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Homelessness, Mental Health, and Stressful Life Events

The Madrid Experience

The investigation of homelessness in Spain and throughout all of Europe involves two specific challenges: (1) that a prepared, official definition of homeless is not at the disposal of researchers, and (2) that few well-controlled studies exist to contribute to the knowledge base in this area. These obstacles are being slowly overcome through sociological [1] and psychosocial [2, 3] studies that provide significant information on homelessness through the systematic gathering of data. In the present article, we synthesize the main data on this topic available in our country, first, by presenting preliminary results of a project investigating the sociodemographic characteristics of the homeless in Madrid [4] and, second, by examining the complex relationships among homelessness, mental health, and stressful life events. The data are directly related to homeless people in the city of Madrid, but we shall compare this information with results from studies in other European and North American cities.

Description and sociodemographics

It is well known that the term *homeless* is difficult to define. As there is no general agreement among researchers or professionals in this regard, varied definitions of homelessness create large discrepancies in the resulting data. For instance, reports from the United States on homelessness cite figures of between 300,000 and 2 million [5–7]. Link [8] conducted an extensive telephone survey and determined that 14 percent of the U.S. population, some 26 million people, have experienced at least one episode of homelessness in their lifetime. The differences in these

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prevalence estimates—based on data collected within the same general time frame—are astounding.

Many studies clearly demonstrate that such widely varying results are due not to measurement problems such as the use of inadequate or psychometrically inconsistent instruments [9], but rather to the employment of distinct definitions of homelessness and/or inadequate, inconsistent, or biased sampling procedures.

Almost all definitions of homelessness incorporate the absence of adequate housing and a certain grade of social network deterioration (or social isolation). Individual definitions differentially emphasize each of these factors; but in practical terms, empirical investigations of the homelessness phenomenon often focus only on the first criterion. However, the unavailability of adequate housing is not always the defining issue for the homeless. Until the 1960s, the U.S. Census Bureau included in its definition of homelessness those who received a pension, lived in skid-row hotels (rarely sleeping in the streets), and demonstrated family or social indifference [6, 10].

The time frame incorporated in the definition is also important. Santiago and colleagues [11] have shown that if the definition of homeless is changed from being literally "without a home" to being "without a home at least once in the last three months," the population in question increases by 50 percent. Such differences indicate that the definition of "homeless" applied in each study ought to be as explicit as possible.

Prevalence estimates in Europe also vary for the same reasons. Avramov [12] determined that between 1.8 and 2.7 million homeless people live in Europe, but her data are not based on a specific, common definition.¹ In Spain, as in any other European country, there is no official definition of homelessness; and the data from different sources vary considerably. Avramov [12] has estimated, on the basis of shelter use alone, that 11,000 people are homeless in Spain (which has a total population of 40 million). Yet, Salinas [13] estimates that 45,000 people are homeless whereas Avramov [12] cites some 225,000 with serious housing needs.

As Calsyn and associates point out [9], sampling procedures also directly impact upon the results of an investigation and impede accurate cross-study comparisons. For example, the location of the sample plays an important role. A National Institute on Drug Abuse (NIDA) study of 999 homeless people demonstrated that the prevalence of drug use/abuse and of mental illness among the homeless varied depending on the location of the interview with clients (e.g., streets, shelters, soup kitchens, or cluster housing areas) [14]. A sampling procedure that focuses only on homeless people who use specialist facilities may not be representative because those who are reluctant to use such services and those who are "at risk" (living in low-cost housing or doubled-up with friends or relatives, etc.) are excluded from the sample [10]. If past studies had limited the location of the sampling to only streets and shelters, they would have lost between 28 percent [14] and 50 percent [15] of their sample populations.

Since study of the "literally homeless" is not an easy task, many studies tend to

oversample homeless people living in shelters and soup kitchens. Even though the homeless are often typically concentrated in a few pockets of the city, this is not always the case [16]; and the search for subjects becomes still more complicated. In addition to methodological difficulties, the resource implications of studying street-dwellers are significant. In the already mentioned NIDA study on substance abuse among homeless people in Washington, D.C., the interviews conducted on the 64 homeless street-dwellers cost two times more than that for the 844 others located through special service facilities [10].

