resources that social support may offer, a person would be likely to suffer from diminished emotional and physical well-being. Gore (1978) found that even low-stress life events showed an association between poor social support and increased emotional and physical symptomatology. Gore (1978) also proposed that stressful life events and low social support had a negative effect on health status. Cassel (1976) postulated that weak social support factors increased susceptibility to disease and a strong social network could reduce disease susceptibility. Social support from the family may contribute positively to the emotional and physical well-being of those living in poverty and reduce their potential for homelessness.

Summary

Social support is a basic need. Kaplan, Cassel, and Gore (1977) postulated that social support from the family can offer health protecting factors as well as social and community ties. The protective aspects of family social support may offer those in poverty a resource that may prevent them from falling into homelessness. Family social

support may also moderate the negative effects of stress, fear, and isolation of those already homeless.

Related Literature

The related literature is divided into five categories: (a) Types of Social Support, (b) Sources of Social Support, (c) Social Networks, (d) Homelessness and Social Support, and (e) Stress and Health Studies. Each category will be discussed.

Types of Social Support

Informational support is the term applied to a process through which other persons may provide information, advice, and guidance (Wills, 1985). He proposed that under usual circumstances, most persons will have the informational support necessary for effective daily functioning. The homeless are unable to function effectively and solve their daily problems. They have no source of informational support, guidance, and advice. The homeless are without a social support network as a source of informational support. This support network (Wills, 1985) is necessary to reduce the homeless person's environmental stress. Informational support will enable the homeless to solve problems and function effectively in society.

Esteem support has also been linked to informational support (Barker & Lemle, 1984). They found in actual helping situations, esteem-enhancing behaviors and advice

usually occur together. Other studies that measured these two dimensions of support found esteem and advice were highly interconnected (Norbeck & Tilden, 1983; Schaefer, Coyne, & Lazarus, 1981). Norbeck and Tilden (1983) and Schaefer, Coyne, and Lazarus (1981) postulated that providing advice may be perceived by the recipient as an expression of caring and concern by the other person, which would be interpreted as esteem support. This type of support would also be relevant for persons who are in highly stressed circumstances such as homelessness. The homeless do not have the information necessary for effective functioning, and they are unable to solve their overwhelming problems due to isolation from sources of esteem and informational support (Norbeck, & Tilden, 1983; Schaefer, Coyne, & Lazarus, 1981; Wills, 1985).

Instrumental support (Wills, 1985), also called aid, material support, or tangible support includes such activities as taking care of children, helping with household tasks, loaning or giving money, and providing material goods such as clothing or a car. This type of support is particularly important for those persons in poverty, who are overburdened with instrumental chores, have smaller social networks, and are financially unable to buy assistance (Wills, 1985). Data from a Chicago study (Rossi, 1989) found that the average length of family instrumental

or material support of a homeless person is about 4 years (p. 189). Rossi (1989) postulated that the family then becomes either unwilling or unable to support or aid the homeless family member. Rossi (1989) also discovered that many of the homeless in Chicago had small social networks and had parents who were unable to help their children either with esteem or instrumental support. Rossi (1989) found the homeless in Chicago were not receiving either esteem or instrumental support from their families. His study (Rossi 1989) found the families of the homeless were so poor they were barely able to sustain themselves in society. Families in the Rossi study (1989) were found to be unable or unwilling to provide family instrumental or material support to homeless kin.

Sources of Social Support

In the literature, there are two types of providers of social support, informal and formal (Hogue, 1985). Informal support is provided by the family. The homeless usually have little contact with relatives and family. Isolated from kin, the homeless person has no informal social support network to turn to for assistance.

Formal support is comprised of human service professionals (Hogue, 1985, p. 64). Community leaders, indigenous lay helpers, volunteers, and self-help mutual aid groups are also providers of social support (Pearlin, 1985).

In contrast, Norbeck (1988) defined professional (e.g. nursing) support as surrogate support which extends or replaces support that is not available in the person's network. Alienated from society, the homeless are suspicious of the formal social support network and in many cases will avoid providers.

Most persons turn to the informal network for support (Griffith, 1985; Tardy, 1985). Only when this source is not available or has failed do the homeless turn to the formal support system. These homeless have minimal ties to others, and few if any formal or informal sources of social support.

Social Networks

Social support and social network are different concepts (Berkman, 1985; Gottlieb, 1983). Social networks, according to House and Kahn (1985), are a complex set of relationships between the members of social systems. Social networks are sources of social support. A person is attached by specific types of relations into a social network. The network may be composed of various groups such as the family, a work group, or other group affiliation. All of these groups are engaged, in some fashion, in a reciprocal flow of resources from one social network member to another (House & Kahn, 1985).

