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A family systems-oriented approach to the treatment of the homeless, mentally ill, older woman

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A FAMILY SYSTEMS-ORIENTED APPROACH TO THE TREATMENT OF THE HOMELESS, MENTALLY ILL, OLDER WOMAN

by

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A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

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ABSTRACT

A FAMILY SYSTEMS-ORIENTED APPROACH TO THE TREATMENT OF THE HOMELESS, MENTALLY ILL, OLDER WOMAN

by

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This project demonstrates the usefulness of a particular clinical approach to work with a sub-group of the homeless, i.e. older, mentally ill women. The project sought to demonstrate the application of a family systems-oriented approach in reducing disaffiliation by strengthening social attachments. Family systems theory, particularly Bowenian and structural theory, provided the theoretical basis of this intervention. This base offered a lens for viewing homelessness within the context of the family and larger system, and provided a framework for interventions aimed at impacting affiliation status by strengthening family connection.

The study was conducted in the context of a treatment group. The participants were a multi-ethnic group of ten recently domiciled women living in a permanent

residence for the homeless elderly. All were diagnosed as chronically mentally ill according to the guidelines of a state funding stream. The mean age was sixty-three (63) years and the average length of stay in the residence was six (6) months. An exploratory study, the findings strongly suggest that increasing the affiliation of older homeless, mentally ill women is far from hopeless, and that a family systems-oriented approach to their care is a useful tool.

The assessment revealed these family systems to be multi-problem and frequently addictive systems. Interventions were useful in increasing affiliations and resolving cutoffs (i.e. attempts to emotionally or physically distance oneself to solve an underlying problem of fusion), and other family conflicts related to homelessness.

Five practice principles emerged from this research, which, while derived from a clinical experience, are more broadly applicable to the provision of a range of services to this population:

1. Include an assessment of the family system as part of the assessment process.

2. Reconnect these women to their families when it is not contraindicated.

3. Design and deliver services so as to preserve remaining affiliations and promote the development of new ones.

4. Focus on enhancing self esteem and autonomy when delivering residential services.

5. Deliberately develop rules and design residential facilities which reflect women's status as mature adults and which support connection to family and significant others.

The findings of this research must be viewed in the context of the stability a residential setting offers. While the findings are strongly suggestive, they are not proven or generalizeable beyond this group.

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CHAPTER I

INTRODUCTION

Overview

It is estimated that on any given night, three million people across the country are homeless (Hagen, 1987a; Koroloff et. al., 1989). As many as half of the homeless population are mentally ill, a result, in part, of the deinstitutionalization and restrictive admission policies implemented in the 1950's and 1960's (Crystal, 1984; Mowbray, 1985; Telsch, 1986). The numbers of women among the homeless are increasing, and women presently constitute about half of the homeless population (Hagen, 1987a; Koroloff et. al., 1989). In New York City, a significant portion, i.e. eighteen percent, of the female homeless population are older women (Struening, 1988). Almost ten percent of the New York City homeless population are estimated to be age fifty and over (Struening, 1988). Blacks are overrepresented among the homeless of either gender; seventy-five percent of the homeless men and seventy-five percent of the homeless women in the New York City shelter system are Black. (Struening, 1988).

Women have received less attention than men in the literature of homelessness and rarely does this literature attend specifically to the older homeless woman.

Discussions of homelessness have traditionally included the notion of their detachment from the social structure i.e. their disaffiliation. This concept generated stories of white, alcoholic men on Skid Rows who were previously accomplished but 'chose' to 'join out' of society. More recently, perhaps fueled by the increased diversity among today's burgeoning homeless population which includes more women and families as well as the mentally ill, discussions of homelessness have included the impact of social policies such as social-service cutbacks, low-income housing shortages and deinstitutionalization. Program and service models also receive a significant amount of attention in the literature. However, despite the growth of the mentally ill subgroup, little of the literature has attended to specific clinical approaches to working with this population.

This study was undertaken to demonstrate the usefulness of family systems-oriented treatment in reducing the disaffiliation of elderly women who are both homeless and mentally ill. The study not only explored the

application of a specific theoretical approach to treatment with homeless people, but also, through this process, began to look at the families of elderly homeless women. Currently, families of homeless people tend to be mentioned only in the case of the single parent or the couple with small or dependent children. This study also includes a focus on Black elderly, mentally ill women as the researcher was interested in understanding their particular clinical needs.

Exploratory in nature, the study examines the response of ten recently domiciled women to a short-term intervention strategy conducted onsite at a permanent residence for the homeless elderly in New York City. A group was conducted by the researcher which incorporated the family systems approach. An analysis of the treatment process suggests that both group and family oriented interventions are very useful in reducing disaffiliation and identifies the emergent practice principles. Emphasizing the family as a potential source of increased affiliation, the analysis addresses the assessment of the family system and therapeutic techniques aimed at reconnection to family. However, family systems and group interventions were employed in an attempt to increase other areas of affiliation as well, adapting a model of affiliation developed by Bahr and Garrett (1976). The group itself was also found to

be a major source of affiliation for the women. This was, to some degree, expected. However, the group, like the family systems interventions, potentiated affiliations beyond group membership for the women. The practice principles which emerge from this research, while derived from a clinical experience, are more broadly applicable to the provision of a range of services to this population.

The study achieved its main intent, which was to demonstrate the usefulness of the clinical approach. However, in evaluating the process, it became apparent that focusing on increased affiliation was a key issue and that this goal could be reached through a variety of clinical and programmatic strategies. The practice principles which emerge from the study point the way for program designs which can enhance homeless, mentally ill women's affiliation status. This is consistent with the notion of family systems intervention which can target any aspect of the family's ecological field, including a program or service.

Disaffiliation and the Homeless Older Woman

Bahr and Garrett (1970) accepted Theodore Caplow's definition of disaffiliation as a "detachment from society characterized by the absence or attenuation of

the affiliative bonds that link settled persons to a network of interconnected social structures," that is, an unjoinedness. Disaffiliation is a sociological construct which emphasizes one's place and membership in society, one's social roles, e.g. spouse, worker, etc. The aged, who are disproportionately women, tend toward greater levels of disaffiliation, and homeless people both male and female are among the most disaffiliated (Bahr and Garrett, 1976).

While Bahr and Garrett's (1976) work did not strenuously challenge the idea that homeless people somehow chose their detached condition, current literature, the researcher's own experience and this study reveal a strong desire on the part of homeless people to retain their affiliations. For the most part, homeless people struggle to maintain their housing, and enter shelters or the streets only after they have exhausted all other resources. Once homeless, they continue to desire safe, affordable housing (Baxter and Hopper, 1981; Crystal, 1984; Flynn, 1985; Sexton, 1983; Sloss, 1984; Sullivan, 1991). Yet, despite their desire to remain connected, the resultant condition of being homeless still is, for many, a detachment from society.

This project focuses upon the loosening of the women's attachments to family and resulting disaffiliation. The

existing literature and the researcher's own prior experience revealed that the social factors relevant to the experience of becoming homeless are different for women. In particular, factors relevant to family stability play a role in women's homelessness (Garrett and Bahr, 1976). In practice, the researcher noted that homeless women referred to a day treatment program for the homeless, mentally ill elderly often cited family problems in the chronology of events to which they attributed their ultimate homelessness. A pilot study, consisting of a chart review of the case records of 25 women, revealed that cutoffs and family conflicts were frequently noted to be among the antecedents of homelessness in the women's own view and/or were presenting problems raised initially or throughout the course of treatment (Sullivan, 1991). For instance, where a cutoff was among the antecedents of homelessness, it generally resulted in limiting the women's resources with regard to housing and other concrete supports. Intervention geared toward resolving the cutoff would, conceivably, strengthen the women's attachment to family, expand their support network and increase their overall affiliation.

FIGURE 1.

Resolution of Cutoffs and Strengthening Attachment as Means of Increasing Affiliation.

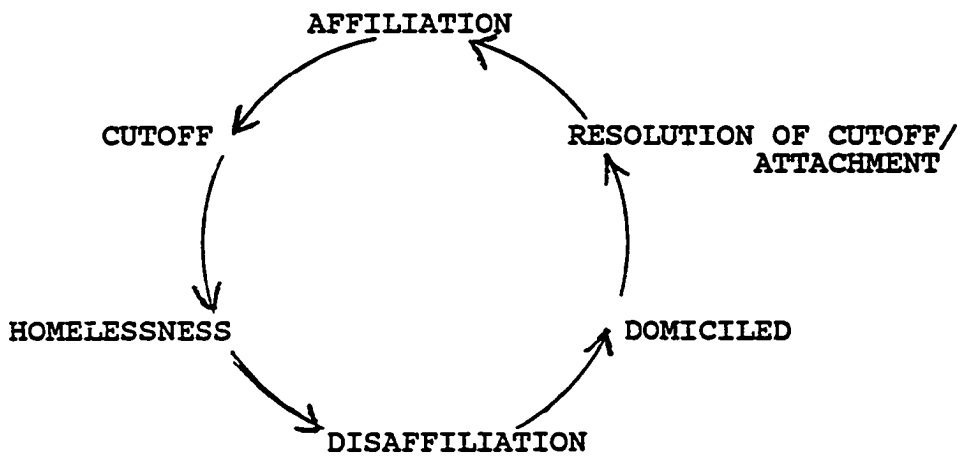

Figure 1. This diagram traces a woman's course from an affiliated state, where she is domiciled and socially connected, through increasing disaffiliation, which may include a cutoff from a significant other. Therefore, once domiciled, resolving cutoffs and strengthening her attachments increases her affiliation.

Family Systems Theory

In a pilot study conducted by the researcher (Sullivan, 1991) family problems were found to be significant in the homelessness of mentally ill older women referred to a geriatric day-treatment program. Specifically, the women frequently mentioned conflictual relationships or cutoffs as factors leading to their homelessness. (See Table 1.) Forty percent of the 25 women treated for varying lengths of time over a three year period presented a relationship cutoff and thirty-six percent presented other family conflicts or problems among their initial presenting problems. Once treatment began, but before permanent housing was obtained for them, sixty percent raised a relationship cutoff as a problem and forty percent raised other family conflicts or problems.

TABLE 1.

Cutoffs and Family Conflict as Precipitant or Presenting Problem Among Homeless, Mentally Ill Older Women

	n	%
N=25		
Precipitating Events Leading to Homelessness		
Relationship Cutoff	7	28
Other Family Conflict	5	20
Initial Presenting Problems		
Relationship Cutoff	10	40
Other Family Conflict	9	36
Problems Raised/Worked on after Intake, Before Permanent Housing was Obtained		
Relationship Cutoff	15	60
Other Family Conflict	11	40
N=4*		
Problems Raised/Worked on Since Permanent Housing was Obtained		
Relationship Cutoff	2	50
Other Family Conflict	3	75

(Responses are not mutually exclusive)

* Refers to sub-group of the women who attained permanent housing.

This seemed to indicate the usefulness of a periodic assessment of family dysfunction, since problems of this nature are elicited not only initially but later during treatment, probably as a function of the development of a trusting relationship or the fulfillment of more concrete needs. Furthermore, intervention in the family system aimed at resolving cutoffs and conflicts could enhance attachment to the family.

This experience generated interest in family systems-oriented intervention with this population. As discussed above, the homeless are a most disaffiliated group. If family dysfunction in the form of severe conflict and cutoffs was a contributing factor in these women's homelessness, then, perhaps, intervention aimed at resolving these problems and reconnecting women to this primary social group would enhance their affiliation.

The current project employed a family systems-oriented treatment within a group context, with the goal of helping women alter the emotional proximity in their significant relationships when this is a factor in their homelessness. A shift in emotional proximity was reflected by one or more of the following:

- a physical or emotional reconnection
- a physical or emotional distancing

- o establishment of new supports

Family systems theory provides a framework or lens for this perspective. While there is no other family systems research focused specifically upon homelessness, there is a considerable body of research applying these concepts to the mentally ill which supports the notion that individual behavior is a function of family relationship styles, especially with regard to the extent and patterns of emotional 'closeness/distance,' 'intimacy,' 'attachment.'

Family systems theories provide a framework for viewing homelessness within the context of the family and larger systems. The family systems perspective explores the transactions between humans and views the individual as being in a circular relationship to elements of the environment, shaping and being shaped by them. Behavior is viewed as being contextually based. Family systems theory holds that when individuals exhibit symptomatic or maladaptive behavior, this behavior is maintained by patterns in the family or the family's ecology. Individuals are viewed as exhibiting or manifesting dysfunction which is actually systemic. Linear causal logic, e.g. the family system caused the individual's problem - is rejected in favor of circular logic emphasizing fit. "The behaviors occurring in the family system have a general complementarity; they fit

together" (Hoffman, 1981, p. 346).

There are several schools of family therapy which grow from different theoretical emphases and have different ideas about change and therapeutic goals. This study relies chiefly upon Bowenian and structural theory. The Bowenian (Murray Bowen) model emphasizes differentiation of self within the family system, avoiding dysfunctional emotional triangles, fusion and cutoffs. The structural model, originated by Salvador Minuchin, emphasizes changing the family structure and rules which maintain symptoms.

The Theory of Murray Bowen

Through research efforts in which Bowen hospitalized entire families, Bowen came to regard the family as a single unit organism and saw the patient as a part of this organism through which the overt symptoms of psychosis are expressed (Howells and Guirguis, 1985). Bowen developed several major concepts of his theory through this experience which are especially relevant to this study. He developed the concept of the undifferentiated family ego mass, i.e. "an intense, clinging interdependence" (Hoffman, 1981, p. 31). He began to view schizophrenia as the result of a three-generational transmission of mental illness. Eventually, health, for Bowen, became differentiation from the family. Bowen developed the concept of

"triangulation," wherein a disturbance erupts in a dyadic relationship and is 'managed' by one party moving toward a third person for support, avoidance etc., rather than working through the conflict within the dyad.

Bowen developed the concept of "cutoff," which conveys an attempt to emotionally and/or physically distance oneself in order to solve the underlying problem of fusion or over-closeness in relationships. Cutoffs, then, in fact, create another problem (Kerr, 1979).

Bowen also developed the use of the genogram, a map of the family emotional system which is used to identify triangles and repetitive patterns of transaction, particularly those which stem from earlier generations yet have impact for present behaviors (Guerin, 1976; Wachtel, 1982). In this study, the genogram was employed specifically to ferret out old patterns relevant to present behaviors related to family attachment.

Bowen came to view health as differentiation of self from others and of thinking from feeling. An optimum level of differentiation would be one in which the individual could be both separate and connected. Thus, the goal of intervention was to achieve more balance in emotional

proximity, not simply to increase emotional closeness. In fact, it is important to note that physical reconnection with significant others was not always advisable, and therefore a careful assessment was very important. The potential for violence and destructiveness to ensue in certain relationships indicated that physical separation was recommended. However, it was expected that in such cases, women might be helped to reconnect emotionally in order to resolve the loss of this relationship and begin to establish new connections. Reconnection to the family was viewed as an important step toward reintegration into society, as a means of aiding the woman's differentiation as she learned to be separate and connected.

The Theory of Salvador Minuchin

Minuchin later elaborated these notions at the Philadelphia Child Guidance Clinic and at the Wiltwyck School in New York, working often with poor, minority families presenting problems with children. Minuchin developed the structural model, describing the family structure utilizing concepts such as hierarchies, subsystems, boundaries and social context. He further elaborated family organization according to rules, complementarity, life-cycle issues and the enmeshed - disengaged continuum. The latter refers to the extent of interdependency in the system. Minuchin also emphasized the function of symptoms in maintaining the

system's homeostasis.

Structural approaches are useful interventions, as they place greater emphasis on the "role of the extrafamilial, wider social contexts in symptom production and maintenance" (Liddle, 1983, p. 29). This is particularly salient in treating poor families, such as homeless families whose treatment necessarily involves intervening in the social context of other service providers. It is also relevant to treating poor Black families who place a high value on family relationships, including extended family, and who may also be reliant on a variety of social services which create their context. The structural approach informed the attempt to incorporate the conjoint interview into the treatment wherein a family member was invited to a session. This approach also informed the assessment of the family ecological field, which includes the residence and the larger service delivery system in which homeless people find themselves. Practice principles are recommended which address how larger systems can enhance or impede homeless mentally ill women's affiliation by supporting their attachment to their families.

While the application of family systems intervention with the homeless is novel, the application with the elderly is also in its infancy. The fields of family

systems intervention and gerontology have developed simultaneously, but with little cross-fertilization. Obviously, aging itself presents no particular limitations to the family therapist. By definition, the family therapist works with people of various ages. However, it is important for the family therapist to be aware of the dilemmas later life can present for family systems, and to be able to recognize their occurrence.

In summary, family systems theory, particularly Bowenian and structural theory, provided the theoretical basis of this intervention with homeless, mentally ill older, women. This theoretical base offered a lens for viewing their homelessness within the context of the family and larger system, and it provided a framework for interventions aimed at impacting their affiliation status by strengthening their connection to their families.

CHAPTER II

REVIEW OF THE LITERATURE

Homelessness: The Mentally Ill, Women, the Aged

Homelessness is not a new problem, and neither is it a new subject of research. There have been numerous studies of the homeless which have focused upon many characteristics of the population: ethnic composition, substance-abuse history, mental and intellectual capacity, previous socio-economic status, friendships, and the subculture of homelessness (Bahr, 1973; Hagen, 1988; Levinson, 1963; Rooney, 1976). Little of the earlier attention was devoted to age or gender differences, societal participation in the problem or family influence.

The Homeless Mentally Ill

The homeless population, which has burgeoned in recent years, is no longer dominated by white, middle-aged alcoholics but is quite heterogeneous, comprising various ethnic groups, every age cohort, men, women and families (Bacharach, 1984; First et. al.; 1988). And, to date, more attention has been paid to the causes of homelessness and societal factors which bear upon the tremendous growth of the homeless population. Despite considerable controversy and lack of hard data, most authors seem to concur that a significant portion of homeless people are mentally ill and either have

psychiatric admission histories or are among those who would have been admitted were it not for deinstitutionalization and the concomitant policy of restrictive admission. (Crystal, 1984; Mowbray, 1985; Watson et. al., 1986). Furthermore, cracks in the social-welfare system, including the shortage of low-income housing, rising unemployment, and cutbacks in social services and entitlement programs, permitted this group to be among those who slipped through since these policies were implemented without developing adequate community supports (Bahr, 1967; Cohen et. al., 1984; Hope et. al. 1984; Hopper, 1984; Mental Health Action Network, 1984).

Perspectives on the causes of homelessness, how it develops and the variance within the homeless population color the notions of what should be done about it. Several authors are adamant in their position that the solution resides in offering safe, permanent housing (Baxter and Hopper, 1982; Baxter Hopper, 1981; Sexton, 1983; Flynn, 1985; Sloss, 1984). These authors stress that homelessness is not a choice, and that when offered safe shelter or permanent housing, most homeless people will accept. Other authors depart from this thinking to a greater or lesser degree as does Lamb (1984, p. 900), who supports social intervention on behalf of this "dependent" population whose

> "essential deficit (is) .. the absence of a stable base or caring or supportive individuals whose concern and support help buffer the homeless against the vicissitudes of life. In this context, it is felt that the absence of such a base, or the inability to establish or to approximate such a base is the essential deficit of patients with no fixed abode".

No literature has been identified which speaks to intervening prior to actual homelessness, and it is generally felt that traditional mental health care and conventional shelter programs fall short of adequately meeting the particular needs of homeless mentally ill women (Baxter and Hopper, 1981; Martin, 1982; Stoner, 1983). However, some authors have addressed, in general terms, treatment approaches for the homeless. For example, meeting concrete needs is the initial task. Other clinical needs can be met subsequently when a relationship of trust has developed (Baxter, 1982; Martin, 1988; and Susser, 1990). This is particularly true of women, who suffer more physical and sexual abuse and violence in the street and in shelters and who more often have histories of desertion, separations, etc. Delaying treatment for even severe psychotic symptoms in favor of attending to concrete needs is also a means of building trust and conveying respect. According to Martin (1988, p. 136), after providing for basic needs and reestablishing ties with the community, ego re-

structuring is the ultimate treatment goal, as women need to re-learn the "rules of indoor living".

Susser et. al. (1990) offer other 'clinical strategies' for working with homeless, mentally ill people. Unfortunately, gender differences aren't always specified. Focusing upon the shelter population, they stress an ethnographic approach to initiating mental health service, wherein clinicians gain an understanding of a select population's feelings, attitudes and assumptions about mental health care. This is important because clinicians may be viewed as threatening and intrusive. Yet, these authors have found that mental health services were more readily accepted by males at the point of entry to the shelter, when they are most vulnerable and most connected to their community social network. Their impression was that institutionalization and the development of social networks within the shelter actually reduce service receptivity.

While these authors admittedly stress what they refer to as 'clinical strategies' rather than a comprehensive framework, they make reference to ongoing family of origin work with a patient who had multiple, serious and interacting medical and psychiatric problems. This was an example of accommodating the treatment to the patient by beginning where the patient was 'at,' i.e. with the

problem the patient was motivated to deal with, as this was key in engaging the patient. These authors also recommend the use of peer groups to create innovative treatment approaches; however, they find these groups to be useful with substance abusers, not those who suffer from major mental illness. Lastly, these authors recommend that all of these approaches should be supplemented by work with the family and other social networks.

There is a small body of literature on the usefulness of groups with homeless people. Martin and Nayowith (1989; in press 1991) find group intervention very successful with homeless people and suggest they be organized around a basic need, such as showers or dinner. Berman-Rossi et.al. (1989) add that residential settings for the homeless mentally ill are especially conducive to the formation of groups, since residents would tend to have many needs in common. In a drop-in center setting, Breton (1989) emphasizes nurturance and education as service goals which can be effected through small mutual-aid groups.

Homeless Women

It is estimated that half of the three million people in the United States who are homeless over the course of a year are women (Hagen, 1987a; Koroloff et. al., 1989).

Most recently, the increasing number of homeless women is being recognized, with some attention being given to their particular route to homelessness, coping mechanisms and special needs. This departs from the previous literature, which referred, in content, exclusively to men despite consistently broad titles.

The population of homeless women differs from that of homeless men in many respects. While Blacks are overrepresented among the homeless populations of both sexes an even greater disproportion of homeless women may be Black. Garrett and his colleagues found forty-four (44) percent of the female homeless population in New York City in 1973 to be Black compared to twenty-five (25) percent of the males (Garett et. al., 1973). Later Struening, however, found both the male and the female shelter population to be about seventy-five (75) percent Black (Struening et. al. 1988).