Though it is difficult to gain access to the population of the literally homeless in a given city, it is important that those who study the phenomenon of homelessness take this population into account. Ideally, investigations based on interviews with homeless people in service centers should estimate the number of homeless street people who are not using any services at a given time (and therefore are excluded from the sample). To accomplish this task, a method called "Night S" may be used to help investigators: (1) determine the percentage of people who sleep in the streets on a given night and, (2) through a brief interview, estimate the percentage of those who have not utilized any service during a specific period of time (e.g., four weeks). As a final consideration, the composition of a homeless sample obtained from the available service facilities in a given area should be determined as a function of the number of different users of each service. Even with a very rigorous sampling methodology—see a discussion of the methodology in reference [17]—there is the risk that the estimations of the various groups (based on service usage) within a homeless sample may overvalue the people who utilize the services more frequently because they have a higher probability of being included in the sample.

In summary, studies of homelessness in a particular city should include the following: (1) an exact definition of homelessness—differentiating between the "literally homeless" and people with housing difficulties, and clarifying the time frame; (2) information on the location of the sample and the percentage of homeless that the sampling strategy has excluded (estimated by Night S or a similar method); and, lastly (3), the composition of the sample with respect to the capacity of the services and the frequency of their use by homeless people.

In Spain only one study brings together each of these elements—a study of the homeless in Madrid [18] currently in the follow-up phase. Our investigation utilized the definition of homelessness from FEANTSA [12], referring to those homeless at the time of the interview (or the literally homeless). We conducted an exhaustive census of homeless services available in Madrid. The "Night S" estimation method, as used in the NIDA study [14] and in Paris [19, 20], showed that the sample gathered in shelters and soup kitchens during the four weeks of the study included 97 percent of the homeless people in Madrid. Therefore, the exclusion of homeless people living on the streets did not create a biased sampling. "Night S" verified that for the given sample, the street did not provide a significant source of homeless people. The sampling procedure also involved data collection from all of the shelters and soup kitchens in the city, represented as a function of

their capacity and usage. To assure truly representative sampling, the data for each variable were weighted by an inverse function of the size of the service chosen and the frequency of its use [20]. In assigning weights, we also considered possible deviations in the theory sample and the empirical sample [17]. Based on these weights, the sociodemographic variables of the sample are shown in Table 1.

As seen in Table 1, the homeless in Madrid comprised 79 percent men with an average age of 42 years. The data contrast with reports from previous studies that suggest that the numbers of women and young people within the homeless population are rapidly increasing. It is possible that the results of such studies were flawed because they were based on data from an inadequate sample that did not accurately represent the true homeless population. Though based on preliminary data, it can be concluded that such demographic changes within the homeless population are not occurring as rapidly as some professionals seem to indicate. In fact, our data might suggest that the social protection services are functioning better for women and children than for adult males. This issue is important as further studies begin to shed more light on the problem of homelessness in Spain and other European countries.

With regard to other sociodemographic characteristics, 97 percent of the homeless in Madrid are unemployed and have low levels of formal education. Most of the homeless in our sample live alone (87 percent) and have a very limited family network available for social interaction and/or support. These findings emphasize that the homelessness problem goes beyond simple economic issues to include social isolation as another defining factor of the "condition." The situation of homeless people in Madrid is also a chronic one—80 percent have been homeless for over one year, and 41 percent, for more than five years. Such data suggest that the current preventive services at work in this area are failing.

After the cutoff point at which a person becomes homeless, it becomes exceedingly difficult to facilitate a return to his or her previous level in society. The social exclusion that comes with the homeless status is pervasive enough to impact upon almost all areas of one's life. In this respect, housing and meal services are in no way sufficient to meet the real needs of this population. The present preventive services do not attempt to reintegrate the homeless into social life. The use and development of more complete, flexible preventative instruments or global reinsertion tools such as programs of assertive community training [21, 22] are ways to facilitate a solution to the problem of homelessness and focus on the reentry of the homeless into the society at large.

Mental health

The majority of the data examining the relationship between homelessness and mental health comes from the United States, though a few controlled studies have also been conducted in other countries (see Table 2).

However, social conditions such as poverty, social security, and social networks

Table 1

Sociodemographic Characteristics of the Weighted Sample of Madrid Homeless (N = 289)

Gender (% males)	86.9
Mean duration of homelessness (years)	4.6
Mean age (years)	38.7
Nationality	%
Spaniards	77.6
Immigrants	22.4
Marital status	
Single	65.4
Married	7.3
Divorced	13.5
Separated	9.7
Widowed	3.5
Living alone	86.6

vary greatly from one country to another [36], and therefore it is difficult to make a generalization about this relationship. In addition, the data that do exist on the mental health of homeless people are not uniform. In his review of more than eighty early studies, Fischer [37] discovered that the percentage with substance abuse problems ranged from 1 percent to 90 percent—see also [38]. These enormous differences can be explained by the different methodology used to obtain the data. Biased sampling procedures and the use of insufficient or inadequate measuring instruments [30] can cause varying results.