In contrast, the homeless are not tied into a social network (House & Kahn, 1985), and in most instances do not

have the resources to allow them to reciprocate to the demands of a social network. They are isolated, unable to give or receive assistance with the tasks and problems of daily life. Without a social network (House & Kahn, 1985), the homeless are unable to acquire financial aid, emotional support, resource linkage, and assistance necessary to carry out the tasks of daily living.

Homelessness and Social Support

Early studies of the homeless population contended that the homeless person was undersocialized (Dunham, 1953; Pittman & Gordon, 1958; Straus, 1946). Bahr and Caplow (1973) presented the homeless as social isolates who were disaffiliated from society; meaning they had absent or tenuous ties to family and other relatives and few or no friends. Rossi (1989) found in his Chicago study of the homeless that they also reported few friends and intimates and had little contact with relatives and family (p. 43). The homeless in Rossi's (1989) study responded negatively when asked if their relatives would want them, he found that the homeless believed they were not wanted by their families. In their analysis of a sample of homeless persons in Minneapolis, Piliaven and Sosin (1987-88) found that as children a very large proportion of the homeless had been placed in foster homes at one time or another. Piliaven and Sosin (1987-88) postulated that alienation from parents is a

long-standing condition of the homeless person's history. Rossi (1989) also found that those persons who are homeless today are social isolates, without enduring and supporting ties to family. Without family social support, the homeless person will become socially isolated and disaffiliated from society (Bahr & Caplow, 1973).

Stress and Health Studies

Many studies have concluded that stress leads to illness. The stress theory of disease, as proposed by Selye in 1956, postulated that stressful daily living could increase susceptibility to disease. Holmes and Rahe (1967) demonstrated that the occurrence of life events that cause change and readjustment, such as a job change, marriage, or death, was positively correlated with increased likelihood of physical illness. Gore (1978) showed the relationship of the multiple links between stress and health and their impact on the psychological as well as the physical health of a person. Her study of unemployed men demonstrated the negative effects of stress on physiological processes (Gore, 1978).

Alienated and isolated from society, these homeless have suffered a high degree of stress. An elevated level of stress leads to reduced emotional and physical well-being as demonstrated in Gore's 1978 study. The homeless in the 1989 Rossi study also tended to be more susceptible to disease

and had a higher risk of early death. Rossi (1989) found mortality levels among the homeless to be ten times higher than among comparable age groups in the sheltered population.

Summary

Social support from the family may help prevent those living in poverty from falling into homelessness (Rossi, 1989). Evidence shows that the homeless have minimal social support ties to their families, and in the Rossi (1989) study, one in three homeless reported not being in contact with any family member. The homeless are isolated from both family and society and are at a greater risk of both emotional and physical illness (Gore, 1978). Family social support may protect the homeless person from the stress, loneliness, and disorganization of a life on the streets. Various studies (Bahr & Caplow, 1973; Gore, 1978; Rossi, 1989) have agreed that social support from the family may reduce stress, improve mental and physical well-being, and increase survival skills of those homeless. Social support from the family is an important resource that merits inclusion when planning interventions for the growing homeless population.

Chapter 3

THE METHOD

This chapter includes: (a) research design, (b) setting and sample, (c) secondary analysis, (d) procedure for data collection, (e) instrument, and (f) analysis of data. Each category will be discussed.

Research Design

This study was a secondary analysis of a larger project, the Stanford Homeless Study (1989-1990). The larger study explored the factors that may predict homelessness. The Stanford Homeless Study (1989-1990) was a descriptive, cross-sectional survey using a structured face-to-face interview technique. Personal interviews readily allowed for clarification of the questions and response options for the homeless participants. This study used retrospective data collected during the larger Stanford Homeless Study (1989-1990).

Setting and Sample

Stanford Homeless Study

The Stanford Homeless Study (1989-1990) was funded by a grant from The Valley Foundation of San Jose, California. The settings selected for the Stanford Homeless Study (1989-1990) were three National Guard armories located in a northern California county. The armories were situated in three different geographic locations. The first armory had

a capacity of 300 homeless persons, and was located in an urban area. The other two armories each sheltered 60 to 100 homeless individuals, and were located respectively in a suburban and rural area, approximately 10 and 30 miles from the first site. These armories were mandated by law to provide shelter from 6:00 p.m. to 7:00 a.m. daily for homeless persons during the winter months. The shelter excluded any homeless individual exhibiting disruptive or violent behavior. To participate in the Stanford Homeless Study (1989-1990), the homeless person had to be 18 years of age or older, of either gender, and willing to be interviewed.

Interviewer training was conducted by the Stanford Survey (1989-1990) supervisors prior to data collection. During the period of time from November 26, 1989 to March 31, 1990, all adult homeless persons registering in the three armories for the first time between the 6:00 p.m. opening of the shelter and 9:00 p.m. were approached by an interviewer and asked to participate in the survey. Participation was strictly voluntary and agreement to be interviewed was considered implied consent. If the homeless participants demonstrated evidence of emotional distress, they were able to withdraw from the interview at any time without remonstrance. The benefits to the homeless participants in the survey interview included the support

and empathy provided by the interviewers listening to their histories. Individual names were not recorded on the survey form. The actual survey questionnaire (Appendix C) took approximately 15 minutes and was administered by nurses and health interviewers. All interviews were conducted in the armory shelter setting. To encourage participation and to compensate the homeless for their time, all persons were given a personal hygiene kit. Participants were not compensated in any other way.