A number of authors have found that women are much less likely to be alcoholic; 15% of women as compared to 45% of homeless men are alcoholic (Anderson et. al, 1988; Bachrach, 1987; Koroloff et. al., 1989; Morse, 1985). Women do suffer more from psychiatric disorders, perhaps twice as much as evidenced by psychiatric admission histories and severe symptomatology. (Bachrach, 1987; Crystal, 1984; First et. al., 1988; Hagen, 1988;

Hartman, 1989; Roth et. al. 1987). Homeless women suffer many of the same physical disorders as men: trauma, accidents, burns, cellulitis, acute gastrointestinal disease, seizure disorders, and insect infestations; they also suffer more from varicose veins and veinous insufficiency, peripheral vascular disease and its consequences (Bachrach, 1987).

The immediate precipitants of homelessness differ for men and women, as well. Most often, eviction and family instability or conflict, frequently in the form of physical and sexual abuse, precipitate women's homelessness. Unemployment, drug addiction and alcoholism are the most frequent precipitants of homelessness for men (Anderson et. al., 1988; Bachrach, 1987; Crystal, 1984; Hagen, 1987b; Hagen, 1988; Martin, 1982; Stoner, 1983).

Family of origin instability has been noted to be more prevalent in the histories of homeless women than in those of men. Garrett and Bahr found that over half of their women respondents hailed from single-parent families due to divorce, desertion or separation, while this was so for one-third of the men and more often due to the death of a parent. (Garret and Bahr, 1976). Notably, for two thirds of the women surveyed by Anderson and her colleagues, the women's physical and

sexual abuse began in childhood. (Anderson, et. al. 1988).

Some authors view homeless women as being less disaffilated than homeless men, as evidenced by findings that once homeless, women are more likely to receive meals from shelters, use social services including public assistance, and maintain contact with their dependent children (Morse, 1985; Stoner, 1983). More than half of homeless women are parents, and Crystal and Corrigan (1984) found that most women look forward to resuming the parenting role (Crystal 1984). Furthermore, women are homeless for shorter periods of time (Bachrach, 1984; Morse, 1985).

Just as women were a hidden sub-group of the homeless, the elderly remain a hidden sub-population of homeless women.

The Homeless Elderly

There remains a dearth of literature devoted to the elderly homeless. Doolin (1986) and Cohen (1989) note that the elderly segment of the homeless are more likely to be severely disabled, both physically and mentally. He characterizes the homeless elderly as the most disenfranchised, having fewer social supports and existing on the lowest level of public assistance.

Other authors contend that the elderly homeless may actually be more likely to have a steady income than their younger counterparts, but that this income is insufficient to maintain a home (Kutza and Keigher, 1991). Cohen (1989), who studied homeless men, notes that most surveys of the general homeless population focus on the youthfulness of the group, neglecting the numbers of elderly represented. Cohen (1989) also found the elderly proportion of homeless people to be much higher among the street subgroup, as evidenced by accounts of outreach programs. This is likely attributable to their fears of the chaotic environments of many shelters. Perhaps related to this preference for the street over shelters is what Martin (1990) considers a retreat from connectedness, and perceived isolation and entrapment, perhaps exacerbated by the prominence and prevalence of loss and death issues among the aged. With regard to intervention, Martin stresses the importance of respect as the elderly homeless, including women often view themselves as bums. Experiencing the clinician's respect may be a key factor in motivating the homeless elderly to reaffiliate. Furthermore, she recommends a holistic approach which integrates health, mental health, social welfare and 'familial / affiliative' needs, and which provides continuity. Physical limitations play a major role in differentiating service to the

elderly homeless, as well as the domiciled, elderly since, as Martin points out, physical debilitations reduce one's ability to access services. The elderly homeless are particularly at risk medically due to the lowered resistance they may experience from exposure.

Disaffiliation is a major issue for all homeless populations. However, Martin points out that it is especially problematic for the elderly, as it conflicts with the major developmental task of old age, i.e. emotional integration; the ability to accept the life one has lived and feel secure about one's future. She states (Martin, 1990, p. 158):

> "During this 'crisis' stage the experience of social, physical, emotional and material loss coupled with the struggle to conserve one's identity create an extraordinary challenge. This is especially difficult and further compounded for individuals who have become homeless, where loss and change of roles and functions is so keen and acute. For homeless adults, whose primary activities appear to involve securing resources to meet basic needs and not those activities resulting in the conservation of identity and /or the process of consolidation, homelessness itself is a challenge which must be mastered for the ego to complete an emotional integration process.... Is it possible to resolve this crisis and be homeless?"

The homeless population is becoming younger, and women tend to be younger than men (Bahr, 1967; Bacharach 1984; Roth et. al., 1987). However, there is a sizeable number of older homeless women. Garrett and Bahr, in their 1973 study, found that the mean age for homeless

women was 47 years, compared to a mean age of 54 years for men (Garret et. al., 1987). In a later survey, their data revealed that 24% of the homeless women they studied were age 55 and over, the second largest group, 10% were age 65 and over, and 14% were ages 55 to 64 (Garret et. al., 1976). A more recent survey of the New York City shelter population revealed that 18% of the women and 12% of the male residents were age 50 and over (Struening et. al., 1988).

Women in Black and in Aged Family Systems

As mentioned previously, Bowen's view of health is measured in degrees of differentiation of self from others and of thinking from feeling. An optimum level of differentiation would be one in which the individual could be both separate and connected. Women in our society, however, are socialized to be rather undifferentiated. Women are raised to have strong affiliative needs and to be emotionally overresponsible in relationships. In families, women are often subsumed in various relationships, emotionally and concretely taking care of others, "reliev[ing] tension and reduc[ing] anxiety within their families, ...[yet] the minority woman [in particular] generally has [even] fewer material resources with which to do so" (Pinderhughes, 1985).

Black and aged families are even more likely to be debilitated due to lack of resources, placing women, who are expected and expect themselves to continue to nurture, care for, give to, and sustain others particularly at risk. Mindel (1983) notes that studies have shown that elderly Black women carry out these instrumental and affective roles in their families much longer than elderly white women. Elderly Black Women are much more involved in the family mutual-aid system, which is an important survival mechanism for the family. Hartman (1990) states that aging is a feminist issue, in that ageism, sexism and racism are evident in the life circumstances of older women. She goes as far as to say that the elderly woman of color is the only person more vulnerable than the older white woman who lives alone. The system which relies upon distancing and cutoffs need not be a system which catapults a member into the path toward homelessness, unless housing and other concrete, social and emotional supports are also lacking.

Reconnection to the family, then, may be an important step toward reintegration into society, as a means of aiding the woman's differentiation as she learns to be separate and connected, and perhaps even as a means of engaging the family for further treatment to work through systems dysfunction. Treatment then can go beyond helping women to re-enter the family.

Family Treatment and the Aged

The aged are not a homogenous group; differences in gender, ethnicity and socio-economic status have great import for their living circumstances and their experience of growing old. Nevertheless, there are some generalizations that can safely be made about growing old. Aging brings changes in physical health, social roles, relationships and cognitive functioning.

While the aforementioned changes constitute the normal process of aging, it is also true that the incidence of psychopathology also increases with age. As many as one in four people over the age of sixty-five exhibit symptoms of mental illness (Manhattan Geriatrics Committee, (1983). Depression is a major problem, due to the losses commonly experienced through deaths of friends and family as well as loss of functioning and retirement. In addition to the late onset of mental illness, those with chronic mental illnesses of an earlier onset are also living longer, well into very old age, as is the general population. Ageism within the mental health delivery system, as well as earlier socialization including a strong sensitivity to the stigma of using mental health services, combine to prevent many elderly from accessing needed mental health care.

According to Erickson (1959), the developmental task of old age is that of achieving integrity versus despair. Eyde and Rich (1983, p. 3) point out that:

> "The individual needs the cooperation of the social environment in order to sense the meaningfulness and purposefulness of life. Integration is not a sullen, isolated choice.....When an individual fails to attain integrity, a unique type of hopelessness and helplessness prevails. There is a loss of connection to others and ...a sense of disconnection from the values of mainstream society."

Similarly, loss of connection to others can produce a sense of hopelessness, helplessness and depression. Most elderly people depend on the family for this sense of connectedness, as only a small number of elderly are placed in nursing homes, contrary to popular belief.

Increasingly, the mental health needs of the elderly are receiving attention in the professional, theoretical and research literature. Probably due to the inherent propensity toward multiple, complex and interacting problems professionals encounter with the elderly population when the client deteriorates, there is considerable documentation in support of involving others in the treatment of the aged client. Ironically, much of this support is outside of the realm of the family therapy literature, where such involvement is assumed. Consistently, the literature documents the significance of family relationships to older people (Sterns et. al. 1984; Brubaker, 1983; Walsh, 1980). Only a small number

of elderly have no informal support system, and extended family most often provide support (Brubaker, (1983). Certainly, older couples take care of each other (Sterns, 1984). And, over half the elderly live within 10 minutes of a child who maintains contact with them. Yet even when there is greater physical distance from relatives, that is no indication in and of itself of their connection, as many retain "intimacy at a distance," remaining in touch through visits or telephone contacts that are weekly on the average (Sterns et. al., 1984). One study has even shown that at moderate distance there were stronger feelings of closeness, and contact was found to be more frequent (Circirelli, 1983).

The aged often form other supportive networks including siblings and informal systems such as friends and neighbors. Due to increased losses and transitions encountered as one grows older, these become increasingly important, whether they are institutionalized or at home. Brammer (1984, p. 36), following a review of various individual approaches and their application to work with older people, states that family systems therapy is among "several contemporary theories (which) hold great promise for applications to older people and which tend toward greater integration of previous concepts and systems". Yet family therapy research has posed "complex problems [since] emphasis is

on person-environment interaction rather than just change in the individual or environment to facilitate adjustment" (Wellman, 1984).

Criticisms of outcome studies in the literature regarding the treatment of older people stress the lack of studies which meet the full rigor of experimental design. However,there is substantial evidence that treatment is effective with older people. The particular needs of the elderly, as documented in the theoretical literature, support group intervention, particularly task and activity groups, day treatment, comprehensive approaches and family involvement in treatment. E. Brubaker (1983) goes as far as to say that she believes the involvement of appropriate family members is the means to increase service effectiveness in all types of programs for the elderly.

The family therapy literature recognizes aging as a developmental phase for the family, and thus speaks of the 'family in later life' (Walsh, 1980) or 'older families' (Kuypers, 1983). These families are, by definition, multigenerational families that have launched their adult children and or have members 50 years or older. Essentially, the tasks and transitions of later life: child launching, retirement, widowhood,

grandparenthood, illness and dependency, cross-generational life-cycle issues and redistribution of power (especially relevant to the changing roles of women in the family) become challenges to the entire family rather than simply to the individual (Walsh, 1980; Haley, 1079; Kuypers, 1983; Here-Biber et. al., 1984). Haley (1973) interpreting the work of Milton Erikson, highlights the importance of mastering the tasks in one generation as a model for succeeding generations. Family therapists recognize that in addition to difficulties in mastering current developmental tasks, treatment may also be necessary when lifelong symptoms become more severe. For example, as the lifespan is extended, marriages now lasting 25 years or more are more common. The accumulation of marital problems over the years may lead to sexual dysfunction, devitalization and even dissolution of the marriage in later life (Kuypers, 1983; Peterson, 1973). This accumulation of unresolved difficulties, coupled with increasing losses and stresses, may account for the fact that the population over age 65 is one of the groups most prone to mental illness (Walsh, 1980). The literature on treatment of the aged repeatedly urges that at least an assessment of the family's level of functioning and interaction patterns is important in assessing the ability to cope with the demands made upon the individual and the system. The literature also addresses the goals of treatment for

the aged and their families. For Haley (1973, p. 310) the goal is to help clients "die gracefully" and "live out their later years as functioning as possible". Cohen (1984) focuses upon the need to assist clients not only with adjusting to loss, but also to motivate them to attain and enrich their lives. Of course, Erickson's (1959) focus is upon the developmental tasks of coming to grips with one's attainments and acceptance of mortality.

With regard to the general application of family systems therapy to work with the aged, Kuypers (1983, p. 228) cautions that "we cannot uncritically borrow from a theoretical and practical literature that is young - family focused. We must borrow selectively and construct our own perspective based on a clear belief that while the older family is similar to all other families, it is also unique." Ellie Brubaker (1983) sums up best some of the salient points made throughout this body of literature: Involving significant family members is essential from the outset of treatment; the system then becomes a resource and furthermore, she states, this fosters trust in the helping relationship which is an issue in engaging the elderly. The aged, then, should be involved in the decision-making process and the involvement of family members enhances the effectiveness of service delivery to the aged.

An obvious limitation of the sparse family therapy literature, as it relates to the treatment of the aged, is the lack of attention it plays to the non-traditional or alternate family system. For example, the older couple without adult children, and the single, never married older woman are not explicitly addressed in the developmental theories. Nor is there mention in the literature of the application of family systems concepts to the treatment of the homeless.

The state of family therapy research has been addressed by Gurman and Kniskern (1981). They note that despite its proliferation in recent years, research designs need to be strengthened, particularly with regard to attending more to therapist effects, and specifying the treatment approach and interventions in more detail. They recognize that there is "no such thing as a true control group" (p. 746), and therefore recommend a treatment on demand (TOD) approach in which each family has access to the therapist upon their own initiation during the study.

Given that most studies have been uncontrolled, they report on improvement DURING, as opposed to BECAUSE of, treatment. This improvement is roughly two-thirds which is beyond chance. They conclude that family therapies are likely more effective than many common therapies when marital or family conflict is central, and probably more

effective than individual therapy even when interpersonal difficulties are not the presenting problem.

In summary, this project draws upon and integrates several different bodies of knowledge: homelessness and mental illness, women, the aged and family systems-oriented treatment. This integrated knowledge base lays the foundation for an exploratory study which seeks to demonstrate the usefulness of a family systems-oriented approach to the treatment of the homeless, mentally ill, older woman.

CHAPTER III

PROJECT DESIGN AND METHODOLOGY

Goals

The goals of the project are twofold: 1) to demonstrate the usefulness of a systems-oriented treatment approach in reducing the disaffiliation of homeless, mentally ill older women; and 2) to develop practice principles which derive from this approach as applied to this population.

This project is a qualitative study, i.e. it is intended to "make sense out of an ongoing [treatment] process that cannot be predicted in advance" (Rubin and Babbie, 1989, p.338). While the aforementioned pilot study (Sullivan, 1991) suggested two practice principles which were expected to be useful in treating homeless mentally ill older women, the project also intended to generate other practice principles during the process.

Methods of Data Collection

Given that the project focuses upon clinical intervention, a treatment situation was thought to be most appropriate for collecting data. Within the context of a treatment, the researcher, as participant observer, could learn directly whether the theoretical framework would be useful and whether interventions stemming from this approach could indeed impact the

women's affiliation status.

Rather than provide several concurrent treatments for each of the participants, the treatment was conducted within the context of a group. Use of a group would not only be expedient, but it was also recognized that group support is clinically important in the treatment of women and the aged. The aged naturally tend to form supportive networks with friends and neighbors due to the increased losses sustained at this stage of life.

Although conducted within the context of a group, the approach remained largely systems-oriented. The group, then, became a mechanism for entering into the family system. It was anticipated that some women might re-establish ties and resolve conflicts in a manner that allows for optimum differentiation, i.e. developing a relationship which allows them to be both separate and connected. The support of other women can be useful not only in the process of reaching out, but in expanding her network beyond a limited one in which she is fused with another. For other women, the reconnection may not occur in a physical sense either because of unwillingness, because physical reconnection is actually contraindicated, or due to circumstances such as death. Rather, the emotional resolution of a conflictual relationship may be the treatment goal. In these

situations also, group support will be beneficial in expanding the woman's support network.

This type of group is essentially different from "coaching" groups in that mutual support is emphasized. It also is essentially different from dynamically oriented group treatment in that the group is not used as a "corrective recapitulation of the primary family group," nor as a vehicle for interpersonal learning (Yolom, 1975). Instead, the women's actual family system becomes the locus of the work. Yolom, by the way, acknowledges there are "curative factors" outside of the group and that "major behavioral and attitudinal shifts can occur without apparent use of interpersonal learning" (Yalom, 1975, p.10). He adds that these external factors may be more than coincidental, and the group may actually help members to take advantage of resources which already exist in their environment.

The Bahr and Garrett Disaffiliation scale was used, not to produce an actual score, but rather as a model which could focus the pre and post assessment along Bahr and Garrett's major indicators: family contact, employment, and participation in voluntary associations. Their "multiple indicator" approach was thought to take into account the variety of ways one might be connected to society and the fact that some affiliations might be

more salient than others. For example, they broadened family contact to include anyone living in the same household and weighted this indicator as equal in importance to employment. Membership in voluntary associations was viewed as being a less binding connection to other members of society and therefore was weighted lower. Participants, then, were ranked according to the number and type of affiliations they maintained. Thus, the lowest score was assigned to the person who lived alone, was unemployed and had no voluntary associations. The highest score was assigned to the person who lived with someone, was employed and belonged to voluntary associations. For the present study, use of social services was added in anticipation of voluntary associations being less salient for this population, while contact with social services is a more likely and pertinent arena for this population. Bahr and Garrett compared four samples, three of which were census tracts in the community, and a population of shelter residents. "Family contact" actually reflects a logical modification of Bahr and Garrett's model. Since all of the women in the study would be living alone, "family contact" will more directly address this issue. While this model is individually focused, it overlaps with the family assessment. Particularly, the assessment of family contact is directly relevant to the concept of cutoffs in family systems. Reversing cutoffs

through reconnection, then, could be an option in increasing affiliation.

The present study uses a qualitative strategy, intended to "make sense out of an ongoing process that cannot be predicted in advance" (Rubin and Babbie, 1989, p. 338). Upon reviewing group outcomes, it became clear that the mere assignment of a pre and post affiliation score would not reflect the extent or nature of change which occurred. Change in a given area frequently could not be rated along a 'none to some' continuum. For example, many women had some family contact, but also experienced a cutoff in another significant relationship. Similarly, women didn't simply work or start working. They increased working, considered working or decided against working. Also, some categories were largely irrelevant to this particular population. Therefore, a more descriptive pre and post comparison of the affiliation status variables, rather than a pre and post score, was used in this study.

The initial assessment began in the individual intake interview and was completed by the fourth group session. It seemed necessary to do this over a brief period of time initially, weaving this assessment into the process of a beginning treatment group. However, the two women who entered the group at midpoint received an initial

assessment within the individual interview. Initial affiliation status was then compared with affiliation status at the end of the group.

An analysis of session process recordings served as the major means of ascertaining whether the project met its objectives of demonstrating the usefulness of a family systems-oriented approach and generating practice principles. Each recording was written immediately after the session to capture as much of the process as possible since this was the major source of raw data for analysis.

Additionally, notes were kept of individual meetings with participants and on meetings with staff to explain the project or begin the referral process. Lastly, a brief questionnaire surveyed the staff's opinions of the impact of the group upon the participants, as well as upon the overall residence program.

Selection of Participants

Ten mentally ill women over the age of fifty-five were identified for the study. Four were Black, one was Puerto Rican and five were white and of varied ethnic backgrounds. All were living at a residence for the homeless elderly and the study was conducted on-site at the residence. Women were referred for participation

if they met the eligibility criteria developed by the New York State-sponsored Community Support Systems program (CSS). (See Appendix A.) This program was originally a National Institute of Mental Health (NIMH) initiative designed to address the aftermath of deinstitutionalization by providing a network of community-based services and technical support. This package was essentially adopted by several states, including New York. Eligibility to receive CSS-funded services is based upon length and frequency of admissions for in-patient or out-patient psychiatric care, and functional deficit which is due to the psychiatric condition. There is a degree of dissension within the professional community over these eligibility criteria, as providers generally feel that the criteria are too exclusive and arbitrary. However, these criteria can be useful in participant selection for this study because they represent a common standard presently in use, and have not been criticized as being too broad. Furthermore, CSS eligibility emphasizes functional disability and specifies the areas of functional deficit to be considered as evidence of significant mental illness. (See Appendix B.) Evidence of disability must be exhibited in at least three of the following six areas: self-care, activities of daily living, self-direction, social functioning, economic self-sufficiency and ability to concentrate.

The residence is a single room occupancy (SRO) setting which accepts a large number of referrals from local shelters sponsored by the municipal public social service department (HRA) and which targets the elderly. This setting provides a fairly stable group membership. In order to stimulate referrals, the candidate presented the project to the director and then to the staff, outlining the eligibility criteria.

The first step in the referral process was for the caseworker to discuss participation in the group with the resident and obtain her consent to meet with the researcher. Next, the women were to be seen individually by the researcher for one intake interview. At that time they were to be oriented to the group, advised of the voluntary nature of their participation and asked whether they consented to participate. (See Appendix C.) At this point, the women were informed of the group structure. Sessions would occur on a weekly basis, meeting for 1 and 1/2 hours each week for a duration of twenty weeks. Since the group would meet at the dinner hour, the women were informed that refreshments could be available and were given the opportunity to express their preference for the type of refreshment. Arrangements were made for the residence to be able to continue the group after the initial

twenty sessions if this was indicated or desired.

Expected Outcomes

It was anticipated that a successful outcome would be reflected by the reconnection physically and/or emotionally of those clients who are cut off from their family system or the establishment of new supports by those for whom reconnection is not recommended.

The study also was expected to yield more specific information about when reconnection is contraindicated. Furthermore, it was expected that additional practice principles might emerge from the treatment process. Lastly, because there was to be a subgroup of Black women, a comparison with the rest of the group was expected to shed some light upon the overrepresentation of Blacks among the homeless.

Given the small number of participants and the exploratory nature of the study, findings were not expected to be clearly generalizeable nor `conclusive' but rather suggestive of directions for further research.

Data Analysis

There were three data analysis strategies:

1. Pre and post assessment of change in affiliation status based upon a modified Bahr and Garrett (1976) model: family contact, use of social services, employment, voluntary associations.

2. Analysis of session process recordings. This analysis focused on the exploration of practice issues, the emergence of themes related to change in the above areas, and the identification of practice principles.

3. Survey of staff impressions of the impact of the group.

CHAPTER IV

FINDINGS, PART ONE. ESTABLISHING THE GROUP AND ENTERING THE SYSTEM

The Group in Context: The Setting

Auspice and Goals

The group was developed within the social services department of a single room occupancy (SRO) residence for poor, homeless elderly. This long-term, supportive residence seeks to 'address immediate needs and strengthen the ability of formerly homeless elderly people to lead a self sustaining life.' The residence specifically targets the mentally ill homeless. The residence is funded by the New York City Department of Mental Health, Mental Retardation and Alcoholism Services through it's Community Support Systems program, and the New York City Human Resources Administration (HRA). Additionally, income is generated through the Supplemental Security Income (SSI) and/or Public Assistance (PA) benefits that residents pay for this housing service.