The most reliable data available on the relationship between homelessness and mental health cite prevalence rates of serious mental disorders among the homeless of between 25 percent and 35 percent [39]; if other disorders (such as anxiety and antisocial personality) are included in the definition of a serious mental disorder, the prevalence rate may increase to 80 percent or more for a given sample [32]. Lehman & Cordray [21] conducted a meta-analysis of six well-controlled studies with sound measures of mental health. Their data show that 46 percent to 49 percent of the homeless have drug dependencies, and 29 percent to 31 percent suffer from problems of alcohol abuse. In studies that have compared data gathered from the homeless and community residents [26, 32, 33, 40, 41], the risk ratios show that, for all diagnoses, homeless people are much more likely to have mental disorders than samples from the general population.

There are also a few European studies that have utilized reliable and valid mea-

Table 2

Lifetime Prevalence (in Percentages) of DSM-III or DSM-III-R Disorders Based on Structured Interviews. Results of U.S. Homeless Studies Compared with non-U.S. Homeless Sample Data Obtained Using Similar Methods

Population and authors	Location	Site	Instru- ment	N	Male (%)	Schizo- phrenia	Major depres- sion	Dys- thymia	Current Alcohol abuse or de- cognitive or de- impair- ment	Drug abuse or de- per- dence	
U.S. homeless:											
Fischer et al. (1986), [23]	Baltimore, MD	Shelters	DIS	51	94	2.0 ^a	13.7 ^b	NR	7.8	NR	NR
Vernez et al. (1988), [24]	California	Shelters, streets	DIS	315	62	11.0	22 ^b	—	NR	57	48
Koegel et al. (1988), [25, 26] ^c	Los Angeles, CA	Shelters, meal programs, indoor congregation areas	DIS	328	95	13.1	18.3	9.3 ^d	3.4	62.9	30.8
Toro & Wall (1991), [27]	Buffalo, NY	Shelters, streets	DIS	76	79	1.4	10.5	7.9	0	52.8	36.6
North & Smith (1992), [28]	St. Louis, MO	Shelters, hotels, indoor congregation areas	DIS	900	66	4.7	16.9	NR	NR	37.2	15.5
Non-U.S. homeless:											
Herrman et al. (1989), [29]	Melbourne, Australia	Shelters, hotels, accommodation houses	SCID	382	82	13	20	4 ^e	NR	44	20

(continued)

Table 2 (continued)

Population and authors	Location	Site	Instrument	N	Male (%)	Schizophrenia	Major depression	Dysthymia	Current severe cognitive impairment	Alcohol abuse or dependence	Drug abuse or dependence
Vázquez et al. (1997), [30]	Madrid	Shelters, soup kitchens, streets, case-management programs	CIDI	261	79	4.2	19.8	16.8	6.3	44.3	13.2
Steegers et al. [31] ^{c,f}	Amsterdam	Shelters, drop-in centers, and service centers	CIDI	50	88	14	22	NR	NR	46.0	58.0
Fichter et al. [32] ^c	Munich	Shelters, soup kitchens, streets	CIDI	146	100	12.4	18.5	5.5	8.9	91	17.8
Greifenhagen & Fichter [33] ^c	Munich	Shelters, soup kitchens, streets	CIDI	32	0	25	50	6	0	91	41
General population:											
Regier et al. [34]	5 U.S. cities	Households	DIS	18,571	41	1.3	8.3	6.0	NR	13.3	5.9
Kessler et al. [35]	48 U.S. states	Households	CIDI	8,098	48	0.6 ^a	12.7	4.8	NR	20.1	9.2

Notes:

DSM-III: Diagnostic and Statistical Manual of Mental Disorders.

DIS: Diagnostic Interview Schedule.

CIDI: Composite International Diagnostic Interview.

SCID: Structured Clinical Interview for DSM-III-R.

NR = Not reported.

^a Includes 3-month symptoms.

^b Includes "affective disorders" in general.