The Stanford Study (1989-1990) conclusions were:

1. Risk factors that precede homelessness must be distinguished from those that are a consequence.

2. Appropriate comparison groups must be used to examine whether risk factors among the homeless are significantly different from those who have shelter.

Secondary Analysis

The secondary convenience sample was randomly and purposively chosen from the total Stanford Homeless Study (1989-1990) sample of 1,437 homeless adults. Criteria for inclusion in the secondary analysis included: (a) United States born, (b) male only population subsample (N = 1,009). The secondary analysis examined only homeless men because the homeless are largely comprised of men (Bogue, 1963; Rossi, 1989). Hispanic, non-United States born males were omitted from the secondary analysis because of unreliable

answers to the foster care survey question, believed to be caused by difficulty in interpretation.

Procedure for Data Collection

To satisfy the ethical standards dictating research, permission for this secondary analysis was obtained from the following sources. Written authorization was obtained from the Stanford Center for Research in Disease Prevention to use specific survey data gathered on the homeless population in the Stanford Survey (1989-1990) (Appendix A). Clearance was also obtained from the San Jose State University Human Subjects Institutional Review Board (Appendix B).

The secondary analysis sought to determine if there were significant differences in social support between the more recent homeless and those homeless over 5 years. In order to answer the research question, four items were selected for analysis from the 33 item Stanford Homeless Survey (1989-1990).

Instrument

The Stanford Homeless Survey (1989-1990) was administered during a face-to-face interview. The Stanford Instrument (Appendix C) was a 33 item questionnaire requiring approximately 15 minutes to complete. The survey questions were open-ended and included demographic questions developed from the 1980 United States Census. Other questions were adapted so the Stanford Survey (1989-1990)

could distinguish whether risk factors preceded or followed the person's first episode of homelessness. Additional questions examined childhood risk factors such as placement in foster care. Adult risk factors were examined and included economic, social, and physical health problems that might increase the risk of homelessness.

The Stanford instrument included items adapted from existing surveys for the homeless study. Therefore, a test for content validity was conducted. LoBiondo-Wood and Haber (1986) state that content validity is necessary in order to determine if the contents of the tool are representative of the behavior domain (p. 186). To evaluate the content validity, a pilot study was conducted. Residents of the Salvation Army Shelter and other homeless shelters in the county agreed to complete the Stanford Homeless Survey (1989-1990). The pilot study revealed that all questions were representative and clear.

In an effort to assure interviewer reliability, 35 homeless persons who were willing to be interviewed again were randomly selected and re-interviewed at the conclusion of the Stanford Homeless Study (1989-1990). The mean time between the two interviews was 38 days. The age, sex, and race of these 35 homeless persons were not significantly different from the overall sample. There was a high degree of agreement for all variables in the test-retest analysis.

Age, sex, and if ever worked full-time showed 100% agreement. Marital status, race, childhood risk factors, and total time homeless showed 90-99% agreement with the original interview in the Stanford Homeless Study (1989-1990).

Secondary analysis (N = 1,009) of selected data from the Stanford Homeless Study (1989-1990) permitted comparison of the recent homeless with those who were homeless over 5 years in order to examine if social support differences existed between these two groups. In order to answer the research question, four items were chosen from the Stanford instrument. The four items were: (a) marital status, (b) foster care placement, (c) family conflict, and (d) family ending by death, divorce, separation, or moving.

Analysis of Data

Descriptive, multivariate, inferential statistics were used to summarize the demographic and social support characteristics of the secondary sample (N = 1,009). To determine if there was a difference in social support between the recent homeless and those homeless over 5 years, four questions were selected from the Stanford Survey (1989-1990). The four questions were:

1. Is there a significant difference between the marital status of the recent and long-term homeless?

2. Is there a significant difference in the number of foster care placements between the recent and long-term homeless?

3. Is there a significant difference in the incidence of a family conflict causing homelessness for the first time, between the recent, and long-term homeless?

4. Is there a significant difference in the incidence of a family ending by death, divorce, separation, or moving causing homelessness for the first time, between the recent and long-term homeless?