The residence is owned and operated by a community center for the elderly, located in the basement of a church across the street from the residence. While the center and the residence are "non-profit and non-sectarian", they are administered and partly staffed by Catholic priests and nuns. The services of the center

are many and are made available to the residents: a nutrition program (breakfast and lunch), recreation and education, health services, telephone assurance and friendly visiting, a theater program for the homebound, shopping and escort service, housecleaning, and a food pantry.

Referrals

Half of the 91 beds at the residence are reserved for those referred from the local municipal shelter system. The Partnership for the Homeless contributes twenty-five percent of the referrals and the remaining beds are filled by community referrals from voluntary agencies, transitional living programs, etc.

Facility

While the center was established in 1977, the residence opened in 1989. The residence facility, previously a run-down transient/residential hotel in the business and theater district, was renovated and donated to the center by a major developer of luxury housing. This was a condition of the developer's city permit to develop luxury housing at another Manhattan location. There are a small number of the original tenants who continue to reside in the building.

The nine-story elevator building has twelve dwelling

units on floors two through nine. Some rooms have a private bath, some share a public bath among five tenants and some have a shared bathroom located between two rooms. There is a kitchen on each floor with individual storage space for residents' groceries and utensils.

There is twenty-four-hour front desk coverage and an intercom telephone system to the front desk from all rooms. Weekly linen service is provided. Room furnishings include a refrigerator. The first floor is devoted to office space for the social service staff, the building manager and a small lobby area with seating, a piano and television.

Services

In addition to basic housing, the residence is intended to provide the following supportive services:

- Assessment of capacity to live independently, and assistance in making the transition from homelessness to the residence such as acquiring entitlements, medical and mental health services.
- Orientation to the expectations and offerings of the residence, and introduction to other residents
- Case management services designed to develop basic social skills, financial management, linkage to other services, crisis intervention, health maintenance, meals and re-establishing family contact.

- Mental health services for ongoing counseling, and rehabilitation and treatment.
- Nutritional assistance and counseling.
- Preventive health care and medical services.
- Home care services.
- Educational, social and recreational services.

When the group began, the case management services were in place. The mental health services were supplied by a part-time psychiatrist who performed diagnostic evaluations for all applicants as part of the admissions process, and who was also available for psychiatric consultations and a part-time psychiatric nurse practitioner who carried a caseload for individual therapy and case management. The psychiatrist and nurse practitioner are on the staff of a midtown hospital department of psychiatry. They provide this off-site service as part of an affiliation agreement with the residence.

An arts and crafts specialist conducted a class weekly for anyone who came down to the lobby to participate, and there were occasional day trips. There had been only one attempt to develop a group of any kind. A caseworker had attempted a women's group within the past year which was intended to be more of a social group. However, the group failed to engage members. This, seemed to have a sobering effect upon the staff, who

began to see the residents as resistant and unmotivated for group services.

Staffing

The staffing pattern is as follows:

1 full-time Office Manager

1 full-time Director of Social Services

2 full-time MSW'S

2 full-time Caseworkers

1 part-time Nurse Practitioner

1 part-time Psychiatrist

1 part-time Social Work Student

Support Staff: Clerical, maintenance.

The Group Referral Process

Referrals to the group were made by the social service staff as a team. This process took place at a team meeting to which the researcher was invited to present the project. Prior to this meeting, the researcher met individually with the director of social service to present the project. The only eligibility requirements set forth were:

- o CSS eligibility.
- o Female gender.
- o Availability.

The team had the opportunity to ask questions. It was

made clear that participation would be voluntary and that this would be explained to the women. It was recommended that each caseworker discuss the referral with their clients first. Then, if agreeable, an appointment was granted for an individual interview with the researcher.

Structure and Attendance

The group met for twenty weekly sessions,of 1 1/2 hours each as planned. Since the group met at the dinner hour, sandwiches, coffee and tea were provided. The group took place in the office of the social service staff.

A total of ten (10) women participated in the group over the twenty sessions. An average of six (6) women were in attendance at each session. This was a good attendance rate, since two of the ten women were not referred until the second half of the group and two (2) women were hospitalized after attending only a few sessions and essentially did not return. Thus, in evaluating the outcomes below, a sample size of eight (8) offers the best frame of reference. For most of the group, no more than 8 women were expected to attend a given session.

The Group Intake Process

During the individual intake interview, the researcher introduced herself as an experienced professional and also a graduate student. Interviewees were informed that this group was part of the researcher's school requirements. For the most part, the individual intake interviews were kept 'light'. The researcher was careful to use herself in a professional yet warm, friendly and engaging manner. An attempt was made to give the women confidence in the researcher and to help them feel comfortable with her. The women responded in kind, and some expressed positive feelings about the researcher in this meeting.

The women were given particulars about the nature and structure of the group, and why they were referred. In lay terms, the purpose of the group was described as being about how women get or don't get support when they need it, and how they use or don't use support. The researcher expressed her belief that using and obtaining support was different for women than for men, and explained that was why this would be a group just for women.

Depending upon how open each woman was during this initial meeting, some background information was gathered from participants: identifying data, family

contact or other social supports, daily activities, use of social services, and route to becoming homeless. The latter was felt to be a sensitive issue, and the researcher was cautious about probing for information. However, most women offered to talk about this freely.

A total of thirteen women were referred to the group, ten of whom agreed to participate. Two women weren't referred until midway into the group process, within a week after they had been admitted to the residence. Each of the eleven women seen for intake prior to the beginning of the group complained of the isolation they felt within the residence. This was reported even by those with family support and other social contacts. The difficulty developing relationships in the residence was a source of disappointment for all of the women, and they expressed feelings of anger and hopelessness about that.

Group Composition

Membership Characteristics

A total of ten women participated over the course of the group. The average age is sixty-three years, with a range of fifty-nine to seventy one years. Five women are women of color; four are Black, including three from southern African American roots and one from African-Caribbean roots. The fifth woman of color is of

Puerto-Rican heritage. The length of stay at the residence ranged from one week to one year and three months, with an average length of stay of six months. Length of time spent in the shelter system varied, although the exact variation is not known. The longest continuous stay in the shelter system was five years. Another woman had 'several admissions'. The exact number of times she was admitted is unknown, as is the period of time over which the admissions extended. This was the first admission to a residence for all ten of the women who had lived either with family members prior to and/or in between their shelter stay(s).

None of the group members spent more than a very brief period on time living on the street. In fact, there was a feeling expressed at one point that they did not identify with homeless people who lived on the street.

Group Members: Case Descriptions

Cynthia

Cynthia was a 62-year-old Black woman, born and raised in Trinidad. She appeared much younger than her actual age. Cynthia carried a diagnosis of major depression and had one or two psychiatric in-patient admissions, including one subsequent to the death of her second husband.

Cynthia had been at the residence the longest, just over

one year. Within a week after her arrival at the residence, Cynthia received notice of the death of one of her daughters in Trinidad. She felt unable to withstand the stress of the trip home initially, but about two months later, she traveled to Trinidad with the financial assistance of the residence. The residence staff were clearly very fond of Cynthia.

Describing her entrance into the shelter, Cynthia stated that once her son's benefits expired due to his age, they had insufficient income to pay rent. Because she had never become a citizen, she was ineligible for benefits. For a while she relied on others for food. Her son resorted to drug dealing and, ultimately, drug abuse. Finally, they were evicted for non-payment of rent. She pleaded with her daughter and her sister to allow her to stay with them even for a few days, but they made excuses. She and her son were then separated when they entered the shelter system. At some point, he was arrested and convicted of selling drugs. She kept contact with him and now feels that he is being successfully rehabilitated.

Cynthia described her relationship with her sister and her daughter as poor. She resented their lack of support, since she had taken them in when they came to

the United States. Her sister is now a nurse, and Cynthia felt she 'looks down' on her. Her daughter, she feels, never forgave her for not raising her. Cynthia attributed this to the father's influence. According to Cynthia, they agreed that she would come to the United States to prepare for the family to come. She found establishing herself harder than expected, but sent money as often as she could. Her husband, however, told the kids she'd abandoned them. Actually, he took a live-in lover and wrote her not to return.

Cynthia suspected her sister never forgave her for leaving the family of origin. Cynthia tells a rather macabre yet plausible story involving the murder of her mother by poisoning. Cynthia continues to feel terribly guilty for her part in this - bringing her mother the purportedly poisonous drink - although she was a child following her father's instructions. She left home early, fearing incest at the hands of her father, and recalls her sister treating her with hostility then. She had her first child very young and her son was cared for by his father's mother who was like a mother to her and took her in. Her son died rather mysteriously as a young child. Cynthia thwarted the authorities' attempts to investigate, fearing she would have no one if this woman was charged. Cynthia resented that she was never acknowledged for protecting

her.

Cynthia feels lonely in the residence, although she keeps contact with her daughter, sister and her son.

Tricia

Tricia, a tall, heavy-set, 63 year old woman of Irish background, was pleasant but very evasive in her initial interview. Tricia carried a diagnosis of manic depression. Upon admission to the shelter, she had acknowledged alcohol abuse in the past.

In the pre-group intake interview, Tricia denied having any problems, although she did feel she would like to get to know people at the residence better. She did have one good friend there who was very ill. That friend died within the first few weeks of the group. Tricia was her companion.

Tricia described her life as very happy: a great, long-term marriage, three or four children, a middle-class existence in the suburbs, house, car. Even when her husband divorced her and married his secretary a year later, she denied the possibility of an affair and proclaimed she had no regrets since they had so many happy years together.

After the divorce, Tricia moved at least twice, and squandered a considerable amount of money from the sale of the house. She "had a ball," which was apparently a manic episode. Finally, penniless, evicted and having lost everything, she found herself standing in front of Macy's department store for a few days, just not knowing what to do. A man took her to the Olivieri center, for which she is still grateful.

Tricia keeps in touch with a daughter and less so with her son. She has another son in California, B., who is schizophrenic and a substance abuser. His visit during the course of the group proved very stressful for Tricia The rest of the family masde it clear that they wanted no part of him. Tricia already had identified in herself a pattern of becoming over-responsible in relationships, then being increasingly exploited until her only out was a break in functioning. This was a pattern she wanted to change. Her son's visit provided an opportunity to do so.

Evelyn

A short, plump, 65-year-old Italian woman, Evelyn was pleasant and compliant but very guarded. She had spent five years in the shelter system prior to coming to the residence. She was diagnosed as having an avoidant

personality disorder.

Evelyn entered the shelter when she could no longer pay her rent. Her live-in 'boyfriend' of fifteen years had died suddenly. This was a terrible emotional loss and a loss of income as well. Additionally, she developed phlebitis shortly afterwards. Being ineligible for medicaid, her savings were more quickly exhausted by medical bills.

Evelyn never felt lonely until she entered the residence. "People here just come and go." She keeps in touch with a sister and her niece.

Althea

A short and simply attired Black woman with neatly braided hair, Althea appeared her age of 71 years. Althea suffered from a moderate to severe memory impairment. She carried a diagnosis of mild mental retardation and chronic schizophrenia, residual. She also suffered from a constant cough which had been undiagnosed, hypertension, and swelling of the ankles.

Althea outlined the circumstances of her homelessness in our initial meeting and repeatedly throughout the group. There was a fire in the apartment she shared with her second husband, with whom she lived common-law. Subsequently, he was taken to live with his mother. His sister keeps in touch with her, and is helping her to

get an apartment with the housing authority or a regular rental. Althea reiterated constantly that she planned to get her "own place". She agreed to stay and begin in the group, provided it was understood that she would be leaving. Another group member continually challenged her on her judgement regarding such a move, reminding her that she needed support as she sometimes couldn't find her own room. Althea brushed off these comments.

Althea had one son who was married but had come to stay with her just prior to the fire. Althea seemed to imply that he and his wife were having difficulties. After the fire, he returned to his wife. Soon afterwards, Althea lost track of him. Both he and his wife were psychiatrically disabled.

Althea felt her son no longer cared about her since he had not looked for her. She had no other relatives.

Constance

I have virtually no information on Constance, age 59, except that she was of Irish decent and suffering from severe and chronic alcoholism with apparent brain damage. Constance was violent, and in a constant state of agitation. Constance had not been referred to the

group but came into the first session, following the other women. She made it clear that she lived in the residence and therefore felt entitled to come in. It was never clear that she fully understood the referral process. Constance was known to go into uncontrollable rages. As I suspected, staff learned that she was drinking again. Upon discussion with the staff, who were really struggling to help her, I agreed that while she would not be sought out to attend, she would be permitted to sit in on the group. Constance almost never participated in the process although she appeared to be following along. She smoked constantly and seemed motivated largely by the refreshments. After a few sessions staff were able to hospitalize her for a lengthy detoxification. Interestingly enough, when she returned to the residence during the week of the last meeting, Constance remembered the group and came to the last session. Clearly, she was now in a better position to use the group. She was given an official status as an observer and offered the opportunity of continuing if the group should continue. It was apparent that in her own way, Constance had felt a connection to the group.

Ilene

Ilene was a petite, 62-year-old physically and mentally frail Jewish woman. Diagnosed schizophrenic, Ilene maintained rather fixed, bizarre delusions and a severe

thought disorder which was not very evident unless she was engaged in conversation at length. She was generally very quiet and would not initiate discussion. For brief responses, she could be quite related.

Ilene had lived for many years with her mentally ill sister in the home of their parents, which they retained after their parents died. These two women led a very marginal existence together. However, when her sister died, Ilene was unable to survive as she was completely unable to care for herself. She was filthy, as was the apartment which had no heat, hot water or electricity when she was removed and placed in a facility for the Jewish homeless. Ilene was unhappy in this residence and left it for the shelter.

Ilene was unhappy in the residence because she felt lonely. She wanted to return to the shelter because there were always people around. Ilene was uninterested in any of the activities at the residence, but wanted to be in the presence of others who were active. Ilene had fallen and broken her arm just before the group began. Several weeks after the group started, she was hospitalized again. It turned out to be a lengthy psychiatric admission, and Ilene didn't return to the group as she was placed in a nursing home upon discharge.

Kathleen

A large woman, Kathleen often dressed in an old-world fashion which bordered on bizarre. She was 61 years old. Her diagnosis was delusional disorder and she'd had at least two psychiatric admissions.

Kathleen was very circumstantial and guarded, avoiding eye contact. While she had an excellent command of language, she suffered from such a severe thought disorder that at times her speech was simply word salad.

Kathleen had a very long common law marriage. Her husband, became demented, a condition she attributed to several muggings which also rendered him unable to work. Kathleen was not happy that he stopped working and seemed unconvinced that his condition was that serious. She resented having to wait on him, especially when he began to have an affair.

Kathleen described a rather muddled story of successive moves after an eviction from an apartment they had lived in for many years. Somehow, they were separated upon their last eviction as Kathleen had wandered off. His family located him at the site of his brother's job many years ago, and had him admitted to a nursing home. Kathleen felt hurt and angry that they showed no concern

for her. She entered the shelter.

Kathleen's father lives in Texas with his second wife of many years. Kathleen is very unaccepting of the wife, still grieving the loss of her mother who died when she was in her twenties. Although Kathleen was not thought to have a memory disturbance, she did not seem to acknowledge the passage of time or her own age. She spoke as if her father's marriage might not work out. She spoke not only of finding a man from "the other side" (Europe), where a room was waiting for her, but also of raising young children with him. Once confronted, she acknowledged that she wouldn't give birth at this point, but saw no problem with raising a family.

Staff was surprised that Kathleen agreed to come to the group and unbeknownst to the therapist, staff had assumed she dropped out since she never took part in anything in the residence. They were stunned to learn that she continued for the duration, missing only two of the twenty sessions.

Carmen

Carmen, a dark Puerto Rican woman, looked younger than her 63 years of age. Dressed casually in jeans and a kerchief most of the time, Carmen usually seemed a bit

self-conscious. Just prior to the beginning of the group, Carmen dropped out of the GED classes she was attending in the evenings because she felt uncomfortable not having suitable clothes to wear to class. Her diagnosis was major depression.

Carmen had six adult children and several grandchildren. At least one of her children was in a shelter, and one was in prison. She often entertained her children at the residence and complained of the lack of facilities to do so. She prided herself on her cooking, and enjoyed cooking for her children when they came by to visit. She purchased a folding table so they could eat in her room, but it took up every bit of floor space next to the bed.

Carmen's mother died either in childbirth or soon after her birth. She was raised by a maternal aunt and came to the United States when she was about twelve. Her husband was alcoholic and physically abusive. Even after their divorce, he continued to come around drunk and terrorize the family. The threat of physical violence was very prevalent in her family. As her sons grew up, they would challenge their father in defense of their mother. When she discovered her son shooting up at home, she grabbed a knife with the intent to stab him.

Carmen worked as a cook in her upper west-side neighborhood, where she maintained a huge six bedroom apartment for only one hundred fifty dollars per month. However, when all of her adult children began to return home along with their children, her income was just not enough to support them all, several of whom had substance addictions. She was forced to enter the shelter. Some of her grandchildren were placed in foster care.

Carmen felt the residence was 'alright', but she wanted her own place. She felt people there didn't like her, although she hadn't done anything to anyone. Perhaps they just didn't like her because she spoke Spanish or because she was dark. She often just lay on her bed looking at the ceiling, exploring the cracks and thinking about her problems.

Carmen visited her sister in the Bronx, who owned her own home. Carmen couldn't live with her because she was too domineering. Actually, her sister never offered to let her live with her; she only offered to give her money to go to Puerto Rico. Carmen felt very angry about this, since she had no connections in Puerto Rico and her sister never asked her if that was what she wanted. Carmen felt her sister had little regard or

respect for her. Another reason Carmen couldn't live with her sister was because her children were not welcome there because of their substance abuse problems. Carmen would never stay where her children were not wanted.

Mae

Mae was a tall, heavy-set Black woman of 56 years who was admitted to the residence only a week before she entered the group. She began at the twelfth session. Mae had an unkempt appearance and a wild look, in part due to her uncombed hair and slight tardive dyskenesia. Her broad smile was in contrast to the rest of her appearance. Records indicated that Mae, diagnosed with chronic undifferentiated schizophrenia, had become violent on several occasions. That prompted psychiatric admissions and high doses of psychotropic medications, but Mae never understood how or why these situations developed.

Mae had been in the shelter several times. She had six children, several of whom were addicts. All of her children, she felt, treated her as though she were a child and they were in charge of her. She resented that. In fact, she felt her daughter, with whom she'd stayed mostly, would start fights by falsely accusing her of something. She saw her children as troublemakers.

She lost her own apartment more than once because of her children's problems and their harassment of neighbors.

Mae wanted to work, but claimed she'd been told she was too old. Now, she wanted a store. However, at this store, food would only be delivered, not sold. She would have a room in the back of the store to sleep in and she would have people come into the store. She would live there by herself. She agreed that she wanted a peaceful place where all her needs would be taken care of and where she could rest.

Mae claimed she would not tell her children where she was, although at some point she would call them. Mae was angry with them for treating her poorly. She feared they would badger her for money, and she feared they would cause her to be expelled from the residence.

Annette

Annette was a rather strange looking Black woman of 71 years who was bald, toothless and had yellowish eyes. Her skin was so extremely dry, it was seemingly transparent, like thin white paper although she was dark skinned. She always wore caps and scarfs to conceal her baldness, but they slid around on her head.

Lively and loquacious, Annette had a wonderful sense of humor and a memory for details that was incredible. One would almost consider whether it was confabulation to mask a memory deficit, but her life stories were too rich and told too consistently.

Her stories of her life in the South as a child were very vivid. She described picking and chopping cotton as a little girl, the different rates of pay for each and how productive she was. She described going to town on Saturdays to buy material for a few cents per yard and Sundays at her grandmother's house. She described rates of pay and chores working for white people on Saturday mornings, and being able to keep a nickel to buy pecans when she went to town.

In addition to all the grueling work as a child, Annette also described the heartaches of her adulthood. Her first husband died six months after they married, while she was pregnant. The second husband 'ran around' a lot. Her only son was found murdered in his apartment in the Bronx as an adult. She didn't know the whereabouts of her daughter in the Baltimore area. Her other daughter died a few years ago while recuperating at home from brain surgery. Annette has a host of grandchildren and great grandchildren, all of whom she remembers by name and age. Most of them are drug

abusers or have other problems. They have offered drugs to her as well as have used them in front of her. They steal from each other and stole a couple of her checks and forged her signature. Her daughter died when she fell trying to go to the bathroom alone following surgery for a tumor. Annette's adult children had shown no interest in taking care of her after the surgery. The tumors were possibly the result of beatings she sustained from her former husband on several occasions. Annette had gone to her home on these occasions to defend her, and would actually fight him. According to Annette, the police would not press charges against her because they agreed with her.

After her daughter died, from neglect, she believes, Annette went South and lived briefly in a trailer until it was destroyed in a fire. She lost everything. Annette was then taken in by a neighbor, but couldn't tolerate her constant lamentations about having lost her husband.

Annette felt hurt and angry that her daughter in Baltimore wasn't looking for her. When this daughter had lived in California, Annette visited her whenever she could. Annette could not hear that perhaps her daughter simply couldn't find her.

Annette was convinced her daughter didn't care enough. She wanted no part of any of her family, whom she saw as trouble. As she aptly put it, "This is not a family that cares about each other."

When the researcher attempted to reach through all the defensive humor to deal with the extremely painful situations Annette presented in the group, Annette shared that she felt no one but God could help her. Only God could bring her son or her daughter back. Only God could take away the pain she felt constantly when she could hardly get out of bed.

Annette complained of stomach pain and was being evaluated for stomach cancer.

Group Process: Cohesion and Mutual Support Facilitate Increased Affiliation

This group became very cohesive, and a strong network of mutual support developed which was inherently useful in strengthening the women's attachments to each other. This process also served to strengthen their engagement as clients in the residence, enabling them to more fully use the services provided there. There were numerous

examples of this throughout the group process. Women used each other for all sorts of needs, from obtaining concrete services to handling fears. The earlier group sessions began with the women sharing various concrete needs and resources which they discovered during the previous week. Very early it became clear that the women's knowledge of the services provided by the very residence in which they all lived varied greatly. The information sharing that became part of the group process enhanced their ability to use the residences' services. Ability to use these services also became the target of successful direct interventions for two of the women:

- Mae, who began the group immediately upon entering the residence, was encouraged to find out who her caseworker was and to involve the caseworker in her plans for her children's visits. She needed consistent prodding just to ascertain who her caseworker was.

- Tricia was encouraged to consult with a staff member regarding a legal concern. While initially reluctant, she was finally able to do so. As mentioned early, Tricia showed a strong need for autonomy and considerable sensitivity to intrusion. She sought the group's help when she was becoming very annoyed by her caseworker's repeated calls to do a room check. First of all, raising the issue in the group permitted her to learn that she wasn't being singled out; everyone had monthly room checks. One member, who felt that waiting for the staff member to check the room was too inconvenient, so would simply leave her key so the room could be checked while she was out. This was not helpful to Tricia. Recognizing that Tricia needed to be in control, the therapist suggested that Tricia offer her caseworker three days and times that she'd be available for a room check. Tricia followed through with her own variation on this intervention. She did wait for the next

spontaneous request, but offered her worker a time later on that same day.