^c DSM-III exclusion rules were not used.

^d Only current episode.

^e Diagnosed with a version of the SCID.

^f Only adolescents.

surement instruments. In one of these studies, our team studied 262 Madrid homeless sleeping primarily in the streets, shelters, parks, or other places normally unfit for human habitation during the previous month. Subjects were randomly selected from the streets and a number of shelters and soup kitchens. The final sample was stratified according to the type and number of services available and the estimated number of homeless people living in the streets in Madrid [30]. To avoid seasonal biases, the sample was collected between autumn 1993 and spring 1994. Subjects were interviewed with the Composite International Diagnostic Interview (CIDI), a structured interview that provides DSM-III-R diagnoses [42]. Only a subset of diagnoses was selected: major depression, dysthymic disorder, cognitive impairment, schizophrenia, schizophreniform disorder, and disorders related to the consumption of alcohol and illegal drugs. Eighty-eight percent of all clients contacted agreed to participate in the study.

Of all of the homeless people studied in Madrid, only 4 percent had schizophrenic disorders (see Table 2). These findings support the results of other studies conducted using multisite-sampling procedures. Although some studies cite much higher rates of schizophrenia among this population [41], their data may be based on inadequate sampling techniques (for example, surveying only the homeless found in a convenient location such as a hostel). The low rate of schizophrenia among the Spanish homeless may be a result of strong family ties. Hogman [43] determined that Spain is the European country with the highest rates of chronically ill people living with their families. For similar reasons, the deinstitutionalization of psychiatric patients has had less of an impact in Spain than in other countries [44].

One of the most significant findings emanating from the study of the relationship between homelessness and mental health involves the high prevalence of anxiety and affective disorders. Not only is the rate of major depression elevated among the homeless—affecting almost 20 percent of the sample—but also the rate of dysthymia (see Table 2). Mania, a disorder that affects fewer than 1 percent of the general population, is also present at a very high rate. Fichter and associates [32] found that 31.5 percent of his homeless sample had suffered at least one manic episode, whereas studies in the United States have found the prevalence rate to be 10.6 percent [26]. Data from various studies show that anxiety disorders also affect approximately 20 percent of the homeless population [26, 32, 33].

Drugs and alcohol

Until the 1970s, traditional views of homelessness were based on the belief that all homeless people were incurable, chronic alcoholics who lived on the streets because of their alcoholism [10, 23]. The data from recent studies demonstrate that even though this perspective is not completely accurate, the rates of substance use and abuse are much higher among this population than among community samples (see Table 2). Consequently, the consumption of alcohol and other drugs has again

become an important aspect of the problem of homelessness [45, 46]. Substance use is an especially relevant issue not only because of its role in creating health problems [47] but also because of the associated risk factors in other areas. Alcohol consumption, for example, increases the probability of death [48], police arrests [49], and, for women, sexual victimization [50].

Data from our study of the Madrid homeless indicate that 50 percent have "[some] substance abuse or dependence" (44.3 percent related to alcohol use and 17 percent to drugs). As expected, men had significantly higher rates for alcohol-related disorders than women (48 percent vs. 18 percent); but there were no gender differences with regard to drug-related disorders. Our findings seem to be similar to the results of other European and non-European studies, with the exception of the Munich study, in which 91 percent of their homeless sample were suffering from alcohol abuse or dependence.

However, in comparisons of specific drug abuse or dependency across countries, European studies (excluding the Munich study) consistently show lower rates than those found in the United States [30, 51]. For instance, data from a sample of homeless people in Los Angeles show much higher lifetime and 12-month prevalence rates than the Madrid homeless in practically all categories [51]. In the lifetime prevalence of "any substance dependence, including alcohol" the Los Angeles figures are twice as high as those for Madrid (72.6 percent vs. 36.5 percent). The same is observed in the "only alcohol dependence" category (57.4 percent vs. 28.3 percent), and still more significant is the difference in the "any drug (except alcohol)" category; the Los Angeles figures are four times higher than those for Madrid (49 percent vs. 12.8 percent). The data corresponding to use of individual drugs show the same tendency: the percentage of homeless suffering from dependence is always higher in Los Angeles. Similarly, the homeless in the Los Angeles sample have significantly more social problems (e.g., effects on work, school, or child care), emotional problems (e.g., lack of interest, depression), and health problems (e.g., hepatitis) related to alcohol and drugs than the homeless in the Madrid sample counterpart [51].