Statistical Analysis for Systems (SAS) was used to code each response to all questions on both the Stanford Homeless Survey and the secondary analysis. The significance level was set at $p \leq .05$. Numeric values were assigned to each variable. Frequencies and percentages were used to describe the numbers of responses to each variable, including the homeless person's marital status, occurrence of a family conflict or family ending, and the incidence of foster care. Those homeless over 5 years ($n = 142$) and those homeless 5 years or less ($n = 867$) were compared in each variable to determine if there was a significant difference between the two groups. A t-test was utilized by the Stanford Homeless Study (1989-1990) to calculate the difference between means for both groups of homeless. The Chi square test was used in the secondary analysis to calculate the relationship

between the length of time factor and the social support factors.

Chapter 4

FINDINGS AND INTERPRETATION OF DATA

This chapter includes the interpretation of the data of the secondary analysis of recent and long-term homeless individuals, and related social support factors. The descriptive analysis of the social support characteristics is included. The research questions concerning the methods of measurement for determination of differences in social support between the recent homeless and those homeless over 5 years were examined, and the results discussed.

Research Question #1

To determine if there was a difference in social support between the recent homeless and those homeless over 5 years, four research questions were asked. The first research question was: Is there a significant difference between the marital status of the recent and long-term homeless?

Marital Status Results

The homeless male respondents exhibited impoverished marital networks (Table 1). Of those homeless 5 years or less 48.3% (n = 867) were never married. Of the men who married, only 7.5% were still married, whereas 29.9% were divorced, 11.3% separated, and 3.0% were alone through death of their spouse.

Table 1

Differences by Percentage Between the Marital Status of Those Homeless 5 Years or Less and Those Homeless Over 5 Years (N = 1,009)

Marital Status	Years Homeless 5 Years or Less % (n = 867)	Years Homeless Over 5 Years % (n = 142)
Married	7.5	4.9
Separated	11.3	9.9
Divorced	29.9	33.1
Widowed	3.0	1.4
Never Married	48.3	50.7
Total	100.0	100.0

Note. ($X^2(4, N = 1,009) = 3.047, p = .544$).

The majority of those homeless over 5 years (n = 142) or 14.1% of the total population (N = 1009) reported they were alone. About half (50.7% of n = 142) had never been married. These men were also more likely to have been divorced (33.1%), separated (9.9%) or widowed (1.4%). Of those men homeless over 5 years, only 4.9% were still married.

The relationship between marital status and the length of time homeless was not statistically significant ($X^2(4, \underline{N} = 1,009) = 3.047, \underline{p} = .544$).

These results are consistent with findings from other studies portraying the homeless male as alone and having few informal support ties to women. Both Bogue (1963) and Bahr and Caplow (1974) discovered the majority of homeless men to be unmarried and most had never been married. Also, Cohen and Sokolorsky (1989) found that homeless men had a smaller percentage of women in their social network compared to men living in the community. Rossi (1989) found homelessness identical with "spouselessness" as 92 to 95% of the homeless in his Chicago study were unmarried.

The implications of these results suggested many homeless men chose to remain alone their entire lives. Those homeless through death, divorce, or separation may prefer living alone rather than risk emotional problems caused by family dysfunction. Unable to cope with dysfunctional family relationships, the homeless men may choose isolation from family and society.

Research Question #2

The second research question was: Is there a significant difference in the number of foster care placements between the recent and long-term homeless?

Foster Care Results

The homeless male respondents showed a high incidence of foster care placement (Table 2). Of those males homeless 5 years or less (n = 867) 11.3% reported being placed in foster care. The percentage of foster care placements was higher in the population homeless over 5 years 16.2% (n = 142).

Table 2

Differences by Percentage in the Number of Foster Care Placements Between Those Homeless 5 Years or Less and Those Homeless Over 5 Years (N = 1009).

Foster Care	Yes %	No %
5 years or less (n = 867)	11.3	88.7
Over 5 years (n = 142)	16.2	83.8

Note. ($X^2(1, N = 1,009) = 2.786, p < .10$).

The relationship between foster care placements and the length of time homeless was not statistically significant. These results indicated both the recent and long-term homeless men may have families who were unable to care for them and placed them in foster care. Kadushin (1967) postulated that families of children placed in foster care were those who demonstrated the greatest disorganization and

impaired parental functioning. The implications were that homeless men lacked positive role models from a stable, supportive family and may be unable to form new relationships because of the family disorganization and inadequate positive parent-child relationships.

Children in foster care are among the most deprived in society. They come from poor, vulnerable families who may be dysfunctional. These families may lack social support and may collapse under the pressures of living in our society. The child in the family without social support, placed in foster care, is vulnerable to the development of serious cognitive and personality impairments (Fanshel & Shinn, 1978). The homeless men who were placed in foster care may be socially and emotionally undeveloped. As a result, they may avoid relationships and become isolated from society.

Research Question #3

The third research question was: Is there a significant difference in the incidence of a family conflict causing homelessness for the first time, between the recent and long-term homeless?