Tricia was very pleased with her handling of this. This was a small but significant move for Tricia, who struggled with a pattern of being overly responsible and accommodating in relationships, then being exploited or taken advantage of until her only way out of the situation was to become symptomatic.

The women's reliance upon each other for concrete needs expanded into other areas of their lives and even began to extend beyond the group meetings. For example, when male resident was losing control and threatening some of the women sexually, they developed concrete plans about how they could look out for and protect each other. They exchanged telephone numbers and resolved to watch out for each other in case this man should follow them onto the elevator. They could, then, call a woman's room to verify that she was alright. Similarly, when Evelyn was almost mugged in the street, another woman offered to accompany her on her walks. And when Evelyn wanted to 'check out' a male resident who seemed to be making advances to her, she used the group to find out what the other members knew about him and their evaluations of him.

The extent to which the group cohesed supports the use

of this modality with a disaffiliated population. Through becoming a group member of a cohesive group, the women experienced a new sense of connectedness and thereby reduced their disaffiliation. Carmen, as previously mentioned, attended only half of the group sessions, and never was the focus of any family systems interventions. In her initial individual meeting, Carmen had expressed strong feelings that people in the residence didn't like her and intimated that this might be partly or entirely because she was dark-skinned or because she was Puerto Rican. Yet, upon terminating, and in response to a question regarding whether she felt she got anything from being in the group, Carmen said she no longer felt alone. Now she felt she had people here she could talk to now. There were countless other examples of the women's ability to support each other, but perhaps Cynthia summed it up best when she said, "We're sisters now." The group agreed.

This experience supported suggestions in the literature regarding the importance of meeting concrete needs as a means of engaging homeless people. It also demonstrated the usefulness of the group in creating a context of connectedness and care which supports and encourages women to take fuller advantage of other services By embracing the client role, they further develop their social attachments. While we know that homeless women

have been more likely to use social services than homeless men, they remain, overall, a disaffiliated group when compared with the domiciled population. For older women, facing prospects of increasing loss, social isolation and dependency, the opportunity to foster and strengthen attachments to peers via group involvement is all the more important.

Entering the Family System: Some Systems-Oriented Interventions

As described above, the treatment at times focused upon facilitating the women's ability to support each other. Gender issues, such as the women's inability to be safe given the threatening behavior of some male residents, were opportunities to do so. Overall, however, the treatment was more therapist-centered than is common in traditional group therapy. This centrality of the therapist in directing the treatment is more common in family systems-oriented treatment. The interventions used throughout the group treatment were not new, and were based upon techniques generally used by a family systems-oriented therapist. However, their application to this population in this setting is new. The question is whether this population can benefit from known interventions applied to their problems.

The treatment was problem-focused. Tasks were often

assigned to be completed between sessions and followed up consistently. Tasks targeted a specific behavior and required that participants try this new behavior in another relationship outside of the group. Examples of task assignments were:

- 'Tricia, give your caseworker three appointment times when it's alright for her to do a room check.'
- 'Cynthia, the next time your sister insults you, tell her she has hurt your feelings.'

Tasks always included a request that the women share how they managed the task with the group in the following session. If they didn't volunteer to do so, someone would inquire. Thus, the tasks were empowering as they helped the women focus on what they could do and the outcomes they wanted to achieve.

Interventions were mostly direct interventions, and the women shared this role with the research practitioner, suggesting tasks and solutions for each other. The few paradoxical interventions were delivered only after the women were generally exasperated after their direct interventions had failed. Paradoxical prescriptions, derived from strategic family therapy, overtly appear to prescribe family homeostasis while covertly calling for change by addressing the secondary gain of the symptomatic behavior. For example, a paradoxical restraint from change intervention addressed Evelyn's reluctance to date again. It acknowledged yet reframed

her loneliness and sadness as a connection to her deceased husband, to whom, emotionally, she was still married. This 'marriage', ironically, offers her an independence, a freedom from worrying about someone else who might get sick, die or just not work out in a relationship. Therefore, it is understandable that she would not want to date anyone else.

The use of the genogram, the conjoint interview of a family member within the group context, and an examination of the therapeutic system will be further elaborated, as these are perhaps less commonly incorporated in the treatment of this population.

Entering Through the Genogram

The genogram is a map of the family emotional system which includes the members of the system and any nodal events such as births, deaths, separations, divorces, moves, etc. The genogram can also include significant others, key organizations or even issues such as alcoholism. Most importantly, the genogram permits a diagrammatic depiction of the relationships among these elements of the system. Genograms are often completed in the session with the client's participation.

The genogram was incorporated into the group process over two sessions. A poster-size paper was hung on the

wall on which to develop the genogram so that all members could see it. It was described to the group as a sort of upside down family tree that could help people see how we tend to repeat patterns from our past. It was useful in engaging Mae into the group at midpoint, as it facilitated the development of the other members' roles as co-therapist with regard to Mae, and acquainted the group quickly with Mae's story. Two sessions were required to complete the genogram, which was posted on a wall and skillfully worked into the group process. The group took part in obtaining the data and drawing connections as they emerged.

Focusing on themes and relationships and minimizing details such as dates was important, as these often couldn't be recalled. The genogram should always be used cautiously, since sensitive information may be revealed before a sufficiently trusting relationship has developed. Or, in an attempt to conceal such information, false information is elicited. Nancy Boyd-Franklin, in fact, cautions against use of the genogram in a first session with Black families for this reason. (1989, p. 142) Mae's genogram was begun in the group after her intake session and two group sessions, and then with her permission. Trust already had developed within the group, and this seemed to be a factor as well.

Mae came to the next session with a handwritten note outlining the birth orders of her children and the orders of her marriages. The women joked about often being asked by welfare workers about their children's birthdates and being unable to remember. They thought a genogram would be good to keep with them in order to answer these questions.

Beyond this practical use, the genogram was therapeutically very useful in understanding Mae's present dilemma. Mae was the second youngest of eight children. She began a pattern of distancing in order to resolve conflict early in life, when she was triangled into her parent's marital conflicts. Recall that Bowen developed the concept of triangulation to describe the tendency of dyads to reduce tension and avoid conflict resolution by focusing on a third person, issue, etc. Mae's parents fought continuously, which included physical fighting. Mae's perception was that they fought mostly about her and, in fact, blamed her for all the conflict and tension in the home because she would stay out late or wouldn't clean her room. From her perspective, her staying out 'worked', in that the fighting would begin again when she would return. Mae and the group were able to see that Mae continues to perceive herself as caught up in something for which she

is unfairly blamed. She continues to resolve the situation by distancing, although the cutoffs are shortlived. Mae bore her six children of four unions. The first husband was an alcoholic whom she 'put out'. The other three unions were characterized by themes of expectations of being completely taken care of and ultimate abandonment. For example, her third union was to a man several years her junior. She had just 'gotten herself straight' with regard to her welfare benefits for herself and her four children, an apartment, their schooling, etc., when she decided to remarry. Mae reports that even her caseworker begged her not to marry so quickly because Mae had worked so hard to get things in place. Mae decided to do so anyway, and was reporting this to the caseworker because her fiance had a 'good job' and promised to take care of her. Two months later, he abandoned her and she had to start all over again.

These recurrent themes and patterns point the way for further exploration of Mae's present situation. As mentioned previously, several of her children are substance abusers and exhibit violent behavior. One avenue of exploration would be to examine whether and how Mae may continue to be triangled into her children's marital conflicts. Another avenue to explore is the function of violence and self-destruction in is the

system.

Mae's desire to cut off from her children, however, was the most immediate issue. This decision and her fantasy reflect poor differentiation of self from others and unsuccessful attempts to resolve this through cutoffs.

The group confronted Mae on the likelihood that she would eventually get in touch with her children, despite their protestations to the contrary. Thus, the group helped Mae accept her need for emotional proximity, and yet begin to achieve a balance in this area by defining for herself how and when she would see her children. Her definition of her children's behavior and the consequences of that behavior for her were not challenged. Nor was her perception of her inability to influence them challenged. Instead, she was helped to look at how close she really wanted to be to them presently, and at what practical considerations could make this work. She also was helped to rely on others, i.e. her caseworker, in a more autonomous fashion in order to implement her plan. Mae was able to do so. She decided how much time she wanted to herself before seeing her children again, or informing them about where she was. She also decided the conditions of their visits e.g., duration, location, etc., and obtained support for this plan from the caseworker.

Entering Through Direct Contact

In two instances, a family member was to be invited to the group. In a third case, telephone contact was made. Neither of the two invited members attended. The invitation extended directly would have resulted in Tricia's son coming, but he was early and staff sent him away. It was an error not to advise the staff of the invitation. The second situation concerned Cynthia, who presented difficulty relating to her sister. A conjoint session was preferrable as it would permit direct assessment and intervention and it appeared that her sister would be accessible since she lived in the city and maintained contact with Cynthia. However, Cynthia refused to invite her sister to a session.

In the third situation, the researcher's telephone contact was helpful in engaging a family member on an important concrete task. In this instance, Althea, who had finally decided to take a step toward locating her son, supplied her sister-in-law's telephone number to help in the completion of a missing person's application. Althea's memory impairment prohibited her from doing this on her own. It was apparent from her sister-in-law's response that Althea had conveyed a sense of trust such that the sister-in-law became quite cooperative. Clearly, the way was being paved to

potentially engage Althea's sister in future work.

These interventions are common tools for entering family systems: using a genogram with one member; reaching out to another's family member via the telephone; assigning tasks and being directive; intervening paradoxically. The point here is that neither the women's age, nor the fact that they have been homeless, rule out their usefulness. On the contrary, this experience suggests that these techniques can be quite useful with this population. The women and their family members responded to these system-directed interventions. Furthermore, these interventions could focus upon issues which are directly related to their homelessness such as in Mae's case.

The Therapeutic System

The concept of complementarity or fit when applied to therapist/client system-interactions describes the nature of what is called the therapeutic system. Thus, systems-oriented therapists are encouraged to also be aware of how their own feelings and behavior are shaped by the family's so that they may more effectively influence the family system. Understanding the family's influence upon the therapist gives information about how the system operates, and what its rules, values, taboos, etc. may be.

This was a unique treatment situation wherein the group, as mentioned above, was a significant therapeutic force itself through the mutual aid it offered. Here, for the sake of clarity, the term 'therapeutic system' will refer only to the group/researcher dyad.

The researcher maintained a very accepting posture which allowed even the more dysfunctional members to manage in the group. The women were able to discuss the impact of their homelessness upon their self esteem. While the impact of mental illness upon self esteem was not broached directly or verbally, it was also presumably an issue. In this situation, the researcher learned that conveying respect and dignity was very important. The acceptance of emotional and cognitive limitations helped to convey respect and served as a model for group members. For example, Kathleen was often completely incomprehensible due to her thought disorder. If no thread could be found to tie her contribution in to the discussion, she was gently refocused and the group moved on. Likewise, probing was done gently, often by requesting permission to do so. Interventions were often framed as suggestions or recommendations, allowing the women the opportunity to feel a sense of control over their lives. This 'information' reiterates the literature which stresses this approach in work with

homeless people.

In summary, this chapter has described the establishment of the group and the setting in which it took place. Following a one- or two-session pre-group intake interview, the women began to meet as a group. Group membership became a significant vehicle of increased affiliation, as the group became quite cohesive and the women connected well to each other. The usefulness of specific interventions such as directives, tasks, the use of the genogram and the conjoint interview were described as well as the dynamics of the therapeutic system. The following chapter will address the women's family systems and the impact of the group in increasing affiliation through enhancing connection to the family.

CHAPTER V

FINDINGS, PART TWO: FAMILY AND SOCIETAL AFFILIATION

Goals Reviewed

The study sought to demonstrate the usefulness of a family systems-oriented treatment approach in reducing the disaffiliation of homeless older women. Affiliation is a function of a variety of social roles. However, roles related to family and relationships with significant others were of particular interest here. Similarly, a systems approach is not limited to treatments geared to impact family relationships, but may target a variety of problem areas. Therefore, it was anticipated that the treatment might also impact affiliation status in other spheres of the women's lives.

With regard to the family, the treatment sought to alter the emotional proximity in the women's significant relationships. An underlying assumption, also to be validated in the process, was that family system dysfunction, particularly in the form of cutoffs, is often a factor in women's homelessness. Reconnecting them to the family where appropriate, or supporting cutoffs where indicated, then would bolster their reintegration into society.

When treating homeless older women, the worker should seek to reintegrate the client into society as fully as possible. This will include, in part, recognition of the role family dysfunction may play in the client's homelessness and the importance of reconnecting clients to their families where appropriate. Specifically, the following guidelines should be adhered to:

Practice Principle 1.

When treating older, homeless, mentally ill women, include an assessment of the family system as part of the assessment process. Specifically, include an assessment of whether cutoffs, family conflicts or other problems in relationships with significant others contributed to the client's becoming homeless and/or whether strengthening these relationships might offer the client support while homeless and once she is again domiciled.

Practice Principle 2.

Reconnect these women to their families when it is not contraindicated.

Given that the study was exploratory and qualitative, it was expected that the treatment process would yield other practice principles which were not predicted.

Family Assessment

It was not possible to fully assess the specific structures of each of the families for purposes of comparison in the brief period available. Such an assessment would vary according to the specific schools of family systems therapy but might include (Liddle, 1983, pp. 25-28):

Bowenian: differentiation of self from family, family emotional reactivity, level of family functioning, family projection process, triangulation, flexibility-rigidity, responsiveness to stress, family's operating principles.

Systems: contextual factors, circular causality and complementarity, systems understanding of family functioning.

Structural: structure, organization and subsystems, boundaries, alliances, enmeshed-disengaged continuum, social context, constructions of reality, life cycle.

Strategic: problem focus, family life cycle, symptoms as relationship metaphors, social context, sequences of behavior.

Symbolic-Experiential: complementarity, focus on metaphors and the analogic, separateness-connectedness, intergenerational themes, therapeutic relationship, growthful aspects of symptoms.

Generally, as in this case, an assessment draws on a variety of the concepts outlined above, crossing the various schools of thought in an attempt to answer the basic questions: "How does this family system operate?"

and "What can be done to change it?".

Consistent with family systems-oriented treatment approaches, assessments were part of this treatment. Responses to interventions form the basis for assessments. Thus, assessments are developed over time throughout the course of the treatment. The group did prove to be a viable model for the assessment of family systems. However, for a fuller family systems assessment, lengthier group time would prove more useful for a membership of eight to ten clients, as in this case.

The salient assessment issues which emerged in the group were:

- These were, by and large, multiproblem families.
- Substance abuse, particularly drug addiction, was often a major problem in the family which contributed to the women's homelessness and/or gravely eroded the family system's capacity to support the women and be a resource for placement.
- The dissolution of marriage was at times among the precipitating factors leading to homelessness for these women. In some other situations, the separation of spouses due to homelessness provided women an opportunity to dissolve unsatisfying marriages.

Multi-Problem Family Systems

On average, the women's family systems included 4.5 of the seventeen problems listed on Table 2. Poverty, cutoffs and substance abuse were encountered most frequently. All of the women (100 %) viewed their poverty as a factor contributing to their poverty and half of them (50 %) noted cutoffs and a family member's drug abuse as contributing factors. For thirty percent (30 %) of the women, alcoholism, a family member's mental illness, or their own divorce or marital separation were factors. Physical illness or disability figured in their homelessness twenty percent (20 %) of the time and unemployment, immigration problems, incest and homicide were factors ten percent (10 %) of the women. Note that the table notes only problems which were contributing factors to the women's homelessness or relevant to their placement in permanent housing or their current situation.

It is noteworthy that in only one (1) case did a woman attribute her homelessness to a single event: For Ilene, her sister's death precipitated her having to go to the shelter. Mae was less specific about the events leading to her homelessness, except to say that she had been in the shelter several times, each precipitated by physically violent behavior with the adult child with whom she was living.

Table 2.

Type and Frequency of Family Problems Contributing to Homelessness or Impacting Placement and /or Current Housing Situation

N=10

PROBLEMS	N	PERCENT
o poverty	10	100
o cutoffs	5	50
o substance abuse: drugs	5	50
alcohol	3	30
o mental illness (other members)	3	30
o divorce, separation	3	30
o other family conflicts	3	30
o death/bereavement	3	30
o eviction	3	30
o organic mental syndrome	2	20
o physical illness/disability	2	20
o violence/battering	2	20
o habitual stealing	2	20
o homelessness (another member)	2	20
o history of incest	1	10
o history of homicide	1	10
o unemployment/underemployment	1	10
o immigration problems	1	10

Addictive Family Systems

The extent to which drug addiction figured prominently in the family systems of these women was unanticipated. Recall that drug abuse is a known precipitant of homelessness for men. While it is not surprising that many substance abusers would themselves become homeless, the abuse can also pose serious consequences for other family members, particularly the older members of the family. Drug addictions rendered adult children emotionally and materially dependent upon older family members who hadn't sufficient emotional/material resources to support them. Jennings (1987), in her discussion of elders as caregivers for adult dependent children, notes that the stress this creates often increases with the age of the dependent child. The elderly, then, would be at even greater risk than younger parents who perform this role. And since caretaking generally falls to women, (Hartman, 1990) it is the elderly women who may be most at risk. For example, Carmen could no longer maintain a large, relatively inexpensive apartment when her children, several of whom were addicted, returned home when they were unable to take care of themselves, in some cases bringing grandchildren home with them. Cynthia's son, with whom she lived, resorted to drug dealing to raise rent money when their eviction was imminent. She later discovered that he also was using drugs himself. They

both entered the shelter system when they lost the apartment anyway, and ultimately he was convicted and imprisoned. Tricia's son, who is homeless, is also mentally ill and acknowledges drug use. His dual problems of mental illness and drug addiction overwhelmed her ability to achieve a balance in their relationship, as she tended to feel over-responsible for him, particularly since the rest of the family had distanced from him completely.

These cases reveal a lack of clear boundaries between family members, characterized in the case of addictions by the overdependence of the adult child who is addicted and the overresponsibility of the parent. This enmeshment is a key feature of addictive family systems. Boundary inadequacy is a symptom of intimacy dysfunction which Coleman and Colgan (1986, p.22) define as "a pattern of thoughts, feelings and behaviors that precludes a balance of identity (separateness) and intimacy (attachment) that appear necessary for satisfying relationships. While this project could not delineate a distinct causal relationship between the addiction and the women's homelessness, the literature on addictive family systems resonates with these women's experiences. As described, these systems would ultimately be ill-equipped to care for a vulnerable elder member.

According to Ziegler-Driscoll (1981), one can think in terms of the 'addictive family system' since research has found no essential differences between the family systems of alcoholics and those of drug addicts. Both the families of origin and the families of procreation of alcoholics and of addicts have been found to have many commonalities such as:

1. There is a higher rate of alcoholism among other family members for both forms of addiction.
2. Addictive families tend to have a high level of reactivity to the abuse, coupled with a low level of knowledge about addiction.
3. The substance abuser tends to be overly dependent upon parent figures as an adolescent and therefore, poorly prepared to handle adult developmental tasks. Locked in a pattern of enmeshment, the abuse functions to maintain the dependence/independence struggle.

Age also figures prominently in the family dynamics of substance abuse, since the addiction most often begins in adolescence, when the threat of leaving the family occurs. Furthermore, when the substance abuser's parents are elderly, perhaps facing retirement, loneliness, etc., there may be pressure upon the substance abuser to remain dependent and therefore addicted, as the addiction maintains their dependent position. This may be played out, for example, by the elderly parent wanting the child to become responsible before leaving home. Van Deusen and Urquhart (1982)

stress the importance of treatment which focuses upon breaking this paradoxical position and changing the nature of the parent/child interdependence.

Gender also tends to be a factor in addictive family systems, as it is typically the abuser's mother who is involved in this enmeshed relationship, with fathers being more detached (Stanton et. al. 1982). Consistent with the pattern of enmeshment, abusers tend to have a high degree of family contact, despite their age - a much higher level of contact than that of the non-abusing population. The enmeshment is generally so severe that, as the abuser begins to be successful, the family often develops some other crisis which triggers the abuser's failure. Once the fear of separation is lessened by the failure, the other crisis may dissipate. Stanton and his colleagues (1982, p. 13) state that "Consequently, the pressure on him not to leave [or to reduce over-dependency] is so powerful that the family will endure and even encourage terrible indignities, such as his lying, stealing and the public shame he generates, rather than take a firm position in relation to him. They also tend to protect him from outside agencies, relatives and other social systems."

Family of origin intervention has been found to be important in the treatment, even when the abuser is

married, not only in the practical sense, since the abuser will often return home as the marriage becomes stressed, but also because enmeshment in the family of origin often undermined the abuser's ability to develop a viable marriage. Madanes and her colleagues (1980, p, 889) agree that addicts aren't, as commonly believed, "peer oriented sociopaths but are enmeshed in dependent relationships with their families of origin or parental surrogates". Without family of origin intervention, the destructive behavior which accompanies addictions, and the continued dependence upon the family of origin would conceivably create an unsafe environment for an older member. It also could create a situation wherein the abuser's dependency would ultimately overtax the elder's ability to complement the dependency. Presumably, these older, mentally ill women would be even more vulnerable to both of these occurrences. A related issue, also identified by Madanes et. al. (1990) is that the nature of the role reversals in addictive family systems reveals that the parent is in a 'down' position in an alliance with the adult child. Previously, it was thought that the addict was elevated to the parental subsystem and was striving to control the family. This suggests an underfunctioning of a member of the parental subsystem.

The assessment of the family system as it relates to

homelessness is useful in determining the extent that the family may be or can become a resource for placement or for concrete or emotional support once the women are domiciled. Substance abuse prevalence indicates a reduced likelihood that the family system will be such a resource particularly for a physically or mentally frail older member. Annette's situation provides another example of these issues.

Annette's family was apparently the most dysfunctional. Coming from a very large extended family, Annette proudly counted her grandchildren and great grandchildren, totaling forty plus, and twenty plus respectively. This family, however, was unable to perform many of the basic family functions, such as caring for sick members. Her daughter's death was apparently due to neglect ultimately, and perhaps due to repeated physical abuse. There was a severe lack of boundaries such that the pervasive substance abuse problems of the grandchildren were flaunted before her, and her entitlement checks were stolen and forged. Thus, when her daughter died, Annette saw no possibility of remaining with her grandchildren. Her own words are the best assessment of her family system: "This is not a family that cares about each other - they don't act like a family." Clearly, it was highly unlikely that this system could be a resource for her placement.