In cases of association between affective disorders and substance abuse, two or more diagnoses often may be applicable to one person [2, 32]. This elevated comorbidity among the homeless makes it even more difficult to adequately provide effective treatment for this population [25, 52].

Stressful life events

It is also important to understand the type of life experiences to which homeless people are exposed in order to identify other factors that may come into play. Evidence from various studies shows how stressful life events (SLEs) are directly involved in the etiology and maintenance of diverse mental disorders [53–55]. The relationship between SLEs and homelessness has also been revealed in recent investigations [2, 56–63].

Specific studies have demonstrated how SLEs may play a significant role in the genesis [4, 28, 64] and maintenance of homelessness. In accordance with the vulnerability models of the condition, homeless people typically suffered a large number of stressful occurrences during their lives. These events, found to occur *before* the first episode of homelessness, may cause a loss of family and/or friendship bonds (or of social networks) and, at the same time, precipitate the mental disorders common among this population. Nevertheless, the condition of being homeless greatly increases one's probability of being assaulted, robbed, or violated or experiencing other such stressful events associated with life in the streets.

In our studies of homeless people in Madrid, we gathered data on the temporal relationship between specific SLEs and the first episode of homelessness [2, 4], using a multisite sampling technique and Rossi's "blitz" procedure [65]. A random sample of 262 people was selected from shelters, soup kitchens, social services, and the streets. The Life Events Questionnaire (LTE-Q) [66] was adapted to include a selection of ten other items proposed by a group of professionals directly assisting the homeless population of Madrid.

As in previous studies [3, 56-59, 60-63, 67], the average number of SLEs *suffered during the lives of those interviewed was very high (approximately nine over a lifetime)*. Table 3 presents the percentage of those interviewed who suffered each one of the SLEs evaluated. In our study we also examined the distribution of these stressful life events across the periods before, during, and after the transition to homelessness. Table 3 also shows the percentage of SLEs in each of the three temporal categories. Chi-square analysis was used to determine the significant differences among temporal categories. General SLEs seem to occur most frequently (45 percent) during the period before the transition to homelessness. Thirty-nine percent of the SLEs were found within the period of transition to homelessness. After a person becomes homeless, the number of SLEs shows a dramatic decline in which only 16 percent of the SLEs that occur within a homeless person's lifetime happen once he or she actually becomes homeless.

The temporal relationship between SLEs and homelessness within our Madrid sample can also be analyzed using Daly's classification of causal factors of homelessness. In her report on the homeless situation in Europe [68], she states that the most common causes of homelessness relate to four types of SLE: material (economic crises, essentially related to poverty), affective/relationships (mainly related to a loss of social support), personal (including illness, both mental and physical addictions, and loneliness), and institutional (relating to all types of institutions). Each of these is discussed below with reference to our Madrid data.

Material factors

Practically all those interviewed (97 percent) were unemployed (the majority for over a month [83.5 percent]) and/or had suffered other economic crises (77.5 percent). Material SLEs appear in the highest proportion during the period of "rup-

Table 3

Occurrence of Stressful Life Events with Respect to the Appearance of the First Homeless Episode

Life events	Before (B) %	During (D) %	After (A) %	N	B-D χ^2	D-A χ^2	B-A χ^2
LTE-Q, Brugha & Cragg (1990) [66]							
1. Personal serious illness, injury, or assault	54	27	19	119	10.7*	1.5	19.3*
2. Serious illness, injury, or assault of a close relative	51	28	19	67	4.7	1.1	10.1*
3. Death of a partner, parent, or child	62	22	14	136	27.8*	2.5	43.6*
4. Death of close friend or relative	62	25	11	103	17.4*	6.1	39.3*
5. Separation due to marital difficulties	34	56	8	72	3.9	26.1*	11.7*
6. Breaking off a steady relationship	40	45	15	108	0.4	16.7*	12.3*
7. A serious problem with a close friend, neighbor, or relative	36	51	12	77	1.5	18.7*	10.5*
8. Unemployed or seeking work unsuccessfully for more than 1 month	17	58	25	190	42.8*	24.3*	3.2
9. Fired from job	28	46	25	80	3.3	5.1	0.2
10. Major financial crisis	17	61	22	171	43.1*	32.6*	0.9
11. Problem with the police and a court appearance	36	42	22	88	0.4	5.8	3.3
12. Something valuable lost or stolen	37	39	23	64	0.0	2.5	2.1