Family Conflict Results

Many of the homeless men appear to have worn out their welcome and were not receiving material or emotional support from their families. The relationship between a family

conflict and the length of time homeless was statistically significant ($X^2(1, N = 1,009) = 8.918, p < .003$). Those who had been homeless over 5 years were more likely (24.7%) than those homeless for a shorter period (14.7%) to report family conflict caused their first incidence of homelessness.

The implications of these responses were significant because the long-term homeless men may have been permanently isolated from their families in an attempt to avoid the conflict of a dysfunctional family. Also, homeless men may have perceived their families as being so unsupportive and dysfunctional they then chose isolation. The long-term homeless men were isolated from families and society, and became chronically and perhaps permanently homeless.

In previously cited research by Maurin et al. (1989), a greater proportion of men were homeless for a longer period of time than women. Rossi (1989) proposed that men were homeless in greater numbers and for a longer period of time because more sympathy and support is extended to women. He found families were more supportive and protective of female members.

Conflict between the long-term homeless men and their families leaves the men with no kin support or contact. The loneliness of a life on the streets may lead to social isolation. These results may be significant because the

longer homeless men were isolated, the more difficult it may be to return to a productive, emotionally healthy life. Some men may live out their lives in a permanent state of homelessness.

Research Question #4

The fourth research question was: Is there a significant difference in the incidence of a family ending by death, divorce, separation, or moving causing homelessness for the first time, between the recent and long-term homeless?

Family Ending Results

The incidence of a family ending by death, divorce, separation, or moving may contribute to the weakening and breakdown of the family support system of the homeless. Of those males homeless 5 years or less (n = 867), 16.6% reported a family ending caused them to become homeless for the first time. In contrast, 22.5% of the males homeless over 5 years (n = 142) found themselves homeless for the first time due to a family ending.

The relationship between a family ending by death, divorce, separation, or moving and the length of time homeless was not statistically significant ($X^2(1, N = 1,009) = 2.913, p < .09$).

These results indicate that both the long-term and recent homeless men came from families who were weakened by death, divorce, separation, or moving. The implications were that these men were homeless due to family breakdown. Rossi (1989) found most of the homeless would not want to live with their families, and they believed their families would not want them. He found the homeless men in his Chicago study (1989) were divorced or separated at a rate three times higher than the Chicago Census rate. He also found that of the few elderly homeless men, most were widowed and alone since the death of their spouse (Rossi, 1989). This group of homeless men chose to live alone on the streets. They did not want to live with their children because of conflict or financial factors (Bahr & Caplow, 1974).

The implications were that dysfunctional family relationships may occur frequently among the homeless male population. Many homeless men were either pushed out or thrown away by their families. This event occurred when the family was no longer financially or emotionally able to assist the family member (Rossi, 1989). These men were homeless due to many factors, including a disorganized, fragmented, unstable, and unsupportive family life. The lack of family social support may have contributed to length

of time the men were homeless as well as their first episode of homelessness.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This secondary analysis focused on the family social support differences between a population of recent homeless and a population of those homeless over 5 years. The analysis examined four social support items selected from the 33-item Stanford Homeless Survey (1989-1990). One-thousand and nine homeless men born in the United States were selected for the secondary analysis. The social support model of Kaplan, Cassel, and Gore (1977) was used as the theoretical framework.

Conclusions

The limitations of this secondary analysis should be considered when interpreting the following conclusions. The secondary analysis was limited to homeless men who were born in the United States, and were sheltered temporarily in a northern California county. The results of this analysis may not be generalized to those homeless who live in other parts of California or in other cities out of state. Furthermore, homeless women were omitted from the secondary analysis. Thus, the results reported may only be suggestive, not conclusive, of the characteristics of the homeless population in the northern California county.

Another limitation is the methodological problem with secondary analysis, in that the researcher is limited to the

questions in the original survey for measuring variables. In addition, as in all surveys, the interview data are limited by possible errors in self-reporting. Lobiondo-Wood and Haber (1986) state that respondents may answer questions in a way that may be acceptable socially, but may not always be truthful. The researcher is forced to assume that the respondent is answering correctly. Lobiondo-Wood and Haber (1986) emphasized that self-report questionnaires were acceptable and were strong approaches to gathering information for research.

Implications of the findings of the secondary analysis demonstrated that all the homeless men had impoverished family social support networks. These data also suggested that those long-term homeless men in greatest need of family social support may be the least likely to receive it. The long-term homeless men may be permanently alienated from their family. Also, these homeless men may be permanently homeless.

Analysis of three questions indicated there were no statistically significant differences in family social support factors between the recent and long-term homeless men. However, there was a statistically significant difference ($p < .003$) between the recent and long-term homeless men in the incidence of a family conflict causing homelessness for the first time. This finding may indicate

that those males homeless over 5 years (n = 142) were unwanted by their families. These homeless men were isolated from their families and had adapted to the social world of the streets. The longer the socially unsupported men remain homeless, the less likely they may readapt to mainstream society, and they may remain life-long isolates.