Marriage

For several of the women, their marital relationship was particularly salient in their homelessness. Developmentally, the task for the family experiencing loss of a spouse is to mourn, to comfort and to rearrange family roles so that the surviving or remaining spouse is comforted, supported and can resume autonomous functioning, perhaps incorporating a new spouse into the system.

For two of these women, the loss of their partner through death or divorce was among the precipitating events which led to their homelessness. Recall that such manifestations of 'family instability' were known to be precipitants of homelessness for women and older women.

For Evelyn, her common law husband's death meant not only a loss of income but a serious depression, loneliness and fear of engaging in another relationship. The loss of income meant that once she exhausted her small savings, she could no longer pay the rent. Her inability to develop a new relationship left her isolated. She avoided the feelings of loneliness while spending five years in the shelter, only to re-experience the loneliness again when she came to the residence. One avenue of increasing her affiliation

would be to help her again feel comfortable in a sexual relationship.

For Tricia, her divorce apparently triggered several manic episodes during which she squandered considerable financial resources. Tricia had no difficulty entering new sexual relationships. However, her situation suggests that through early intervention in marriages where presumably there is an overfunctioning partner and an underfunctioning one, the latter's homelessness might be prevented if the risk is identified as such.

In other cases, the homelessness was not precipitated by divorce or marital separation per se, but by events such as a fire, or the wandering off of an organically impaired spouse. These events served as a 'solution', resolving or dissolving marriages which were no longer satisfying. These women were unhappy in their marriages but could not leave due to moral prohibitions or economic/emotional dependence. For example, Althea explained repeatedly that after the fire, her husband went to his mother's house and she went to the shelter. Whenever she was questioned about this arrangement she would only respond that she figured "He was alright where he was at and [she] was alright where [she] was at." On one occasion, Althea seemed to acknowledge that she wasn't very happy in the marriage but could not

leave. Although she was not content to stay in the residence, she had no intention of reuniting with her husband. She wanted an apartment of her own. She would always say that she sees him occasionally and talks to him on the telephone whenever she calls his sister and he happens to be visiting, "and that's enough".

Kathleen was a bit more open about her dissatisfaction with her common-law marriage of many years. She suspected her husband of having an affair, then felt overburdened by caring for him once he became both physically ill and mentally impaired. When he wandered off and his family located him, they placed him in a nursing home. Kathleen hasn't visited him or talked to him. When the group began, she was deliberating about sending him a Christmas gift, which she finally was able to send with the group's support. The impression was that this was a good-bye gift which would relieve an unexplained guilt, although she denied this. However, after sending the gift, she stopped focusing on her husband and began to fantasize about a new relationship, marriage and having children. For both Althea and Kathleen, entering the shelter offered them the chance to leave relationships which they would have continued to endure unhappily, otherwise. They had no desire to be reconnected to their spouses. Indeed, such would likely be contraindicated even if it were feasible. Increasing

their affiliation would require exploring other roles.

Long-Term Family System Dysfunction

Long-term family system dysfunction may play a particular role in the homelessness of the elderly. In this situation, the family dysfunction did not manifest itself in the form of a particular group of problems which had an adverse impact upon the older members. Instead, dysfunction in the family of origin strained relationships such that the system could not offer sufficient support to a member in order to prevent her homelessness, which was precipitated more directly by problems in her family of procreation. As one's support network narrows, due to the launching of children, retirement, losses, etc., reliance upon the family system increases. However, one may then encounter old conflicts which come alive again later in life. For instance, when she was evicted, neither Cynthia's daughter nor her sister would permit her to stay with them even temporarily. Cynthia saw this as directly related to the poor relationship she had with them based upon long-term family conflicts. Strengthening her support network was clearly indicated in order to prevent repeated homelessness, particularly since she seriously considered leaving the residence. Cynthia also understood her homelessness as related to the support, or lack thereof, she received or could receive

from her family. Furthermore, Cynthia perceived the likelihood that she could be successful living independently as directly related to the amount of support she could expect from her family.

Cynthia's family history included, from her report, incest, matricide and infanticide. Themes of blame, forgiveness, exposure and punishment are replete in this family system. These crimes were never exposed, and Cynthia frequently played the role of protector and savior by keeping the secrets. Yet, because she left the country of her family of origin, she was possibly felt to have escaped and to have abandoned her daughter. In fact, upon leaving the household of the family of origin earlier, her sister may have been at risk of an incestuous relationship with their father. Cynthia had "lost her voice", i.e. her ability to speak up for herself, as protecting others had become more important. In fact, she felt she was protecting herself since exposing the others meant she would be left alone, as they were all she had. Yet, in the end, both her sister and daughter, whom she helped to establish themselves when they came to this country remain angry with her. Each of them denied her request to stay with them even for a couple of days when she was evicted. Improving and strengthening her relationship with her sister and her daughter would mean changing her behavior which

stems from an old role. Yet, strengthening these relationships could provide additional support for Cynthia, particularly if she should decide to leave the residence to live independently again.

Affiliation Status

A major goal of the group was to positively affect affiliation status. Thus, an assessment of each woman's affiliation status was conducted using a modification of the Bahr and Garrett (1976) model which addresses: family contact, employment status, use of social services and participation in voluntary associations.

Of the ten women who participated in the group, a pre-assessment of their affiliation status revealed that before participating in the group:

- five women had no family contact.
- eight women were unemployed.
- only one used any social services outside of the residence.
- only one attended religious services regularly.

Clearly, they were highly disaffiliated as a group.

Particularly with regard to family contact, however, the pre-test/post-test model proved not to be useful in assessing change. This is because women may have had contact with one family member, yet been cut off from or

in conflict with another member. It is important to note, however, that three of the five women who reported having no family contact - Kathleen, Annette and Mae - did take some steps toward resolution of the problem. The other two women who reported no family contact - Ilene and Constance - did not remain in the group.

Family Contact: Cutoff and Reconnection

A major assumption of the study was that cutoffs would play a significant role in the women's homelessness, and that reconnection would strengthen their social reintegration, increasing their affiliation.

Indeed, (See Table 3.) five, or over sixty percent, of the women did experience such cutoffs and all of them made some attempt to resolve the cutoff during the course of the group. It is important to note that half of the total group had regular family contact with one or two family members, and two of these four women were among those also experiencing a cutoff.

Two women, Ilene and Constance, attended only a few sessions, and Constance, who was never really referred or assessed, was ultimately designated an observer status.

Table 3.

Cutoffs and Other Presenting Problems Relevant to Being Homeless and Steps Taken Toward Resolving Them.

CUTOFFS & OTHER PROBLEMS	RESOLUTION BEHAV/PERCEP
Cutoff from husband placed in a nursing home. (Kathleen)	Sent him a gift symbolizing the termination of the relationship.
Cutoff from mentally ill, drug-addicted son. (Tricia)	Maintained contact during his visit, but with limits.
Cutoff from son. Felt son didn't care enough to look for her. (Althea)	Filed missing persons application.
Cutoff from entire family. (Annette)	Enlisted worker to find grandson. Then called on her own.
Cutoff from entire family. Didn't want them to know her whereabouts. (Mae)	Decided this would be temporary. Took steps to limit family visits.
Bereaved. Fearful of another relationship. (Evelyn)	Began dating.
Very conflictual realtionship with daughter and sister. (Cynthia)	Spoke up re daughter's uncaring attitude.
Very conflictual relationship with sister. (Carmen)	No Change.
None Presented (Ilene)	----------
None Presented (Constance)	----------

Consistent with family systems theory and treatment principles, the goal of treatment was behavioral change or change in perception of the problem rather than insight. In all but one case (of the women who attended regularly), there was behavioral evidence of a shift in the direction of resolving conflict, coping better with bereavement and ending cutoffs. Thus the approach is judged successful in achieving this goal.

Cutoffs were resolved by direct attempts to contact the family member, indirect attempts such as contacting someone else in the system, by actually altering the proximity within the relationship or making specific plans to do so. Some examples of behaviors aimed at ending cutoffs were:

- Althea completed a missing person's application to locate her son, whom she initially dismissed by saying "He's not looking for me so I'm not looking for him." She engaged another family member in supplying information for the application. Later, she also encouraged Annette to do so.

- Tricia was cut off from her son, B., who was homeless, mentally ill, and had a substance abuse history. The entire nuclear family was cut off from him. B. came from the West Coast to 'visit' without a place to stay or money, etc. Tricia felt unable and unwilling to simply turn him away. She was able, however, to regulate the emotional proximity of the relationship better by seeing him regularly, several times a week, not giving him money, and by attending to her own affairs during the visit. Most importantly, Tricia did not have a breakdown as she had done in the past and as her family feared she would. Tricia was able to express her acceptance of her

son's condition and his sibling's decision to distance from him.

- For Kathleen, resolving the cutoff from her husband who had been placed in a nursing home meant terminating the relationship, not reconnecting. Kathleen ceased agonizing over her obligations to him and began to fantasize having a new relationship, children, etc. Instead of offering myriad excuses as to why she could not see him or talk to him, or agonizing over sending him a present, Kathleen finally sent the gift, and seemed much relieved. She did finally acknowledge, however , that the relationship was over.

- Annette was cut off from her entire family. For the most part, this was indicated since the family was highly dysfunctional and destructive. One daughter, however, who lives out of state, had found Annette once in the shelter. Annette missed her but felt her daughter didn't care enough to come back. Annette could not be convinced to try to locate her. She did, however, request that the researcher help her locate a grandson who could give her information about another grandson who was brain-injured and seriously disabled. Annette wanted to know how he was doing. The grandson was located, and upon termination, Annette was calling him although they hadn't spoken as yet. However, to Annette, she had found him and she was thankful.

- Mae also had a violent, abusive family system. She decided that she did not want to see her family or to even let them know where she was because they would 'start trouble' which might get her 'put out'. The 'trouble' was often precipitated by their insisting that she give them money, usually for drugs. She would either give in, or a fight might erupt. Challenged by another member that she would never really

maintain this distance, Mae acknowledged that this was so. She just needed a break to 'get herself together'. Having Mae make concrete plans helped her to experience some control over the situation,in which she complained her children treated her like a child. She decided to contact her children in July, to allow them to visit, but only in the lobby, and only for a specified duration. Mae, who, sought and obtained her caseworker's backing on this plan, hadn't known who her caseworker was initially.

One participating member reflected no change.

- Carmen had a tremendously conflictual relationship with her sister, who lives in a private home. Carmen felt living with her sister was not an option because her sister was too domineering and treated her as inferior. Carmen's poor group attendance -she missed half of the sessions -was attributed to the amount of time she spent caring for her sister's household. She was called upon to help when the sister's estranged husband died and the sister was subsequently admitted to psychiatric in-patient care. Carmen felt obligated to help her but resented it greatly.

In two cases, problems other than cutoffs were prominent in the women's homelessness: conflict and bereavement.

- As described above, Cynthia, who struggled throughout the group with deciding whether she should move from the residence into her own apartment, had a very conflictual relationship with her sister and her daughter. Cynthia understood the relationship between the hostility in the relationships and her entrance into the

shelter. She associated having her daughter's support with her ability to maintain her own domicile. She was acutely aware that the lack of support from her daughter (and sister) contributed to her entering the shelter. If they had helped her, she might not have had to go to the shelter. Sometimes, she felt she might have her daughter's support now, and could therefore chance moving out of the residence. At other times, she feared doing so and treasured the support she would get from the residence, especially if she should she become ill or disabled. As stated above, the goal for Cynthia was to change her behavior by 'finding her voice', dealing with the expressions of hostility or uncaring in these relationships. Cynthia was directed to gently but directly confront her daughter and her sister when they are hurtful to her. Cynthia took a step in this direction, albeit an indirect one. Cynthia talked to her sister about her daughter's uncaring behavior. This was a triangulation; that is , Cynthia was bringing her sister in as a third party in her relationship with her daughter, a move which could not resolve the problems in the former relationship. Yet, it was also a significant step for Cynthia to voice any feelings of discontent in this system.

- For Evelyn , bereavement, or adjustment to widowhood, was problematic. While her common-law husband had died ten years ago, Evelyn never entered another relationship. First, Evelyn's relationship was acknowledged as a marriage, emotionally. This established a commonality between her and the other group members as she'd previously identified herself as single, and never married. Unlike many of the other women's marriages, Evelyn had felt hers was very good. " The only problem was that he wouldn't get married." She finally tried to accept it. When he died, she "cried until [she] decided to stop crying.." Evelyn said she really didn't feel lonely when she was in the shelter. Upon coming to the residence, she began to feel lonely but was afraid of entering

another relationship "because what if he dies, too?" Framing the relationship as a marriage also permitted Evelyn the status of 'widow', and she was thus entitled to mourn and then could move on. One might speculate whether this frame also resolved a conflict posthumously. The direct interventions of group members failed to help Evelyn to move. They tried confronting her with the fact that, yes a partner might die, or that, yes, they worry about that, too, but she shouldn't be stopped by it. A paradoxical intervention supported and respected her decision to choose to be alone, as she had a great relationship with J. and was probably still very connected to him in her loneliness. Since there could be no guarantees about future relationships, and the possible pain they might bring, it was understandable if she chose not to risk entering a new one. After all, she was doing pretty well now. This restraint from change maneuver was effective. Evelyn began dating someone her sister had been trying to introduce her to for years. They went out several times and were still dating when the group ended. She described going out to dinner, taking walks, etc. Evelyn shared: "I guess I didn't really let go. That's why I didn't feel lonely."

Factors Which Impede or Enhance The Use of Social Services

Differences were noted in the extent to which the women used the variety of agency services which were, presumably, equally available to all of them by virtue of their residency. Group participation had a positive impact upon the extent to which they used these services.

A considerable amount of the group process centered on how group members could access a variety of social services. As noted earlier, homeless women have been found to use social services more than homeless men across all age groups. These elderly women who were recently domiciled remained highly motivated to obtain a variety of social services. Yet, the extent to which they actually used the services provided by the residence varied according to:

- the women's knowledge of the service offered.
- the women's personality characteristics.
- their perception that a request for help could have negative consequences for someone else.

These barriers became apparent as the women developed the strong mutual support network mentioned previously, which actually served to overcome them. The group, then, became a mechanism for addressing the disparities in their use of social services, an indicator of their level of affiliation. The group context, the essential development of a system of mutual support which in itself increases affiliation status, also potentiates the use of social services, a second means of affiliation. The importance of delivering concrete services as a means of developing a relationship for professionals working with poor or homeless people has been well documented and is a basic operating principle of social work practice. This principle can also be

applied to clients who engage in the process of helping each other. In fact, the support system began with a focus on concrete issues. In the group setting, sharing and providing concrete resources functioned to help the women experience each other as supportive and caring. With regard to affiliation, this experience indicates that the involvement of the women in this role for each other both strengthens their relationship with each other and increases their service use even beyond the resource of the group itself.

From the very beginning of the group, it was apparent that the women did not all have the same information about the kinds of help they could receive at the residence. It is important to note that this setting was not a large, bureaucratic one. It is, in fact, small and very organized by an extremely caring staff who work closely as a team. Yet, from items such as toilet paper and clothing to loans and safe deposit, to obtaining and administering medicines for the sick, all women did not have sufficient information on how they could use services. The early group sessions, in fact, all began with women sharing what they needed and the resources they knew of either in the residence or in the community.

All the women acknowledged receiving a written

description of the services on an 'orange paper' once a member questioned them about this. They differed in how thoroughly they had read it. Furthermore, at least one woman in the group was illiterate. Moreover, it appeared that the written list of services could not have possibly been exhaustive, as clearly this was a staff that would help with any problem presented. Personal characteristics were also a barrier. Women who were more assertive or had greater desires for autonomy were less likely to use the range of services offered. A woman who had little difficulty asking for help would apparently receive more help. Cynthia clearly was such a woman.

Cynthia was the only group member who was aware of every service mentioned in the group. In fact, she assumed and was designated the role of "the one who knows," and questions regarding resources were principally directed to her. Cynthia had clearly the best and closest relationship with the staff, who were very fond of her. She proudly expressed her lack of hesitancy to ask for anything she wanted. She had little difficulty being vulnerable and dependent.

Only once did Cynthia feel her autonomy suffered, when staff admonished her for buying a sweater for her son because a few days later, she needed to ask for a loan.

Personal autonomy was much more of an issue for some of the other women. Tricia, for example, felt the staff's constant checking of her room, and initial visits to check on her when she first came to the residence were very intrusive. Evelyn had a similar reaction. She recalled her embarrassment when staff, believing she was not in, inadvertently let themselves in to check her room accompanied by a male maintenance worker when she was inside undressed. She hadn't responded quickly enough because she was undressed.

Carmen had an ongoing struggle with the staff over a welfare check. The check was to cover her first month's rent, but it was supposed to be returned to welfare since Carmen entered the residence a month later than planned. Carmen objected, feeling it should have been given to her to do so. These difficulties seemed to occur particularly early, when the women are newly admitted to the residence. It may be that the women's need to make the transition from the shelter environment to a private space is at odds with staff's possibly well-meaning attempts to take care of them.

Tricia and Carmen were clearly more assertive in style than Cynthia, They were more distant from staff, and had much less information about the services offered at the residence. In fact, at least one staff member

experienced Carmen as "angry" and having a "chip on her shoulder". One can speculate that these personal styles impacted their ability to avail themselves of services. Anderson et.al. (1989) note that women whose personality characteristics do not conform to dominant cultural expectations are at risk for being mistreated by therapists. It certainly appears that these women's personality styles, were a barrier to their receipt of services.

The perception that obtaining assistance for self could negatively impact someone else was also a deterrent to using help. Specifically, if the women thought a resident would be evicted and made homeless again, they were very reluctant to seek staff's help for problems they encountered with the person. A portion of the group process focused upon problems the women faced from male residents who sexually harassed them. On more than one occasion, when discussing men who acted out sexually in a threatening way with them, the women were reluctant to inform the staff because they didn't want the men to be put out of the residence. They only wanted them to be hospitalized, and wanted assurances in advance that this would happen.

Group support did lessen the impact of these barriers. After processing the situation with M. in the group, the

women were not only able to share with each other the various incidents they had encountered with him, but they finally did begin to make staff aware of them. In fact, they organized a means of protecting each other. They agreed to watch out for each other whenever he was around. They exchanged telephone numbers so that if they saw him get onto an elevator with a woman, they could call the room to be sure she was alright. The staff was appreciative of the information. M. was admitted to a hospital for psychiatric care.

Carmen, on several occasions, discussed her intense anger with staff over their handling of her check. The group encouraged her to talk to staff about her feelings, which she did. She didn't share the content of the discussion, but said that she had 'worked it out' with them. In the group, Carmen was also encouraged to seek staff's help arranging for her to visit her son who was incarcerated upstate. As mentioned earlier, Tricia was encouraged to consult with staff about a legal issue which she did. Similarly, when she needed some help with her son and felt her worker wasn't really trying hard enough to help her, Evelyn and other group members convinced her that the way to "let her (the worker) know", was to keep going back again and again. Tricia did, and obtained the help she requested. What began as sharing with each other all of the concrete services

staff could provide: clothing, money, medicine, sick care, etc., evolved into an increased reliance on staff and each other.

Only one of the women in the group used any social services from an outside agency. Tricia attended a "health group" at another hospital center which was a discussion group within a rehabilitation program. There was no indication that women's use of outside social services increased by the end of the group. In this sense, use of social services as an indicator of level of affiliation was more salient for the community sample Bahr and Garrett studied than for these women living in a supportive residential setting. Upon their admission to the residence, each of the women was automatically assigned a caseworker who acted as her case manager. In addition, the residence is part of a larger church-sponsored agency which includes a senior center. As residents, the women are entitled to the services of the community center, which is part of the agency, and some residential services that overlap those of the center, for example, meals. While the women are still theoretically free to use or not use these services, the likelihood that they would do so is much greater since their dependence upon them and their access to them is greater than that of women living in the community. For example, all of the women ate two meals each day that

were provided at the center.

Affiliation Through Employment

At the initiation of the group, three of the women were working. Interestingly, only one of the women identified herself as being employed. Cynthia worked as a companion and domestic worker for another elderly woman, one day per week. By the end of the group, Cynthia was working three to four days per week. Evelyn was also working as a companion, spending a few hours per day with Ilene, who was a group member. Evelyn did not share this until Ilene was hospitalized. Ilene had been assigned to her by the senior center, as this was one of its services. Once it was clear that Ilene would not be returning to the residence, Evelyn was approached to take another client. Evelyn was interested in continuing, but only with clients who lived in the residence, and therefore had to wait for a new assignment. Similarly, Tricia had been a companion for another resident who had been a close friend of hers. This client died during the early phase of the group. Due to her grief over this loss, Tricia was undecided about working again. Ultimately, she decided against doing so. Kathleen stated that she would like to work, but didn't know what she would like to do. She finally decided not to work, at least not for now. Mae, who was

the youngest member of the group and in her 50's, stated that she would like to work, but was frequently told that she was too old.

How 'work' is defined is a pertinent women's issue. Much of the work women do is in the home, caring for others. Thus, Evelyn and Tricia simply "never thought of it as working," although their clients were formally assigned to them by the residence or the affiliated senior center, and I believe they were paid a small sum for their services. Also, the services Carmen performed for her sister, running her household and caring for her children, could certainly qualify as unpaid 'work', although Carmen didn't view it that way.

The women's affiliation status was actually lowered by the fact that few of them were actually employed in the beginning, and even fewer when the group terminated. For over half of the women, employment was an important issue in their lives. Although few of the women were actually working in the traditional sense, the role of 'worker' remained an important one for all but those who were too frail or disabled. Three members, Constance, Annette, and Althea, were obviously unable to work due to their physical frailty. Still others were either planning to work again, were specifically preparing for work, or were making a decision about whether to work.

Reaching a decision not to work again may be as valuable as increasing one's work, from a clinical standpoint. The adjustment one makes to aging, including the adjustment to continued work or retirement, is the important issue. For instance, although Kathleen didn't elaborate on her decision-making process, it is probably fair to conclude that her age played some part in her decision not to work. If so, this decision is far more reality based than her aspirations to marry a European and start a family.

Given that this was an elderly population, physical decline which prevents working, coupled with the decision to retire from working, negatively impacted their affiliation status. These aspects of normal aging contribute to the greater disaffiliation of the general aged population.

Affiliation Through Voluntary Associations

Garrett and Bahr (1976, p.14) "recognized [family and employment] as generally more salient or 'important' in binding one to society than the residual 'other' category": "voluntary associations". However, they included this variable, which was to encompass less "demanding or binding" roles such as union or professional association, and membership in church and

charity, recreation and political organizations. Among the homeless women in their sample of fifty-two women who were younger with a median age of forty-seven (47), only about forty percent (40%) of the women reported regular church attendance as adults. There is no specific data on whether this attendance was continued while in the shelter. The shelter group was drastically less affiliated with regard to other affiliations.