Additional items (suggested by experts on homelessness)

13. Alcohol abuse	46	45	9	123	0.0	30.2*	30.2*
14. Drug abuse	52	36	11	44	1.3	5.7	11.6*
15. Being in jail	41	41	19	69	0.0	5.5	5.5
16. Orphanage	92	4	4	24	19.2*	0.0	19.2*
17. Psychiatric hospitalization	42	32	27	60	0.8	0.3	1.9
18. Felt abandoned by relatives and friends	29	53	18	142	9.9*	23.8*	3.4
19. Special Army corps	82	14	4	44	21.4*	2.0	30.4*
20. Job away from home	71	23	6	82	19.7*	8.2	44.6*
21. Serious mental illness	36	36	27	23	0.1	0.6	0.3

Notes: Bonferroni = 0.004; * P < 0.001.

Before: Period of time > 2 years before the first homeless episode.

During: Period of time between 2 years before and 1 year after the first homeless episode.

After: Period of time > 1 year after the first homeless episode.

ture," or break-off, into homelessness. However, a few of these SLEs, such as unemployment or a great monetary loss, had a high probability of occurring before and continuing after the first episode of homelessness.

Affective/relationships factors

There was a relatively large number of SLEs in this category, and the majority affected nearly 50 percent of the sample (see Table 3). Almost one of every three people interviewed had suffered the death of a principal relative (parent, child, or partner), and almost two-thirds had suffered the death of a family member or close friend. Emotional problems or troubles with relationships appeared as often before the first episode of homelessness as during the transition, but the probability of the occurrence of an affective/relationship SLE dropped sharply after the first homelessness episode.

A significant conclusion can be drawn from these findings. At least in our sample, the loss of social skills and ties is important principally in the process of becoming homeless. It is probable that once a person arrives at the point of homelessness, the emotional isolation is so complete that there are no more relationships and therefore none that could become problematic.

An interesting pattern appears in the temporal relationship between affective/relationship SLEs and homelessness. Events such as the death of a friend, family member, etc., and sickness (in either themselves or those close to them) occurred before the first episode of homelessness, and the same pattern was seen with regard to having jobs that drew the subjects away from home. Nevertheless, problems associated with relationships and the loss of social support tended to appear during the transition period between having a home and becoming homeless.

Personal factors

One of every two homeless people interviewed reported having had serious health problems. However, only 18.4 percent had suffered from serious mental problems. More than half of the sample admitted problems with alcohol abuse (53.4 percent), yet drug abuse affected a relatively small portion of the sample (8.6 percent). On the temporal axis, personal factors tended to appear before and during the transition to homelessness. Problems with mental health were the only exception. Once a person has become homeless, there still appears to be a significant probability that he or she will suffer a mental illness.

The other personal SLEs either do not occur after the transition to homelessness or are not seen as new problems. These types of problems may occur before the first episode of homelessness and afterward either disappear or continue without change, in which case they are not considered new problems.

A comparison of temporal relations among categories showed that the affective/relationship and personal SLEs are both more likely to appear during the transi-

tion to homelessness. For example, feelings of loneliness and abandonment affect two of every three homeless people (63 percent) and appear with greater frequency during the transition to homelessness. Thus, the SLEs involving emotional and social issues tend to be more problematic during the process of becoming homeless.

Institutional factors

Institutionalization during childhood affected relatively few people in the sample (10.9 percent). Only 26 percent had been institutionalized for mental illness at some point in their lives, and in most of such cases for only short periods of time. Problems occur with similar probability throughout the subject's life, although incidents involving institutionalization of children or youths generally appear before becoming homeless.

Interestingly, the data obtained on previous psychiatric hospitalization are in line with those obtained in other studies [69, 70]. Even though a few authors maintain that an inadequate deinstitutionalization policy has led to a huge increase in the homeless population [71], scientific evidence does not exist to support this point of view [72]. Our data suggest that deinstitutionalization does not play an important role in homelessness, at least in Spain, where those few people living on the street who had been previously institutionalized had been hospitalized for only less than six months [73].

Discussion

Given the available data on the relationship between homelessness and stressful life events of all types, it is possible to draw some general conclusions. Although mental health problems and alcohol and other drug use are not necessarily associated with homelessness, it is clear that these problems, along with SLEs, are prevalent at much higher rates than found in the general population.