The overall findings of the secondary analysis are supported by the social support concepts of Kaplan, Cassel, and Gore (1977). Their framework focuses on family social support gratifying basic human needs for affection, esteem, belonging, identity, and security. Those who are homeless lack family social support and have none of their basic human needs met in a family context. Isolated from family and lonely, the homeless are highly stressed and are vulnerable to increased emotional and physical disabilities which may lead to depression, disease, and death.

The health care system is becoming more oriented to the concepts of health maintenance and promotion. Family social support concepts in a health promotion program may offer those homeless a method of avoiding deterioration of emotional and physical well-being. Nurses should find family social support theory and concepts a valuable addition to health promotion programs designed to assist the homeless.

Efforts must be made to reduce poverty and family instability. Family counseling as well as economic support must be available for poor families in crisis in order to reduce the numbers of those homeless. Nursing support services must be expanded, and interventions using social support theory must be incorporated into programs designed for those already homeless.

Nurses are challenged to find satisfactory solutions and offer nursing services to the homeless population. Nurses are in a unique position to give care to the homeless and must move forward to design and implement programs using social support theory. Clearly, it is time for action on the part of every nurse.

Recommendations

As a result of this secondary analysis, the following recommendations are proposed:

1. Nurses should promote interventions using social support as an appropriate contribution in the prevention of homelessness, as well as improving the well-being of those persons already homeless.

2. Further research is needed in order to help understand the processes leading to homelessness.

3. The survey questionnaire used for this study should be revised to include questions measuring specific social support variables.

4. A follow-up to the present analysis should include a random sample of the total homeless population to better generalize the findings.

5. The concepts of social support should be incorporated in a homeless social skill and network development program in order to improve the lives of those homeless and return them to mainstream society.

REFERENCES

References

Abdellah, F. (1985, March). Four major issues for nursing through the year 2000. Research Conference, University of Maryland, Baltimore.

Bahr, H., & Caplow, T. (1974). Old men drunk and sober. New York: N.Y. University.

Barker, C., & Lemle, R. (1984). The helping process in couples. American Journal of Community Psychology, 12, 321-336.

Berkman, L. F. (1985). The relationship of social networks and social support to morbidity and mortality. In S. Cohen & S. L. Syme (Eds.), Social support and health (pp. 241-259). Orlando: Academic.

Bogue, D. J. (1963). Skid row in American cities. Chicago: University of Chicago.

Cassel, J. (1976). The contribution of the social environment to host resistance. American Journal of Epidemiology, 104, 107-123.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.

Cohen, C., & Sokolorsky, J. (1989). Old men of the bowery: Strategies for survival among the homeless. New York: Guilford.

Dunham, H. W. (1953). Homeless men and their habitats: A research planning report. Detroit: Wayne University.

Fanshel, D., & Shinn, E. (1978). Children in foster care. New York: Columbia University.

Gore, S. (1978). The effect of social support in moderating the health consequences of unemployment. Journal of Health and Social Behavior, 19(6), 157-165.

Gore, S. (1985). Social support and styles of coping with stress. In S. Cohen & S. L. Syme (Eds.). Social support and health (pp. 263-276). Orlando: Academic.

Gottlieb, B. H. (1983). Social support strategies: Guidelines for mental health practice. Beverly Hills: Sage.

Gottlieb, B. H. (1985). Social support and community mental health. In S. Cohen & S. L. Syme (Eds.), Social support and health (pp. 303-326). Orlando: Academic.

Griffith, J. (1985). Social support providers: Who are they? Where are they? and the relationship of network characteristics to psychological distress. Basic and Applied Social Psychology, 6(1), 41-60.

Hoch, C., & Slayton, R. (1989). New homeless and old: Community and the skid row. Philadelphia: Temple.

Hogue, C. (1985). Social support. In J. Hall & B. Weaver, Distributive nursing practice: A systems approach (2nd ed.) (pp. 58-84). Philadelphia: Lippincott.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. Journal of Psychological Research, 11, 213-218.

House, J., & Kahn, R. L. (1985). Measures and concepts of social support. In S. Cohen & S. L. Syme (Eds.). Social support and health (pp. 83-108). Orlando: Academic.

Jahiel, R. (1986, October). Profile of the homeless. Conference on homelessness in the U.S., American Public Health Association, Las Vegas, NV.

Kadushin, A. (1967). Child welfare services. New York: Macmillan.

Kaplan, B. H., Cassel, J., & Gore, S. (1977). Social support and health. Medical Care, 15(5), 47-58.

Lobiondo-Wood, G., & Haber, J. (1986). Nursing research. St. Louis: Mosby.

Maurin, J., Russell, L., & Memmott, R. J. (1989). An exploration of gender differences among the homeless. Research in Nursing & Health, 12, 315-321.

Norbeck, J. S. (1988). Social support. Annual Review of Nursing Research, 6, 85-109.