For women in this study, as well, this variable, as originally conceived, was not as salient. The women did not belong to any secular associations. It was expected that church membership would be the voluntary association most likely to be a source of affiliation for these women. Yet, only one of the women identified herself as a regular attendee and member of a church, the one with which the residence was affiliated. This woman, Cynthia, was Black and of West Indian heritage, and likely was reared as a Catholic. Given the strong religious and spiritual aspects of Black culture, a higher rate of church attendance among the group was anticipated. However, it is possible that the other women were not Catholic. Perhaps they were less comfortable with the options available to them through the sponsoring agency church or in the neighborhood, which may not include Black Protestant churches. Mae, for example, had attended church services regularly

until she left the shelter, as the shelter provided transportation to a specific church for a group of women each Sunday. No such arrangement was available at the residence.

However, participation in this group can be considered a type of voluntary association since women were only referred by staff; it was made clear that they were free not to join the group.

Agreement to enter the group, continued participation, the development of group cohesion and the aforementioned impact upon the women's use of and connectedness to the residence, indicate that the women were more affiliated upon the close of the group. During their individual interviews, in which the women were offered an opportunity to participate in the group, each of the women interviewed complained of the fact that residents did not relate to each other: 'people here just come and go'. This yearning for greater sense of connectedness was possibly a motivating factor which aided the success of the group.

Staff Perceptions of Group Outcomes

The researcher was interested in knowing what, if any, impact the development of this project might have had upon the rest of the residence system. Following the tenet that, a system is composed of interdependent parts, and that, therefore, a change in one part will have an effect elsewhere in the system as well, it seemed reasonable to expect some impact upon the overall program. Systems-oriented treatment often makes use of a more meta position to obtain information about a system which may not be obtainable with more intimate involvement. Thus, outside consultations are frequently used to aid in treatment progress. Since staff were not aware of the group content or process except through their observations from outside of the group, their observations might lend greater validity to the project if they should coincide with the researcher's findings. Therefore, staff were canvassed to ascertain their perceptions of the impact of the group, if any, upon the overall residence program and upon individual members (Appendix D). Eight respondents represented the total social services staff, including interns. Open-ended questions allowed staff to elaborate as they wished, so responses are not mutually exclusive. The questions were:

1. What impact do you feel the women's group has upon the total program?

2. Have you observed any impact the group may have had upon group members? Please describe. Feel free to relate your response to any group member, not just women on your caseload.

Unfortunately, staff responses confounded the two items so that all staff did not really respond to question Number 1 regarding the impact of the group on the program. Some respondents referred to impact upon individuals in answer to this question as well. This may reflect a poorly worded question or an unfamiliar frame of reference since this first question reflects an ecologically oriented perspective.

Four of the staff respondents did respond appropriately to this question. They cited the development of a men's group, and increased interaction and support among residents as outgrowths of the women's group. The men's group began in response to a request of men in the residence who envied the women's group. With regard to the latter, they specified that the increased interaction referred not just to the behavior of group members vis-a-vis each other, but their interactions with other residents as well. Three respondents noted that group members and other residents had become more "vocal" and "assertive" since the group began. Three of the four respondents also reported that the interest of members and non-members in other residence activities increased. One respondent mentioned a heightened

realization of the "problems women face".

With regard to staff's impressions of the group's impact upon individual group members, Question 2, responses seem to fall into two categories: goals which relate to the use of the group modality and the more specific treatment goals for each member.

Of the eight respondents, seven identified the group's cohesion in terms such as "increased bonding...interaction... support...a feeling of comraderie...looking out for each other". Four respondents identified specific outcomes:

- "Cynthia learned how to deal with people, how to say no."
- "Evelyn associates more with the other women, she feels more important"
- "Tricia was helped with her son."
- "Mae and Annette found family members they lost touch with."

These responses do support findings reported by the researcher. They reflect staff impressions possibly influenced by their work with their respective clients but without researcher influence as the group process was confidential. Since the survey was anonymous, it was not possible to correlate responses with case assignments in order to ascertain whether specific observations were apparent even to those not directly

involved with particular group members. Note also that the degree of involvement with their assigned residents varied from worker to worker.

Motivation to be Domiciled: A Continuing Issue

While the preceding 'outcomes' compare the women's initial affiliation status with, in many instances, specific indicators of change in the direction of increased affiliation, this pre - post model does not fully address a significant variable which might be seen as an antecedent one: their strong motivation to be domiciled. Their stories are consistent with the literature which states that homeless people do accept safe, permanent housing when offered, and are not people who have simply chosen to drop out of society.

None of these women were severed from their domiciles easily, nor were they on the street for more than a brief period, perhaps a few days. Cynthia begged for food and money from family and friends and pleaded with her daughter and her sister to let her stay with them temporarily. Kathleen and Althea stayed in unhappy marriages until other problems forced them out of their homes. Evelyn worked and spent all of her savings. Tricia was evicted after she'd gone through thousands of dollars in a manic phase of her illness. She resisted

the eviction and sought police intervention to be permitted to remain in her apartment.

Neither did their homelessness nor their placement in the residence extinguish their tenacity. While the residence was considered a permanent placement, throughout the group, women made unsolicited references to their desires, fantasies, and disappointments with regard to having a place of their own. Carmen was clear that she had no intention of remaining in the residence; she would eventually obtain an apartment of her own in "the projects". She was very frustrated, as were several of the women, by the cooking facilities at the residence. The kitchen was shared by everyone on the floor, storage space was inadequate and there was no oven nor table and chairs. Women found it inconvenient and unsafe traveling back and forth between their rooms and the kitchen while cooking. Carmen wanted her own kitchen and a place where she could have a table to eat with her children occasionally. Presently, she had a folding table which took up the entire floor space of her room. She greatly resented some staff members' remarks that she spent too much money feeding her children. In fact, she revealed in the group what the staff didn't know: that since they had no cooking facilities at all, her children were giving her their food stamps and she would then cook for them.

Althea never let a session end without stating her plan to 'get [her] own place', with the help of her sister-in-law. Cynthia constantly challenged her on this in a caring but firm manner, confronting Althea with the fact that her memory was failing and she often couldn't find her room. Cynthia was very clear that Althea needed the supportive environment of the residence.

Cynthia vacillated on this issue herself, grappling throughout the group with her desire for a place where she could be more autonomous and her fear of being without support when she could no longer function independently. She once shared her fantasy of waking up in the morning in her own apartment, in her own time and being able to make a cup of coffee which she could enjoy at a table with a beautiful tablecloth on it. Additionally, Cynthia looked forward to becoming a U.S. citizen.

Mae fantasized living in a store with a back room where she could sleep. However, this would not be a store where she would sell food; food would only be delivered. She confirmed my impression that she wanted a safe, peaceful place where she could just be and have everything she needed without worry.

While Kathleen had great difficulty with the reality focus of the group, her psychosis permitted a rich fantasy to be shared about a room in Europe which is prepared for her. She had actually lived there before, that is before the 'explosions' occurred. In the meantime, while she was trying to return to this room, she carried her "connections" to her father, her mother and her sadnesses in her bag.

Their struggle to be housed shifted from attempts to merely hold on to whatever housing they had or could obtain, to a deep desire to have the home they really wanted. Often, their 'permanent' placement met their needs but fell short of fulfilling this desire.

Women of Color

Given that four of the ten women were Black and one was Puerto Rican, it would appear to be more useful to look at them as a subgroup of minority women or women of color. With regard to the variables this study focused upon, these women did not appear to be much different from their white counterparts. Where differences were noted, the sample size was too small to validate their significance. Their families were multi-problem families averaging 4.5 of the sixteen (16) problems listed above, whereas the white women averaged 4.0 problems in the family. Cutoffs and substance abuse

were the most frequent problems for both the women of color and white women. It appears that the family systems of homeless mentally ill women are more alike than different with regard to their ethnic background, given the variables observed. If group attendance and outcome reflect motivation to resolve one's problems, then again, the women of color appear similar to the white women. Four of the five women missed no more than one session. But, actually, overall attendance was extremely good. The three white women who were in the group for the duration missed no more than two sessions.

The sameness of two culturally different groups is remarkable. Where they differ, of course, is their proportionate numbers among the homeless population. The logical explanation would relate their greater risk to factors related to racism and unequal access to resources that may prevent homelessness. Finding no significant differences in family functioning or motivation supports Hartman's (1990) and Minkler's (1985) contention that socio-economic factors and discrimination are responsible. For example, since the Black elderly women are the poorest of the poor (Minkler et. al., 1985) they may be more prone to have unstable living situations and fewer resources with which to stave off impending homelessness such as the possibility of doubling up.

In summary, assessment of the family system appears to be a useful tool in work with homeless mentally ill older women. In this study, the assessment revealed that the women belonged to multi-problem families in which cutoffs and conflicts were prominent problems, and that homelessness can impact marital status. The prevalence of substance abuse in their family systems was an unanticipated finding. While the pre-test/post-test model proved less useful than anticipated, there was clearly evidence of the usefulness of the family systems approach in increasing reconnection to family. The other indicators of affiliation did not show positive change during the course of the group. A review of staff perceptions seemed to concur with some of the findings and indicated that in some cases, the women began to use the other program offerings more. The women remained highly motivated to remain domiciled, and some still wanted to live independently. The variables studied did not differentiate white women from women of color. The following chapter will address additional practice principles which emerged from the group process.

CHAPTER VI

FINDINGS: PART THREE. PRACTICE PRINCIPLES WHICH SUPPORT REAFFILIATION: TREATMENT AND PROGRAM DESIGN

It was expected that the group process might yield unanticipated insights. What follows are some of these 'learnings' which lead to further questions about women's experience of homelessness and may point in the direction of further research.

From Shelter to Residence and Home Again

The women shared how being homeless was a terrible blow to their self esteem. They were acutely aware of the low evaluation others had of them because they were homeless. Some women expressed shame and attempts to dress in such a way that they would not appear to be homeless. One such woman coped by a sort of projection, deliberately convincing herself that perhaps others she passed on the streets and subways were also homeless despite how well they looked. Perhaps another means of coping with their lowered self esteem, the women differentiated themselves from those who lived on the street. As mentioned previously, these women, although they had been homeless, did not spend much time on the street. There was a feeling expressed at one point, that they did not identify with homeless people who lived on the street. This may be a class stratification

among the homeless.

During the course of the group, the women often made references to their experiences in the shelters. Some of the experiences were disturbing but not surprising, confirming what is already known about life in the shelters, i.e. homeless people perceive them to be crowded, chaotic and unsafe. Women spoke of the lack of privacy and personal space; counting rows in the hundreds in each direction like coordinates in order to locate their cot. They spoke of witnessing the sexual relations of the other women and their confusion about and fear of lesbian sexuality and older women's sexual activity.

Some of their comments were pertinent to the issue of family reconnection. They complained about being unable to get telephone messages at the shelter. "They don't care when people call. They tell them anything." The women recounted examples of shelter residents and guards answering telephones with no intent or ability to locate a resident. Carmen almost lost track of her daughter, who was a resident of another shelter, when she (the daughter) was transferred to a different shelter. Carmen was brushed off on the telephone; she was told that her daughter wasn't known there. Since her daughter had visited her the previous day and told her

where she was being transferred, Carmen persisted. Yet, other women steadfastly believed they could rely on the shelter system to assist their family in locating them. Annette, for example, typified the belief in the system to the point that she felt her family couldn't be so interested in finding her because she knew they could contact her through staff at the shelter if they desired.

Surprisingly, however, the women didn't experience the shelter as entirely bad, although they all were glad to leave and no one turned down an opportunity to leave. While the food was generally bad at all the shelters the women had lived in, it was good on occasion and then they would eat as much as they could. And, as Mae put it, "At least at the shelter, you could eat."

For some women, loneliness was less of a problem at the shelter. Evelyn said: "I wasn't lonely in the shelter. You could go out with a group of girls sometimes - girls in their twenty's, thirty's and forty's. Here, they don't do anything." Ilene, in fact, was so lonely at the residence, she wanted to go back to the shelter. She didn't care to participate in activities, but liked being around " a lot of other people who talked to [her]".

Although the women were glad to leave the shelter, they did sometimes experience leaving as a loss. This step has been referred to as a "pyrrhic victory" for a woman who has to give up old ties in the shelter system and adapt to a new setting in the community (Koegel, 1987). Koegel, (1987) and Martin (1988) also refer to this adjustment process as women move from the street to indoors or from shelter to a residence. They note that the process occurs and suggest treatment goals. The nature of the process itself needs to be further clarified. Some of the women had intentions of visiting the shelter after discharge, although they didn't do so during the course of the group. Cynthia intended to make time to visit to speak to a group of women at the shelter at the request of her old caseworker there, who felt she could offer the women some hope. Several of the women remembered being upset and frightened when they saw so many women leave and come back to the shelter. They reported that often two residents would get an apartment together. They usually returned because they ran out of money or because of a drug problem.

Becoming domiciled may be a process as well. Entering a residence may require a period of adjustment wherein women need to adapt slowly, with time to rest and to settle in emotionally. Recall Mae's desire not to deal

with seeing her family for a few months. Tricia was very upset by well-meaning attempts to make her comfortable in her new room, which she experienced as intrusions. Several of the women identified with this, noting that they, too, 'didn't want to be bothered too much at first'. A number of them remembered sleeping a lot during their first few days or weeks at the residence. This may be a period where women prefer to have more time alone, perhaps to regain a sense of a more autonomous self and adjust to a less institutional, chaotic pace.

Mae and Annette's entrance in the middle of the group, only a week after being admitted to the residence, elucidated many of these issues. The difference in their presentation as compared to the other women was striking. They seemed to almost carry the shelter with them in an intangible way. More than their disheveled appearance, they seemed a bit frenzied and as though the environment around them was chaotic and frenzied. The other women seemed to be uncomfortable with them, beyond their newness to the group. Some references were made to their disheveled appearance with a mixture of disdain, and protectiveness. One had the impression that the other women saw themselves in them and at once hated what they saw but also felt a beneficence toward them. They acted on the latter feeling and actually

incorporated them into the group rather quickly. The former members shared experiences similar to Mae's and Tricia's. They wanted to rest and to 'get themselves together' before facing their problems and 'starting over' again. It is possible that this drastic change of environment is stressful, albeit positive, and sad, albeit desired. As well, it may signal that problems which were secondary to coping with shelter life, or which could be avoided while one was in the shelter, now needed to be confronted as one was domiciled in a stable setting. Martin (1991) discusses the process of adaptation to street living or institutional living. She stresses that in order to assist them in readjusting to life in the community, providers need to supply all the services that institutional settings provided, to be constant, and accepting of their need to gradually shift from the 'freedom' their previous condition offered to the social demands which domiciled community life entails. She further notes that this adjustment means reapproaching a situation in which the individual had previously failed and a system which has failed the individual. These women's experiences coincide with this thinking, and further suggest that the actual point of admission to a residence is quite stressful and emotionally demanding, representing an abrupt, rather drastic change. Women at this point may be experiencing a wealth of emotions: depression, fear, anger related to

the loss of a familiar way of life, and the sudden prospects of succeeding in a new way and facing old problems. Further research in this area could guide residences in developing an admissions policy that reflects a sensitivity to the women's needs and enhances the women's ability to use available support. For example, the admissions procedure might be designed to provide constancy, assuring women of the availability of services, particularly basic needs, while lowering the social demands at first.

A better understanding of the women's perception of the residence's role in their lives may also enhance their ability to use the residence once the transition process is under way. While the women appreciated the supportive services the residence offered, they seemed to view the service as housing primarily, and not always as permanent housing for them. Imbimbo and Pfeffer (1987, p. 17) in their study of homeless women's concept of home found that a group of shelter residents' concept of home was not unlike that of the shelter staff: They wanted "homes to encourage a family life, a social life and a community life". When shown pictures of a variety of housing options for homeless people, including group homes with social services, the women in their study rejected all of them and asked: 'Why would anyone build a type of home they themselves wouldn't want to live in

?' So the fact that homeless people do, in fact, accept referrals to these settings underscores their motivation to be domiciled and more affiliated. However, this project revealed that the placement wasn't what they really wanted. Most of the women really wanted to live more autonomously, in their own apartment where they could cook, entertain their families or friends and have privacy. Some women complained of the policy against overnight guests, and others supported it but mainly for reasons of safety. They complained of feeling "watched", controlled, infantalized. Some compared the residence to a shelter, a jail and to a mental institution. They described all sorts of infringements upon house rules which transpired during weekends, some of which made them feel unsafe, such as men who entertained prostitutes. While some complained of feeling bored on weekends when staff were not present, others felt more free.

The women not only viewed the residence as temporary because of their own wishes to leave, but they also lived with a fear of being evicted if staff should be displeased with them. This limited their openness with staff. The fact that the researcher was not viewed as being part of staff and clearly had no such power was an asset. They could share more, including their frustrations with the staff or the program. Women often

shared feelings and information in the group which they acknowledged they would not want the staff to know for fear that their own or another's stay might be jeopardized. It may not be ideal or even feasible to be at once landlord and therapist/caseworker. The women feared the staff's power to evict them and make them homeless again. Interventions centered upon educating them about the legal, practical and political constraints of eviction and their own rights as tenants could not fully allay this fear. They did value the staff's caring, and noted the difference between the social service staff and the management. The latter was perceived as being concerned "only about the building".

This relationship between staff and residents is, then, complex, characterized by dependency, appreciation, fear and underlying tension. Staff-client conflict has been known to thwart the placement process in shelter programs (Barrow and Struening, 1987). Minimizing staff-client conflict in residential programs should be beneficial as well. One source of the tension seems to be based upon a triangulation that occurs between staff, residents and their families. While homeless women were known to look forward to resuming parenting and to actually maintain some contact with their dependent children, this elderly group was actively involved with their adult children, who were emotionally and

materially dependent upon them and who had a variety of social and emotional problems of their own such as: homelessness, substance abuse, mental illness, incarceration and physical abuse. Often, it was this relationship with a dependent dysfunctional adult child in which the women had the most difficulty balancing emotional proximity.

Staff's inability to intervene in this area, based upon their individual focus, often resulted not only in missed clinical opportunities but in increasing alienation from the residents. The women's primary loyalties appropriately remain with their families. For instance, Tricia's daughter called the staff, fearing that her brother's arrival would lead to her mother's decompensation as it had in the past. She asked the staff to protect her mother from him, stating clearly that she cared only about her mother. Recall that he was homeless, mentally ill and a substance abuser. He'd left the West Coast with no resources to come to "visit" his mother who was overwhelmed by him. Staff's declared position was the same: Tricia was their only concern. Tricia however, was very involved with her son, struggling to achieve a better balance in her closeness to him. Tricia refused to believe that her daughter had called the staff, and insisted that it was the staff who'd called her daughter to complain about her son.

Tricia's alliance with her daughter was stronger; she would hold the staff rather than her daughter responsible for taking what she perceived as a harsh position with her son. Of course, both the daughter's and the residence's approach would be unsuccessful at changing the transactions between Tricia and her son, as she felt unsupported herself and more protective of him. A version of a cross-generational alliance, a cross-system alliance had developed (Coppersmith 1983) wherein the daughter had developed an alliance with the staff to deal with her conflict with her mother over how to handle her brother. The staff, believing the triangulation to be a true alliance, took on the role of limit-setter and protector rather than leaving this dilemma within the family system. This cross-system alliance short-circuits the possibility for solutions within the family.

An appropriate therapeutic stance would be to avoid being seduced into alliances with the family. The agency, however, had its own interests in this situation as there were other residents to be concerned about, and they did not see the son as their client. This situation, may again underscore the benefits of the role of therapist being separate from that of residence staff. An attempt was made to intervene at the interface of these two systems. The intent was twofold: 1) to

return the family dilemma to the family, empowering the mother to set limits with her son and obtain the staff's support in doing so; and 2) to address the residence's interests, assuring that the son would not create problems for the residence by hanging around unsupervised. For example, when Tricia learned in the group that her son had come by on his birthday as they had agreed, yet the staff turned him away, she was asked to speak to the staff about this. Since she was so fearful of their power, it was recommended only that she first clarify if this was true, then inform them that she had asked him to come that day. She could also suggest that in the future, they could call her when he came and she would tell them if she couldn't see him. Tricia refused to do this. She apparently was afraid, seeing this as confronting the staff, a risky position. She agreed only to speak to her son about what happened. The fear of angering the landlord could not be tempered with objective information. Subsequent intervention would need to focus on the residence system so that it might be more receptive and encouraging of Tricia's new behavior.

This presents some interesting issues regarding the provision of on-site mental health services in residences for this population. Residence staff could become more aware of avoiding cross-system alliances if

they defined their role as one consistent with promoting women's integration into their families, or at least, had a stronger sense of the women as being part of and influenced by their family system. Furthermore, this experience suggests that perhaps this clinical role is best placed in the hands of a clinician who is not of the residence staff. The clinician could then be in a better position to intervene in the resident's total ecological field, including the residence.

The staff member/clinician may be constrained by priority residence goals, even if the clinical role is broadened to include family systems intervention. The experience of having been homeless and the resultant fear of being rendered homeless again is a significant aspect of the resident/staff relationship. Their role as landlords who have the power to evict may mitigate against the role of clinician, and their ability to engender the required level of trust. Separating out the clinical role may serve not only to potentiate clinical effectiveness and reduce client staff alienation and conflict, but also to positively alter the power imbalance which the dual role creates in the resident/staff relationship. Admittedly, one's clinician and one's landlord are inherently in positions of power. The dual landlord/clinician role may tip the power imbalance too far. This dual role has the

potential to raise other ethical dilemmas as well. What is the nature of the contract the client/resident is entering? Is treatment a condition for housing? Can a resident refuse treatment? Regarding confidentiality, can information shared in treatment be used with regard to only housing status?

Gender and Aging Issues

It was anticipated that gender-related issues would be part of the process of a women's therapy group. The specific gender issues which become salient to this population, however, are worth noting as they contribute to an understanding of their lives in general, and particularly their current situation, which is especially relevant to designing housing services and treatment for them. Both gender and aging issues are discussed together because they generally emerged intertwined as issues pertinent to older women.

A major issue, as mentioned previously, was the women's feeling or lack thereof of safety vis-a-vis the male residents. The women recounted several incidents involving male residents accosting them with sexually threatening behavior, for example, trying to enter women's rooms without permission. One particular resident was known to act out sexually and had, in fact, molested a student who was working at the residence.

The notion of 'supportive living arrangements' is presently being called into question, as it appears that the mere grouping of people with problems such as mental illness creates a stressful environment for them to live in. Hodgins et. al., (1990) found that residents of a supervised apartment complex were readmitted for psychiatric hospitalization as often as their counterparts who lived on their own. The authors concluded that living with other mentally ill people presented additional stress, since this population has a higher incidence of other problems such as violence, suicide, substance abuse and psychological deterioration and the setting offered no protection from these additional stressors.