The causal factors that precipitate homelessness are still far from being well understood. Professionals who work in this area agree that intervention must be broadly based and incorporate all economic, social, and psychosocial factors that initiate and maintain the conditions of homelessness. Yet even with a general consensus on how to proceed, each factor's weighting and critical moment of appearance remain unknown.

In analyzing the temporal sequence of the process of becoming homeless and the history of drug and alcohol use in Madrid and Los Angeles [51], we found that in both cities between 78 percent and 100 percent of the homeless with a history of alcohol or substance abuse had their disorder *before* experiencing their first homelessness episode. A similar finding has been found in a sample of German homeless women [33]. Although this relationship does not imply causation, some authors suggest that family and economic problems and the lack of housing can exert an especially grave influence on people with mental and/or drug abuse prob-

lems [34]. The high prevalence rates of mental illness found previous to the onset of homelessness tend to be preceded by a large number of SLEs from childhood [18]; but, once again, we cannot make a simple causal interpretation of these findings.

Further understanding of the relationships between homelessness and SLEs is crucial, because knowledge in this area may lead to the design of possible *early* preventive strategies in diagnosing and treating high-risk persons. The findings presented here emphasize the need for tools that work in a comprehensive fashion to resolve the multiple psychological, social, and economic problems that characterize the homeless population [10]. In the area of mental health, for example, the data show that even though the homeless have a positive outlook regarding their health [32] and their future [4], a percentage of them succumb to adverse life circumstances that ultimately lead to major depression and dysthymia.

Despite the fact that some studies show high prevalence rates of dysthymia, mania, and anxiety disorders among the homeless population, very few studies have investigated this topic. Future work involving more exhaustive coverage of diagnostic categories will help professionals provide more adequate services. For instance, one effective intervention with this subset of the homeless population might include an effort to alleviate their mental problems by employing normal mental health services in conjunction with special services that focus on outreach strategies [41, 74, 75] and community-oriented interventions [22, 76].

In order to better understand homelessness and the causal factors that initiate and maintain the condition, it is important to examine both cross-cultural studies [69] and cross-national studies [77]. Unfortunately, each study tends to employ its own methodological techniques, involving the use of different measurement instruments, varying definitions of the sample population and descriptions of the composition of the sample, and manipulation of the data. Such procedural differences make comparisons difficult and can hinder valuable cross-cultural investigations [32, P. 194].

Despite the obstacles, the resulting data can be very useful. For example, the rates of alcohol abuse and dependence are considerably lower in the sample of Spanish homeless than in the sample of North American people without homes. However, this pattern is not seen throughout Europe. In Germany, the rates of alcohol abuse among the homeless are even higher than those in the United States [32]. In examining homelessness in Europe and the United States, it appears that being homeless in Europe is related less to poverty and more to other, additional factors such as mental health and a dramatic reduction in social networks, etc. [32, 44]. This might possibly be due to the relatively good public health and welfare systems that exist in European countries. The analysis of such similarities and differences can help enrich our knowledge of the homelessness phenomenon.

Besides cross-cultural approaches, research is also lacking in the areas of work with high-risk people (there is no precise definition of this group) over long periods of time. Longitudinal studies allow for evaluation of the processes into and out

of homelessness and for a more in-depth examination of the concrete causal antecedents of the condition. The data gathered in our investigation regarding the temporal relationships between SLEs and homelessness provide only a small amount of information; data are still scarce in this respect. Nevertheless, studies of this type will soon begin to shed more light on this important area of research [78, 79].

In conclusion, in order to improve the situation and circumstances of homeless people, particularly those with mental ill health (including alcohol and drug abuse) and social problems, study of this population should not become a mere academic exercise but rather provide a practical guide to the development of possible intervention strategies and future service improvements. In this sense it becomes especially important to adapt existing services for the homeless to meet the real needs of the population for which such services are intended. Some studies have enhanced the assistance provided to homeless people in the city in which the study was conducted [10, 80]. Although most researchers currently have little or no direct connections with service providers and political institutions, we believe that the weight of the scientific data resulting from the rapidly developing, methodologically consistent investigations of the homelessness phenomenon will have a positive effect by impacting upon social service assistance, influencing public policy, furthering understanding of the homeless situation, and ultimately helping to relieve the suffering of the homeless.

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Note

1. These figures were estimated, in 1990, on the basis of data collected by FEANTSA (Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri) from the following countries: Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, and the United Kingdom.

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