Norbeck, J. S., & Tilden, V. P. (1983). Life stress, social support, and emotional disequilibrium in complications of pregnancy: A prospective, multivariate study. Journal of Health and Social Behavior, 24, 30-46.

Pearlin, L. I. (1985). Social structure and processes of social support. In S. Cohen & S. L. Syme (Eds.). Social support and health (pp. 43-60). Orlando: Academic.

Piliavin, I., & Sosin, M. (1987-88). Tracking the homeless. Focus 10, 4, 20-24.

Pittman, D. J., & Gordon, T. W. (1958). Revolving door: A study of the chronic police case inebriate. New York: Free Press.

Ropers, R. (1984b, October). Typology and profile of the homeless. Conference on homelessness in the U.S., American Public Health Association, Anaheim, CA.

Rossi, P. (1989). Down and out in America. Chicago: University of Chicago.

Schaefer, C. Coyne, J., & Lazarus, R. (1981). The health-related functions of social support. Journal of Behavioral Medicine, 4(4), 381-406.

Selye, H. (1956). The stress of life. New York: McGraw-Hill.

Straus, R. (1946). Alcohol and the homeless man. Quarterly Journal of Studies on Alcohol, 7, 360-404.

Tardy, V. P. (1985). Social support measurement. American Journal of Community Psychology, 13(2), 187-202.

University of California, San Francisco, Department of Family Health Care Nursing. (1981). Definition of family. Mission Statement (Fall).

Webster's new world dictionary. (1988). (3rd ed.). New York: Webster's New World.

Wills, T. A. (1985). Supportive functions of interpersonal relationships. In S. Cohen & S. Syme (Eds.), Social support and health (pp. 61-82). Orlando: Academic.

APPENDIXES

APPENDIX A

Authorization Letter from Stanford Center for Research in Disease Prevention

Stanford Center for Research
in Disease Prevention
STANFORD UNIVERSITY SCHOOL OF MEDICINE

1000 WELCH ROAD
PALO ALTO, CA 94304-1885
TELEPHONE: 415 723-1000 TELEFAX: 415 725-6906

October 29, 1990

Ms. Judith Sherman
220 Palo Alto Avenue #307
Palo Alto, CA 94301

Re: Human Subjects Institutional Review Board
San Jose State

Dear Judith:

This is to confirm that you will have access to the data from the Stanford Homeless Survey with which you have been involved. Specifically, you will have access to the data on demographics (e.g., age, sex, race, marital status) and childhood risk factors (e.g., foster care). In addition, you will have access to the open-ended question that describes the circumstances that led to a person's first episode of homelessness.

It is my understanding that you will request data analyses from our computer/-biostatistical group at Stanford and that we will provide you with the results. The analyses will focus on profiles of homeless adults in Santa Clara County, stratified by marital status. Appropriate comparison groups will be adults from the 1980 U.S. census and other homeless who were interviewed as part of our study.

I encourage you to prepare a manuscript of your findings for the medical literature. If you take primary responsibility for the writing of this manuscript, you would be first author and I would be a co-author.

I look forward to working with you as you plan your data analyses and findings on this topic.

Best regards,

Marilyn Winkleby, Ph.D.
Director of Evaluation/Epidemiologist

MAW:dm

APPENDIX B

San Jose State Human Subjects Institutional Review Board Approval

SJSU SAN JOSE STATE UNIVERSITY

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Judith A. Sherman, Nursing
220 Palo Alto Ave. #307
Palo Alto, CA 94301

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: November 15, 1990 Charles R Bolz

As required by University policy, the Human Subjects Institutional Review Board has reviewed your proposed project entitled:

"Length of Homelessness and Social Support Factors: A Comparative Analysis"

Because your project is to be limited to the collection of existing data that cannot be identified or linked with human subjects, your project is exempt from further review. Therefore, you may proceed without further review by the Human Subjects Institutional Review Board.

I, however, do caution you that whenever people participate in your research as human subjects, they should be appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity with regard to any and all data that may be collected from the subjects. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised when people participate in your research as human subjects, each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

APPENDIX C

Stanford Instrument

STANFORD HOMELESS SURVEY

Date: __/__/__ Initials of person doing survey: _____
We are asking a few questions about your health and background so we can learn more about homelessness. We do not record your name and all information is confidential.