Parenting adult children, particularly those adult children who are dysfunctional, was also an issue as women struggled with letting go of or getting closer to their adult children, accepting their children with their shortcomings and supporting their children emotionally or in concrete ways.

Cynthia was relieved to see that other women had similar difficulties with their children, even though they raised their children, since she had always attributed her problems to the fact that she hadn't raised hers. It

was somethiing about which she felt very guilty.

Tricia had great difficulty acknowledging the extent of her son's problems. She was confronted very supportively in the group. Carmen fed her children partly to avoid the dilemma of giving them money which might be used on drugs.

Sexual relationships were often a focus as women sought to develop new relationships and review and share about past problematic relationships. The use of metaphor such as the "hooks" women get hung up on was helpful: Mae made a very unwise marriage choice because "the boys need a father"; Mae and Cynthia also entered poor relationships because of promises of being taken care of. This latter phenomena resonated in the women's current lives, since for the first time they were aware that they didn't need a man for concrete assistance -the residence provided that for them. What they really always wanted, but often didn't get, was companionship and emotional caring. Cynthia, for example, acknowledged that she was relating with a male resident because he carried her groceries and fixed things for her. However, he was impotent, had diabetes, a heart condition and a drinking problem. She knew she had to terminate the relationship when he started encouraging her to drink also. She felt guilty, as though she had

used him, but no longer wanted to play "mother, maid and nurse." She also feared that he would die in her room, a fear Evelyn also shared regarding relating to older men.

Some of the women felt morally prohibited from entering a sexual relationship, and their shelter experience provided an opportunity for 'independence' from their spouses. Some women were comfortable in a relationship, but felt rules against overnight guests were problematic. Interestingly, the legal status of the marriage, and whether the ceremony had been civil or religious, had varying implications for their comfort with acknowledging the dissolution of the relationship once they entered the shelter. For example, Kathleen could not leave her husband before entering the shelter because she felt obligated to take care of him. But once homelessness separated them, the fact that they hadn't been married in a church meant parting was alright because this wasn't a real marriage, anyway.

Thus, these women were dealing with many of the issues their never-homeless counterparts might also face: safety, relating to adult children and having a sexual partner. Of course, they encounter these issues in the context of a family system with mental illness and require support to deal with them. Nevertheless, their

current situation may be quite contrary to the stereotypes of older women. For instance, older women are often seen as totally abandoned by their families, childlike, asexual, and unable to change. Their very placement in a residence which provides the kind of support they previously expected from men can challenge their traditional views of relationships and marriage. It is also contrary to the notion of residential settings as protective environments for mentally ill people. In fact, in this co-ed environment, the women's safety was sometimes jeopardized by male residents.

As well, these women were emotionally and sometimes in practice very involved with their families. Despite the fact that they were living alone in a single room, they were not complete loners. They continued to be very emotionally invested in their families' well-being and continued to feel concern and responsibility for other family members, even those from whom they were cut off. This underscores the benefits of moving from an individual to a family-oriented focus for this population. The approach would not influence only the supportive services, but the administrative policy and even the building design. Baker and colleagues (1990), in a study of the CSS population, found that the adequacy of their residential environments was

positively related to the extent of their unmet needs; their level of community adjustment and their perceived quality of life. The adequacy of the residential setting was based on the rating of the physical condition and the adequacy for basic life activities: sleeping, maintaining personal hygiene, eating, preparing food, relaxation or leisure, and socializing with others. These authors stress that more must be done than to simply take people off of the streets; they must have access to housing that is "of reasonable quality and appropriate for their needs". (Baker, 1990, p. 504.) For instance, there would be provisions for overnight guests, and visiting facilities for family visits.

Increasing Affiliation Status: Principles of Practice

The major goal of this research was to demonstrate the usefulness of family systems-oriented treatment in reducing the disaffiliation of homeless, mentally ill older women. Since attending to context and to the ecological field is inherent in systems-oriented treatment the practice principles which emerged are relevant to that ecology, not solely to the family system. The practice principles below address the broader design of programs and services which can impact homeless older women's affiliation status. The ecology

of these women includes them as individuals, their families, the group, the residence, the social-service delivery system, etc. Thus, the family systems orientation, inherently contextual and ecological, while employed mainly as an approach to psychotherapy, has been useful in the development of practice principles which are more broadly applicable.

The first two practice principles relate to the family system. The arrival at these principles has been fully described above. The third and fourth practice principles address: the potential for housing services to further sever women from roles and relationships; the impact of homelessness upon self esteem and autonomy; the adjustment required to adapt to the stressful periods of transitioning from one level of housing to another; the women's fear of becoming homeless again; the power imbalance potential inherent in the landlord/role, and the negative therapeutic impact of this dual role. The fifth practice principle addresses the import of age and gender in designing services which support increased affiliation. The stereotype of the 'old, single woman' doesn't convey the diversity among them with regard to their concerns about safety, their family involvement or their sexual relationships. Even housing designs which do not support women's actual affiliations, or those they aspire to develop, are

perceived as unsatisfying and perhaps even temporary.

Practice Principle 1.

When treating older, homeless, mentally ill women, include an **assessment of the family system** as part of the assessment process. Specifically, include an assessment of whether cutoffs, family conflicts or other problems in relationships with significant others contributed toward the client's becoming homeless and/or whether strengthening these relationships might offer them support while homeless and once they are again domiciled. Assess the overall functioning of the system and the adequacy of the system's resources to provide care and support for a vulnerable member.

Practice Principle 2.

Reconnect these women to their families when it is not **contraindicated.**

Practice Principle 3.

When serving homeless, mentally ill older women reintegrating them into society and increasing their affiliation status is an important goal. The provision of supportive services with housing is important in achieving this goal. These services must be designed and delivered so as to **preserve their remaining affiliations and promote the development of new ones.** This principle can be operationalized by:

- Providing reliable **means for residents to maintain communication and contact with others** in their system.
- Protecting their **right to refuse** services, but also actively identifying and addressing **barriers** to using social services.
- Providing opportunities for **work, volunteerism** and for **leisure**, according to

individual ability.

- Making use of group methods as **group membership** strengthens attachment to peers, which is especially important to older women.
- Providing opportunities for the women to provide **mutual assistance** to each other. This can be accomplished through group methods or other programs designed to involve the women in outreach activities to other residents or potential residents.
- Providing linkages to **religious** organizations for women who are interested in a religious affiliation.

Practice Principle 4.

When delivering residential services to homeless, mentally ill older women, care should be taken to enhance their **self esteem and autonomy.**

This goal can be operationalized by:

- Allowing for a **transition** process as women undergo the stressful process of moving from one housing status to another.
- Organizing services so that **dual relationships** are avoided and contracts are clear, especially the housing contract. It is particularly important to spell out the conditions of eviction and the client's rights as a tenant.

Practice Principle 5.

When designing residential services and facilities for homeless, mentally ill older women, it is important to avoid stereotyping and instead, deliberately **develop rules and design facilities which reflect their status as mature adults and which support their connections to their families**

and significant others. This principle can be

operationalized by:

- addressing **women's safety** in the policies and procedures and in contracting with candidates for admission to the facility. Specifically, address the consequences of sexual assault.

- providing more housing options for single, older women. **'Scattered site'** housing is an option for some women. Efficiency apartments in the community would allow for entertaining, cooking, and privacy. SRO housing **exclusively for women** is a better option for others.

- acknowledging **older women's sexuality** in programming. For example, provide groups devoted to managing sexual relationships. Ascertain 'marital status' beyond the 'single', 'married', 'divorced' categories. Inquire, for example, whether the woman is currently involved in a relationship, or would like to be. Include this information in planning for residential placement.

- Allow for **family visiting** in facility design and residence policy. If rooms are too small, provide several lounges and develop procedures for families to use them privately. Outline procedures for access and responsibility for the space. In the case of dysfunctional members, involve women in planning for family visits.

Perhaps a major finding of the research is the importance of strengthening affiliation as a treatment and service goal. While homeless people are known to be among the most disaffiliated groups of our society, services designed for them do not appear, presently, to be designed for reaffiliation. The family systems lens is perhaps most suitable for viewing affiliation. Affiliation is, in a sense, about systems, i.e. about connections, and joinedness, how parts and wholes relate

and shape each other. That thousands of homeless people are lining our streets and crowding increasing numbers of shelters is not simply an individual problem. It is related to a social context which, in systems terms, 'maintains' it, or in other terms, permits it to occur. The parts of the whole are interconnected; a change in one will produce a change in the others. These women, for example, cannot be fully integrated without other shifts occurring which are suggested by the practice principles. To be fully reaffiliated, they require a context which shapes them in many roles, not just as isolates, marginals, stereotypes. The treatment of these women has been an entry point into the larger social problem. Systems-oriented treatment of children with school behavior problems reveals the poor fit between some children and the school system. This treatment situation has revealed much about the service system for homeless people. Just as interventions aimed at the school system can result in a change in the child's behavior, interventions aimed at the service delivery system can strengthen affiliation.

CHAPTER VII

CONCLUSIONS

Review of Findings

In Theodore Caplow's (Bahr and Garrett, 1976, p, xvi) view, the disaffiliation of homeless women is hopelessly irreversible:

> "For this group...there is little that anybody can do in the present state of sociological knowledge that would promise more effective rehabilitation than the existing shelter program, which provides bed, board and access to television in a grudging and hostile spirit. The bleakness of the program reflects the hopelessness of the underlying social technology. Something ought to be done about the bleakness, for decency's sake, but the hopelessness is probably irremovable."

Certainly, more has been done in the last fifteen years to assist homeless individuals into our society. And, certainly, not nearly enough has been done. Thus, our homeless populations continue to grow. We continue to need a federal social policy agenda that supports access to low-income housing and adequate social services as a basic right. In the absence of this essential change, a variety of program models, e.g. outreach, emergency care, supportive residences, on-site shelter programs and transitional living programs, have been developed to meet the needs of homeless people, including homeless women. These programs generally employ a case-management approach to care and have begun to outline their strategies for engaging and maintaining homeless

clients in a helping relationship geared toward their ultimate placement in a permanent domicile in the community.

In further response to the question of what can be done for this population, this project suggests practice principles which stem from a more contextual view of the homeless, mentally ill older woman and which have as their aim, the reduction of their disaffiliation. While focusing upon the treatment of the participants, it became clear as the project proceeded that it had to be seen in the context of its ecology: the group, the residence program and the larger service-delivery system in which the residence is imbedded. This contextual lens is in keeping with a systems-oriented framework which recognizes the interrelatedness not only of individual members of a family system but also the interrelatedness of social systems impacting the family. It also became clear that this shift in orientation has ramifications not only for treatment but for program design and policy development. Thus, the practice principles which evolve from this project relate to each of these levels of intervention.

Characteristics of The Women

The participant's histories and their engagement into the group in which the research was conducted reflected the profile of the population of homeless women in the literature: (Bachrach, 1987; Crystal, 1984; First et.al.,1988; Hagen, 1988; Hartman, 1989; Roth et.al., 1987). They had anywhere from one to many psychiatric admissions and they had lived with family members prior to or in between stays in the shelter. Five of the participants were women of color, reflecting their overrepresentation in the general homeless population (Garrett and Bahr, 1973; Struening, 1988). During their pre-homeless period, they made numerous attempts to remain domiciled and only entered the shelter when they saw no other alternative. The women were highly-motivated to obtain housing, a point well documented in the literature (Baxter and Hopper, 1981; Baxter and Hopper 1982; Sexton, 1983; Flynn, 1985; Sloss, 1984). In fact, some of them continued to contemplate more desirable housing even after being placed in the permanent residence.

Half of the women maintained regular family contact with one or two family members, again, consistent with the literature on homeless women (Morse, 1985; Stoner, 1983). While a complete assessment of the family system of each participant was not possible within the time

frame of the project, it was possible to identify some common attributes of their family systems. First, these were multi-problem systems. Their family systems included an average of 4.5 of a list of seventeen problems, which excluded the mental illness of the woman participant. Second, problems of addiction figured prominently - in fifty percent (50%) of their family systems. Note that the list of problems includes only those that women identified as relevant to their homelessness, their placement or their current situation. The extent of problems and the prominence of drug addiction in the family systems of homeless mentally ill women may be a contribution to the knowledge base regarding this population.
None of these women spent more than a very brief period on the street. This latter point may at first seem to contradict the thinking that more elderly homeless women may not enter the shelter system. However, for this project participants were selected from the residence, which only accepted referrals from city shelters and community shelter programs. Thus, findings may not be generalizable to the population of homeless older women who choose not to enter a shelter.

The women's engagement into the group also reflects the motivation homeless women are known to have to use help; homeless women are known to use social services

more than their male counterparts (Morse, 1985; Stoner, 1983). Only three women who were offered participation declined. The researcher built on the engagement strategies that have proven useful, developing trust, conveying respect, addressing concrete needs and promoting empowerment. Nevertheless, two occurrences were striking. Universally, the women, in their initial intake interview, complained of feeling disconnected from others in the residence. This appeared to be a main reason for entering the group, and is indicative of their motivation to affiliate. Secondly, the rate of attendance was exceptionally high. On average, women missed only two (2) of the twenty sessions. Some of the women never missed a session.

Group Membership: A Potent Vehicle for Increasing Affiliation Status

While the focus of the project was the use of the family systems approach, the importance of the group as a means of enhancing affiliation should not be ignored. The group provided an opportunity for the women to experience membership in a peer 'organization'. Particularly for older people, the strengthening of peer attachments is important as other affiliations decline (Rathbone-McCuan; et.al. 1983). The mutual support network developed by the group members proved to be a potent force for increasing affiliation: It connected

the women to each other and it facilitated other affiliations by supporting the strengthening of family attachments and their ability to use social services, an indicator of level of affiliation. There were several specific examples of how women used each other for support around emotional and concrete issues. A known principle of professional practice with homeless people, i.e. engage around concrete needs first, was useful in binding the women to each other. More importantly, this occurred spontaneously in this women's group and likely speaks to women's experience, having been socialized to affiliate through caring for others.

Affiliation Status and The Family Systems of Homeless, Mentally Ill Older Women

The growing literature on homeless women is beginning to recognize that they are less disaffiliated than men and are, for instance, more in contact with family members such as their children. However, the system of care designed for them does not yet reflect this knowledge (Moore, 1985; Stoner, 1983). Entering the family systems of these women was not difficult. The facility with which the family systems interventions were carried out may be attributed to the fact that often, the women themselves saw their homelessness, their current problems in maintaining their housing or their future

housing prospects as directly related to family problems. To apply another known practice principle from generic social work practice, their families were where they were 'at' (Susser et. al., 1990), and therefore family concerns were acceptable issues around which to build treatment. They were engaged around a variety of systems interventions and were able to take significant steps in the direction of strengthening their attachments to their families. (See Table 3.) Regarding this objective of the project, a basic assumption apparently coincided with the women's own view of their situation; i.e. the assumption that loosening of attachments to family in the form of cutoffs or in the form of conflictual relationships plays a role in homeless mentally ill women's disaffiliation and homelessness. Moreover, resolution of cutoffs and strengthening attachments is likely to increase their affiliation and thereby enhance their reintegration into society. Gerontological practice indicates that the family is the major source of informal support for the elderly, especially the minority elderly (Rathbone-McCuan et.al., 1982; Taylor, 1986). The importance of family to women is also a known traditional value, which would then, likely hold more true for older women. An understanding of the family system of the elderly makes clear that the functioning of the individual elder is partly related to

the overall functioning of the system. The relevance of these concepts to practice with homeless, mentally ill women is further clarified by findings from this project.

The project deployed a variety of systems interventions and techniques, particularly those of Bowenian and structural approaches, to intervene in the women's family systems based upon systems-oriented assessments of the presenting problems. Consequently, the treatment was problem focused, and directive, and relied heavily upon tasks. Constructing a genogram was useful in identifying a pattern repeated from an earlier generation which was relevant to present conflicts with family that impacted the homelessness of a Black woman who joined in the middle of the group. Since the literature (Boyd-Franklin, 1989) cautions against introducing the genogram early in treatment, particularly with Black clients, one can speculate that the cohesion and level of trust already established with the group was a factor in the successful use of the genogram under these circumstances. Efforts to incorporate conjoint family interviews into the group process met with less success. In part, the failure to engage a family member to attend a session was related to a conflict with the individual focus of the residence as well as a failure on the researcher's part to

communicate with the residence staff. This situation highlighted the differences in agency goals which view women in context, as opposed to viewing them as isolated individuals. It also revealed the importance of intervening in the therapeutic system - client system/professional system - to avoid cross-systems alliances which can function to remove the family dilemma from the family system, as it plays out between sets of the professional systems or, as in this case, a family member and the agency.

One outcome of the intervention was that sixty percent (60%) of the women took an identifiable step toward resolving a cutoff or conflictual relationship which was related to their homelessness, and therefore toward increasing their affiliation status. This identifiable step was evidenced by either a behavioral move or a change in their perception of the problem consistent with the notion of change according to systems theories.

Knowledge of the older family system and of dysfunctional family systems, particularly the addictive family system, suggests possible explanations for this occurrence. Obviously, the maintenance and care of an elder may overtax a system which is grappling with numerous other problems. Women's place in their family is often that of the caretaker, the one responsible, or

the over-responsible one. One form of dysfunctional family system is organized around the parent's continued emotional or practical responsibility for dependent, adult children. This is common in addictive systems (Kaufman, 1986, 1989). When that parent is vulnerable and/or disabled due to age and/or mental illness, and the dependent adult child is addicted, this may produce a highly dysfunctional hierarchical reversal which places the elderly member at risk. Thus, while the project emphasized reconnection to the family system as a means of reintegration or reaffiliation, the addictive system presented a clear example of when this would be contraindicated.

Other features of these family systems are: boundary inadequacy, high reactivity and enmeshment. That these women would come from enmeshed family systems is consistent with the prevalence of cutoffs, since cutoffs are extreme attempts to resolve over-closeness, by using distance to create a boundary between self and other. Drug abuse is known to be a precipitant of men's homelessness (Anderson et. al., 1988; Bachrach, 1987; Crystal, 1984; Hagen, 1987; Hagen, 1988; Martin, 1982; and Stoner, 1983). This intersection of homelessness and addictions in the family systems of older, mentally ill women warrants further exploration.

Marriage was also salient to the women's homelessness. The dissolution of marriage is also known to be a precipitant of women's homelessness. Two women virtually separated from their spouses upon becoming homeless, despite the fact that circumstances were no longer keeping them apart. For a third woman who, incidentally, spent the longest time in the shelter - five years - the shelter may have played a stabilizing function, helping her to avoid the loneliness the death of her spouse precipitated. That stasis, however, was at the cost of her being able to complete the task of moving on and entering new sexual relationships. The notion that homelessness, precipitated by other factors, might provide a more acceptable solution to or opportunity to dissolve a marriage is novel to the homeless literature. However, it is consistent with the concept of interconnectedness in family systems. Homelessness, representing a change in the system, can expect to reverberate throughout the system, effecting other shifts as well. Liddle and Saba (1983), in discussing how change occurs within family systems, note that families "feed on the random". (Liddle and Saba quoting Bateson, **Mind and Nature,** New York: Dutton Press, 1979.) It is a reminder to therapists that change is not produced only by therapy; serendipitous life events can precipitate and influence change. This is not an attempt to minimize the gravity of

homelessness nor certainly to reduce it to solely an issue of family dynamics. On the contrary, the point is that as a crisis of such magnitude, homelessness has the ability to alter other family structures. What is suggested here is that the context of an aging system, with traditional rules and values about how marriages stay together, may have an unexplored impact. A forced separation in the form of homelessness - there are no shelters for couples without children - may provide the system with a resource to solve the problem of an unsatisfying marriage.

Lastly, long-term family system dysfunction was also a precipitating factor of homelessness in one situation. Long-term problems are a known contributor to problems presented by the elderly. The stresses of meeting the demands of the aging system often make old conflicts come alive (Zyl, 1983). The key here appears to be whether the old problem reduces the woman's support network.

Affiliation Through Use of Social Services

This indicator of level of affiliation was added as a modification of the Bahr and Garrett (1976) scale in anticipation that their 'voluntary associations' category would be less salient for use with only a homeless sample. Only one woman was using a social

service outside of the residence at the outset of the project. However, the intervention was useful in enhancing the women's use of the services provided by the residence, including those of the sponsoring agency. As mentioned above, the system of mutual aid which developed as an outgrowth of the group process and the systems intervention was helpful on several occasions in increasing the members' use of the agency's services. While homeless women are known to use social services more than their male counterparts, the group process became a vehicle for further elaborating some of the obstacles to women's use of services and for overcoming these obstacles. According to the existing literature, women use services when they are accessible, when they are offered in an environment of safety, and when they are offered with respect. All of these conditions were seemingly optimal in the residential setting, yet there was initially sizeable variance in how the women used the services.

Simply by their application and admission to the residence, the women were taking advantage of a service. Yet, some were using the offerings of the residence more than others. Three factors accounted for their differential use of the services offered: 1) their knowledge of the services offered, 2) personality characteristics; and 3) their perception that their

request for assistance might have negative consequences for someone else. The first, obviously, is related to accessibility. Anyone needs to know of a service in order to use it, so homeless people are no different in that respect. However, given their greater need, and the importance of increasing their affiliation, more attention could be paid to providing them with this information. Certain personality characteristics were sometimes a hindrance as well. Women who found asking for help difficult, women who were more assertive, and women who were more sensitive regarding their autonomy had less access to services. Again, some of these issues apply to the general population. Perhaps, that is what is to be learned: that the mere provision of services even on-site, without sensitivity to the same issues which often act as barriers to service for the general population will militate against their optimal use. The impact of not using available services, however, will presumably be greater for an already disaffiliated population.

Affiliation Through Employment

Three women were working at the outset of the group and only one of them was working when the group ended, although she was working more days. For the elderly, the task is to make a satisfying choice about whether to continue working or to retire. Half of the participants

were undecided about whether to work again and resolved this dilemma during the course of the group, mostly by deciding against working.

Consistent with traditional male and female gender roles, lack of employment is known to be a precipitant of homelessness for men, whereas factors related to family dissolution are more frequent precipitants for women. For the elderly, retirement is a major source of disaffiliation as increasing disability makes continued employment unlikely (Bahr, 1976). Several of these women were too physically or psychiatrically disabled to work. While their work histories had not been explored systematically, it appeared that their experience was limited as well. Nevertheless, it may be that even when one has had a limited work history, one may face in old age the need to let go of work aspirations.

A gender-related issue was apparent in that the women often didn't define their caretaking responsibilities as work, even though these were formally assigned to them and possibly for pay. Of equal importance, however, is the developmental issue here. Adjusting to retirement is the task at this stage of life, and therefore the area of employment represents a major source of disaffiliation for the general elderly population.