1. Sex: Male _____ Female _____
2. Main language: English ____ Spanish ____ Other ____
3. What is your race? White ___ Black ___ Hispanic ___ Asian ___ Am. Indian ___ Other ___
4. What is your birthdate? ___/___/___
5. So your age is? ____ years

6. Where were you born? State _____ (If not the U.S., what Country?) _____
7. At what age did you move to San Jose or the Bay Area? _____ Age
8. In what city was your last permanent home (or address)? _____ City

9. What is the highest grade in school that you completed? (high school graduate = 12)
   Circle highest: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+
10 Did you receive a: regular high school diploma ____ GED ____ or neither ____

11. Are you: Married ___ Separated ___ Divorced ___ Widowed ___ or Never Been Married ____

12. When you were growing up, would you describe your family as:
    Lower income ___ Middle income ___ or Upper income ___

13. Before age 18, were you ever physically abused?
    Yes ___ No ___
15. Before age 18, were you ever sexually abused?
    Yes ___ No ___
16. Before age 18, were you ever arrested or sent to juvenile court? Yes ___ No ___
    (If yes) Did you have a probation officer?
    Yes ___ No ___
    (If yes) Why were you arrested? _____

17. Is the first time you have ever been homeless?
    Yes ___ No ___

18. How long have you been homeless this time?
Under 1 week ___ 1-4 weeks ___ 1-12 months ___
1-5 years ___ Over 5 years ___

19. How much total time have you ever been homeless?
Under 1 week ___ 1-4 weeks ___ 1-12 months ___
1-5 years ___ Over 5 years ___

20. At what age did you first become homeless?
_____ Age in years

21. Did you ever serve on active duty in the military?
Yes ___ No ___
(If yes) Which branch? Army ___ Marine ___ Navy ___
Air Force ___ Other ___
(If yes) What years did you serve? 19___ to 19___
(If yes) Did you serve in combat? Yes ___ No ___

22. Have you ever worked full-time? Yes ___ No ___
(If yes) What type of job did you work in the longest?
(give job description, not just company) _____
(If yes) How long did you work full-time between age 18 and the time you were first homeless? _____ years (or months ___)
(If yes) How many hours did you work last week?
____ hours/week

23. What was your main source of income before you were first homeless? Job ___ Family or spouse ___
SSI/disability ___ Social Security ___
Welfare/AFDC ___ Pension ___ Other ___ (If other, what? _____)

24. What caused you to become homeless for the first time?

(Interviewer: code the one main personal reason):
___ Alcohol only
___ Drugs only
___ Both alcohol and drugs
___ Injury/medical problem
___ Emotional/mental problem
___ Family conflict (kicked out/abuse/fighting)
___ Family ending (divorce/separation/death/moved)
___ Just immigrated/moved to new area
___ Just released from hospital/jail/rehab program
___ No personal reason
___ Other reason (What? _____)

(Interviewer: code the one main economic reason):
___ Evicted or home condemned
___ Laid off from work/job ended
___ Quit or fired from work (Why? _____)
___ New financial obligations (What? _____)
___ Decrease in income or government support
(Explain _____)
___ Rent raised
___ Working but couldn't afford rent
___ No economic reason
___ Other reason (What? _____)

25. Did you ever think that you were an excessive drinker?
Yes ___ No ___
(If yes) Was it: Before you were first homeless ___
After ___ Both before & after ___

26. Did you ever drink 7 or more beers, 7 or more drinks, or 7 or more glasses of wine every day for 2 weeks or more? Yes ___ No ___
(If yes) Was it: Before you were first homeless ___
After ___ Both before & after ___

27. Have you ever used any illegal drug every day for 2 weeks or more? Yes ___ No ___
(If yes) Was it Cocaine ___ Crack ___ Heroin ___
Speed ___ Other ___ (What? _____)

28. Have you ever visited a doctor or mental health specialist for emotional or mental problems?
Yes ___ No ___
(If yes) Was it: Before you were first homeless ___
After ___ Both before & after ___

29. Have you ever stayed overnight in a hospital or treatment program for emotional or mental problems?
Yes ___ No ___
(If yes) How many times? ___
(If yes) Was it: Before you were first homeless ___
After ___ Both before & after ___

30. Did a physical injury or medical problem contribute to your becoming homeless for the first time? (Exclude mental problems, alcohol or drug use) Yes ___ No ___
(If yes) Was it an injury ___ or medical problem ___
(If yes) What was the problem? _____
(If yes) How did it occur? _____

(If yes) How old were you when this occurred?
___ years
(If yes) Did you have health insurance for this problem? Yes ___ No ___
(If yes) Does it keep you from working full-time now?
Yes ___ No ___

31. Do you currently have any kind of health insurance or Medi-Cal or MediCare?
None ___ Medi-Cal ___ MediCare ___ Private/Kaiser ___
VA ___ Other ___

32. How many cigarettes do you currently smoke a day?
(20 cigarettes = 1 pack) A few or none ___
About 1/2 pack ___ 1 pack ___ 1 1/2 packs ___
2 or more ___

33. Where have you usually slept in the last month?
Outside ___ Vehicle ___ Tent ___
Deserted/public building ___ Mission/shelter ___
Hotel/room/apt/house ___ Other ___

(END--THANK PERSON, GIVE GIFT, AND REFER TO SIGN IN)
(DON'T ASK: Outcome) Completed ___ Refused ___
Mentally unable ___ Drug/alcohol problem ___