Learning to gain satisfaction from leisure activity or engaging in volunteer activity are common post-retirement strategies. Leisure can be understood as not simply the absence of activity, but the ability to enjoy an activity simply for its own sake, not as a means to another end (Teaff, 1985). Also, voluntary associations are important in maintaining social integration for older adults. Volunteerism is often a satisfying alternative to paid employment and is consistent with traditional women's experience. Leisure or recreational activities are traditionally part of programming for both aged populations and for chronic mentally ill populations. According to staff reports, project participants did show a greater involvement in these activities at the residence. However, this information is not quantifiable; neither can it be attributable to specific interventions or group process. The residence did not provide opportunities for volunteerism as part of its program. However, introducing these opportunities would appear to be beneficial.

Affiliation Through Voluntary Associations

As anticipated, this category was not salient for this poor and working-class population. No women belonged to any clubs, unions, etc., at the time the project began. It was expected, however, that church attendance would be salient. Yet, only one member attended, and one had

attended regularly while in the shelter. There was no change in this area. It would seem that religious affiliation represents an opportunity to increase level of affiliation. For the Black elderly, in particular, religion and church affiliation tend to be very important. Taylor and colleagues (1986, p. 642) state that "other than the family, few social groups provide such an enduring context for supportive relationships." The authors also found that the elderly who benefit most from the support the church offers are those who have someone else to provide a link between the services available. It appears likely, that if additional options for attendance at church services were provided, with the agency serving this linkage function, women would avail themselves of the opportunity.

Findings Specific To Women of Color

The women of color, representing half of the group, did not appear to be significantly different in any of the variables focused upon in this study. Perhaps this is a significant finding, since these were variables related to family and individual functioning and response to the treatment approach. While these variables may be associated with homelessness, this association appears to be across racial and ethnic groups. This finding actually supports the notion that factors such as discriminatory economic policies and race-based

discrimination are more responsible for the disproportionate numbers of Blacks among the homeless.

The Shelter and Residence Experience

This study also resulted in other learnings stemming from the women's sharing of their attitudes and feelings about their experiences in shelters and in the residence which should stimulate further thought and research with regard to designing services for this population. Shelter life was viewed as a very undesirable existence overall, but not without some positive attributes largely related to the relationships they developed there. Severing these relationships to leave the shelter represented a loss for the women.

The role of the shelter system in supporting the disruption of family ties certainly warrants further attention. Most of the women found the shelters generally disinterested in connecting them with callers. It is possible that the shelter system's exclusively individual focus actually thwarts families' own attempts at maintaining their connections or reconnecting.

Upon placement, the women may need a period of time to adjust to the loss of their connections at the shelter, as well as a time to make the transition to a new setting which requires different coping strategies and a

period of withdrawal to accomplish this 'acculturation'. Koegel (Synthesized from proceedings of NIMH-sponsored conference, 1987) discusses the re-socialization process as women make the transition from street to shelter life and speculates that this may apply to women transitioning into permanent housing as well. These women's experience suggest that this is the case.

These women were highly motivated to remain affiliated and to re-affiliate. They struggled not to become homeless, and never resigned themselves to a homeless condition nor to social isolation. As mentioned above, half of the original members did not view their placement in the permanent residence as permanent. They maintained their goal of independent housing, even though in some cases they were conflicted about their ability to function without the additional support the residence offered. Their ability to function autonomously was key. For some women, this was a time in their lives which represented a new opportunity for independence since they had felt stuck in unsatisfying relationships. The supportive services which the residence offered also challenged at least one woman's view of her sexual relationships since the shelter now provided much of what she had come to expect from men.

Despite the supportive services offered, the women saw the service as that of housing, and saw themselves not only as residents, but the staff as landlords who had the power to evict them for a variety of causes. This fear of eviction had an impact upon their decision-making regarding therapeutic interventions. It also had an impact upon their interaction with other residents and their relationship with social service staff. Thus, while on-site mental health services seem beneficial, the provision of integrated mental health services is called into question. Providing on-site services, delivered by a separate team, may enhance the development of a trusting therapeutic relationship, allow for a more appropriate balance of power in the relationship, and provide greater protection of client's rights. It also permits the therapist to intervene in the ecosystem, targeting the transactions between clients and the professional system more effectively.

Summary of Findings

This project sought to demonstrate the usefulness of a family systems-oriented approach in reducing the disaffiliation and strengthening the social attachments of a particular sub-group of the homeless, i.e. older, mentally ill women. The participants in the study were a small, multi-ethnic group of ten recently domiciled women living in a permanent residence for the homeless

elderly. They were all diagnosed as chronically mentally ill, according to the guidelines of a state funding stream. The mean age was sixty-three (63) years and the average length of stay in the residence was six (6) months. The findings must be seen in the context of the stability such a setting offers. While the findings are considered strongly suggestive, they are not generalizable beyond this group. However, as an exploratory study, the findings strongly suggest that increasing the affiliation of older homeless, mentally ill women is far from hopeless, and that a family systems-oriented approach to their care is a useful tool.

The assessment of the family system revealed that these were multi-problem families and frequently addictive family systems. Systems-oriented interventions were useful in resolving cutoffs and other conflictual family relationships which the women saw as related to their homelessness or their current or potential housing status. The systems-oriented interventions were also useful in increasing affiliations, as reflected in the women's use of social services.

No change was reflected regarding employment status. This index of affiliation was not salient for an elderly population. Similarly, for voluntary associations as an

index, the only association anticipated to be salient was church affiliation, which never became a focus of intervention and showed no change. Membership and participation in the group itself, the context in which the interventions took place, was considered a type of voluntary association. Solid engagement, cohesion and a high level of mutual support also facilitated increased affiliation via use of social services in the residential setting.

The group process also revealed the women's attitudes and feelings about their experience of the shelters and their present residence. They found shelters clearly undesirable, yet experienced the loss of the relationships they developed there. They found the shelters largely uninterested in supporting their ability to remain in contact with others.

While the women were pleased to enroll in the residence, they indicated a need for a transition period at first in order to make this adjustment.

Some of the women experienced mixed feelings about their current housing situation in the supportive residence. They continued to want a more autonomous living situation in the community, and lived in fear of the staff's ability to evict them. Yet, they appreciated

the services which the residence provided, especially should they become more dependent in the future. They viewed the service mainly as housing and the staff mainly as landlords although caring.

A set of five practice principles emerged from the study which address the enhancement of affiliation for homeless older women:

Practice Principle 1.

When treating older, homeless, mentally ill women, include an **assessment of the family system** as part of the assessment process. Specifically, include an assessment of whether cutoffs, family conflicts or other problems in relationships with significant others contributed toward the client's becoming homeless and/or whether strengthening these relationships might offer them support while homeless and once they are again domiciled. Assess the overall functioning of the system and the adequacy of the system's resources to provide care and support for a vulnerable member.

Practice Principle 2.

Reconnect these women to their families when it is not **contraindicated.**

Practice Principle 3.

When serving homeless, mentally ill older women, reintegrating them into society and increasing their affiliation status is an important goal. The provision of supportive services with housing is important in achieving this goal. These services must be designed and delivered so as to **preserve their remaining affiliations and promote the development of new ones.**

Practice Principle 4.

When delivering residential services to homeless, mentally ill older women, care should be taken to enhance their **self esteem and autonomy.**

Practice Principle 5.

When designing residential services and facilities for homeless, mentally ill older women, it is important to avoid stereotyping. Instead, deliberately **develop rules and design facilities which reflect their status as mature adults and which support their connections to their families** and significant others.

Implications for Social Work Practice

The social work profession has played a significant role in serving the underclasses, the alienated, the homeless, the elderly and the mentally ill. Social work has served women, who predominate among those who use social services in general and mental health services in particular. Social work, from its inception, concerned itself with the family as a unit, although later, advances in this area began to take place outside of the profession (Germain, 1983). Nevertheless, social workers provide family systems treatment and have contributed greatly to the development of family approaches. Similarly, the social work profession has traditionally used and developed group approaches which are practiced in a variety of settings and with a variety of populations, including the chronically mentally ill and the elderly.

Social work values and practice principles are also very relevant to practice with this population. Some that are especially relevant are (Vigilante, 1983):

- The inherent worth of every individual.
- All are equally entitled to social services which the community is responsible for providing.
- Individuals have the right to interact with others and need to do so in order to develop their potential.
- People can change and can be assisted to change.
- People have an unlimited ability to develop themselves and others.

The particular approaches relied upon for this research have already been described. However, other family systems approaches may be as useful. Group methods are very important in enhancing affiliation and should be incorporated into programs for this population, particularly when family reconnection is impossible or contraindicated. Obviously, casework services and the provision of concrete services are essential to work with this population. The concrete services provided by the casework staff were already in place in the residence. While the project focused upon optimizing the use of these services, it bears reiterating that this is an essential component of work with this population, both with regard to engagement, and increasing affiliation.

Rather than delimiting **the** approach to working with homeless, mentally ill, older women, the findings of

this project are significant in that they expand upon the methods known to be useful (e.g. case management) by suggesting an additional approach and the practice principles which emerge from it. Hopefully, further elaborations of family systems-oriented approaches or the other clinical practice models in use with this population or similar populations will be forthcoming. Additionally, the project has demonstrated the usefulness of a multi-method treatment service. Recall that each of these women also had a caseworker and the family systems-oriented treatment took place in a group context. The treatment goal is key; for, the goal of increasing affiliation could mean not only strengthening attachment to family but also better engagement as a client recipient of social services. Practice models such as systems-oriented models which broaden the unit of attention beyond the individual or even the individual-in-the-environment, i.e. those that are more ecologically oriented, are particularly useful to this treatment goal. However, the identification of increased affiliation as a treatment goal is probably of equal significance as a contribution to practice with this population, for it represents a shift in our view of the homeless woman and the problem of her homelessness which has wide-ranging implications not only for practice, but for policy development and program planning as well.

Lastly, the project suggests a caution relevant to the role of the clinical social worker with this population. Practice with this population needs to take into account the particular effects of homelessness upon women's self-esteem and feelings of vulnerability. The development of trust, so crucial to the clinical relationship in general, may be mitigated by placing the clinician in the dual position of being landlord as well.

Program and Policy Implications

No policy recommendation for homeless people can proceed without first reiterating that the problem of homelessness is attributable, more than any other single factor, to the shortage of low-income housing options. While this project has focused upon the mentally ill and upon a treatment approach to reduce disaffiliation, acknowledgment must be given to the fact that if sufficient and appropriate affordable housing were available in the community, far fewer of the disaffiliated, including the mentally ill, would be homeless.

Elderly women predominate among the numbers of elderly mentally ill. It is generally agreed that comprehensive psychiatric care is required for chronically mentally

ill women, care which includes concrete services, access to health care, psychotherapy and psychotropic medications (Bachrach, 1988a). Deinstitutionalization and restrictive admission policies, along with the shortage of low-income housing and inadequate community mental funding, have contributed to the prevalence of homelessness for women. However, chronically mentally ill women present different symptomatology, i.e. they tend to present with self-destructive or verbally assaultive behavior, instead of sexually and physically threatening behavior and this may further limit their access to care. In addition to limiting their access to in-patient care, their psychiatric symptoms may limit their access to some shelters (Bachrach, 1988b). As noted earlier, there are differences in women's route to and experience of homelessness, and services must address their special needs and multiple disabilities.

This project has focused less on the root cause(s) of homelessness than on an approach to caring for a select subgroup of the homeless: the mentally ill, older woman. Specifically, the project sought to demonstrate the usefulness of a family systems-oriented approach to reducing their disaffiliation.

Bahr and Garrett's (1976, p. 186) elucidation of the phenomenon of disaffiliation in older women is poignant:

> "Like an actress facing the stage without a part, the disaffiliated woman faces the world without a role. Through retirement, death, illness [including mental illness], or old age, she has lost her accustomed position, and lost with it is much of the meaning she had ascribed to life and the fulfillment she derived from it. She is forced to personally and socially redefine herself. **Her success may depend on her ability to question the importance of roles or to choose new, appropriate, and workable roles which will provide meaning and lead to reaffiliation."** [Parenthesis and emphasis mine.]

Beyond housing, these findings suggest that older, homeless, mentally ill women could benefit from policy and program development which goes a step further, defining increased affiliation, or reaffiliation as a goal not only of treatment but of policy development and program planning. The findings suggest that unless these goals are deliberately stated and implemented, it is unlikely that maximal affiliation will be accomplished as an unintended consequence of individually oriented treatment alone.

The adoption of this stance requires an essential shift in perspective from a singularly individual perspective to a more contextual one. Whereas the current perspective focuses solely upon their individual characteristics, needs, disabilities, and diseases, a contextual view places them in relation to the institutions and social structures which compose our society: family, religion, economy, welfare system, for

example. This view addresses their place in that society and how they can be more tightly connected to it. This connection is both social and psychological, but takes the point of view that the social connection, i.e. the role, will provide for the emotional experience. Bahr and Garrett (1976, p.286-287) discuss the "imputed [individual] defectiveness" which continues to underlie attitudes toward the homeless:

> "The imputed defectiveness, validated in interaction and internalized, acts to prevent the establishment of new affiliations or the reactivation of old ones...with the attenuation of affiliations goes what little power [she] could command...[she] is on the outside; their organizations and programs represent their interests, not [hers]. The disaffiliate has no voice in their decisions about [her] treatment or [her] future."

Should reaffiliation become the intent of social policy and the goal of programming for this population, their empowerment could result. Again, Bahr and Garrett (1976, p.286) "recognize the importance of affiliations in generating 'significant others', affirming identity, and creating means for controlling one's environment."

These findings support the literature on the relevance of family to homeless women: family dissolution is a prominent precipitant of their homelessness and they tend to continue some family contact. The women in this project desire greater affiliation. This motivation coupled with the fact that women are known to be less

disaffiliated than men, should indicate that efforts toward greater affiliation may be more successful. A systems-oriented approach which focuses on relationships and interconnections is well suited to the goal of increasing their affiliation. However, this will be difficult to achieve without a change in program and policy focus. It will be difficult to intervene in the family system, when programs and treatments are designed only for the individual women as clients. Cross-system alliances, discussed here, are only one potential problem. Systems-oriented treatment can be more labor-intensive, impacting caseload size, reimbursement rates, etc. Presently, for example, there is no reimbursement rate for family treatment. This shift may even affect facility design, possibly a costlier proposition. Some still view the homeless older woman only as an elderly woman who is alone and suffers from mental illness, therefore needing care in the form of social services which are managed for her. She can also be viewed as a former tenant who tried her best to hold onto her apartment but was overwhelmed by the problems of her children and her grandchildren, whom she can't control and whom she alternately worries about and wants to stay away from. She goes into the psychiatric hospital from time to time, but either managed alright when her husband was alive and is afraid to have a new boyfriend or is relieved that her now ex-

husband is on his own. She really wants to be close to other people, but also to have some power over her life. She really wants the same kind of home most people want, and thinks about going back to work maybe.....

Our service delivery system may need to change to address this latter view, her entire context. The service delivery system would be designed to re-integrate and accommodate people with disabilities, rather than just treating their disabilities. The reintegration begins with housing them, but goes further. In fact, the point of placement is perhaps among the weakest links in the continuum of care presently. Susser et.al. (1990) discuss the serious limitations of community resources which lie not only in their scarcity, but in their inability to provide sufficient support to maintain formerly homeless people. The recidivism even concerns shelter workers, who sometimes have difficulty letting go of clients, knowing that support may not be there. Strategies and approaches which can create that support within the woman's own context may have a better chance at maintaining her than sole reliance upon the welfare system, which has already failed her and remains inadequate. Ironically, it is the social welfare system itself which may need to change to re-incorporate her and thereby empower her, as Bahr (1976) suggests so that

she is less dependent upon the system.

A contextual view would locate the service system within the ecology of the family system. In this sense, cutoffs could be seen as partly a function of transactions between the family system and the shelter system in as much as the shelter may function to maintain the cutoff. If the shelter system views its residents as isolated, loners and the undignified, it will, then, shape them that way. If, instead, they are viewed as lost mothers, grandmothers, sisters and companions, coworkers, friends, matriarchs and church women, in their families and communities, different rules of operation would go into effect and different types of services could also be provided.

Beyond clinical practice methods, there are a variety of interventions and services which different types of programs for homeless mentally ill women could employ. These would reflect the women's present affiliations while strengthening and expanding them, and thereby empower her. A few of which have been mentioned above:

- Providing telephone access to shelter clients and a reliable message service.
- Developing volunteer roles within the program. It is possible that men's programs have a greater tendency to offer volunteer opportunities than women's. (Bahr, 1976.)
- Establish self-help groups. Groups can be formed around a variety of needs, such as

where to obtain community services.

- Establish client orientation groups or involve clients in outreach. A particular transitional living program for homeless women organizes residents to do outreach for the program at the shelters. In addition to the benefits of the volunteer role, the ability to connect with each other as group members, this program has a positive effect on shelter residents who get to see women who are succeeding. (Susser, 1990).

- Establish a transition policy for new residents which provides them the opportunity to pace their induction into the setting.

- Design facilities which optimize autonomy and connection to family/significant others such as: providing one or two family visiting lounges per floor in residences along with eat-in kitchens or rooms large enough to accommodate a guest for a meal. Also, the scattered-site apartment option may achieve these goals. One study (Hodgins et. al.,1990) showed this type of service to be as effective as the residence-type-setting in reducing psychiatric recidivism despite that the residence was provided support services right across the street. The authors attributed this to the increased stresses associated with living with other mentally ill people who have higher rates of violence, suicide, etc.

- Develop liaisons with religious affiliations and provide transportation. Some shelters do so currently; this remains important after placement.

As individuals, older women are often in a position of "multiple jeopardy" (Butler, 1975, p. 353). They are additionally affected by the multiplicity of problems of their significant others, on whom they rely for support. The number and extent of problems in these women's families raise questions about the interrelatedness of these problems. Homelessness, similarly, touches a

variety of other interactive needs and problems (Bahr and Garrett, 1976). The concept of the multi-problem poor family is not a new one from a clinical standpoint. Yet, from a policy standpoint, greater cross-fertilization between aging policy, substance abuse policy, mental health policy etc. would benefit families.

Implications for Further Research

There is much more to learn about the characteristics, care and treatment of homeless, mentally ill, older women. This research strongly suggests that systems-oriented treatment can be useful in increasing affiliation, and that reaffiliation is an important treatment goal with this population as family dysfunction appears to be associated with homelessness and placement. Further research should center upon 1) an elaboration of family system factors associated with homelessness and disaffiliation; and 2) treatment approaches and program interventions which increase affiliation.

With regard to family system factors, this project suggests that multi-problem family systems and addictive systems may be associated with these women's homelessness. The interface of addictive family systems and homelessness is particularly interesting. How

strongly associated are these variables? Is it age, mental illness or gender that renders one most vulnerable to homelessness in an addictive system? Is the number of problems, i.e. the extent of dysfunction, more salient than the type of family structure? Larger studies which focus on the assessment of their family systems may further elaborate risk for older mentally ill women with regard to ensuing homelessness and placement. Similarly, with regard to marriage, this project suggests that perhaps pre-homeless marital satisfaction may play a role in reunification upon placement. Not enough is known, however, about the nature of the marital dysfunction and its relationship, if any, to older, mentally ill women's homelessness. Again, larger, perhaps empirically based studies might illuminate this area.

The systems approach employed in this research relied heavily, although not exclusively, on the Bowenian and structural approaches. Are other family systems approaches as useful? How well can family systems assessment and treatment be integrated into programs serving homeless women? This research was conducted somewhat outside of the usual constraints of program operation. Are certain levels of care such as permanent placement settings more conducive to this approach?

The identification of other means of increasing affiliation through program or service interventions, perhaps in the absence of family treatment, would be useful. For instance, how well do religious organizations actually incorporate homeless women into their congregations? What opportunities for volunteerism and mutual assistance can shelters and other programs serving the homeless employ as part of a strategy to increase affiliation? Can the nature of the 'transition' process be further described so that programs can better allow for this process? Groups appear to be an important tool for increasing affiliation, but more knowledge of the type of groups that work best in various settings is needed.

Can specific program features which attenuate affiliative ties, such as shelter policies and additional barriers to social service use, be identified? Is there a better operational definition of affiliation which would be more salient to the contemporary homeless population? Inherent in this question is the question of how to measure affiliation. The present model was designed for the general population, including a homeless sample and clearly differentiated homeless from domiciled groups. However, might a more refined model might further enhance study of the homeless general population and aid intergroup

comparisons?

The research literature on homelessness is expanding. Increasing attention is being devoted to women, including mentally ill women. Much less is known about the elderly, homeless woman, particularly the elderly, homeless woman who suffers from mental illness. Any research that further distinguishes her from her counterparts may assist in the development of better methods of servicing her.

A major research question which pertains to probably every subgroup of homeless people addresses recidivism. What is the rate of return to homelessness after placement, and what factors are associated with the failure to remain domiciled?

Answering these questions will not eradicate the problem of homelessness, but should greatly add to our ability to treat and serve those who become homeless.

APPENDIX - A

Community Support Services
ELIGIBILITY DETERMINATION

1. Facility Name | Facility Code | 2. Unit Name | Unit Code

3. Client has Authorized Release of Information ☐ 1. Yes ☐ 2. No | A. If "Yes", Date Authorized MO. DAY YEAR | B. Staff Initials | 4. This Form is an: ☐ 1. Initial Submission ☐ 2. Update or Correction

REFER TO REVERSE SIDE OF FORM FOR INSTRUCTIONS

5. Client Name PRINT (Last) (First) (M.I.) | 7. Social Security Number

6. Address (Number) (Street) | 8. NYS ID Number

(City) (State) | 6a. Zip Code | 9. Date of Birth MO. DAY YEAR | 10. Sex ☐ 1. Male ☐ 2. Female

11. Most Recent Diagnosis *Principal diagnosis must be psychiatric. Use DSM III and specify codes as well as diagnoses.*
A. Principal Diagnosis DIAGNOSTIC CODE | B. Other Diagnosis DIAGNOSTIC CODE

12. Functional Disability *This client is functionally disabled in the areas indicated (Three areas are needed to establish eligibility).*
☐ A. Self Care ☐ B. Social Functioning ☐ C. Activities of Daily Living ☐ D. Economic Self-Sufficiency ☐ E. Self-Direction ☐ F. Ability to Concentrate

NOTE: The client may qualify for CSS under both Items A and B. Check both boxes and complete 15,16 and 17.

13. The client is eighteen years of age or older, functionally disabled due to mental illness, has a principal psychiatric diagnosis, and
☐ A. Meets the permanent eligibility criteria (complete item 15 below).
☐ B. Meets the categorical eligibility criteria (complete items 16 and 17 below).
☐ C. Waiver request submitted (complete item 18 below).

☐ 14. No determination of eligibility was made. This client is a resident in a shelter for the homeless or an adult home and is eligible to receive on-site rehabilitation or outreach services (complete items 16 and 17 below).

15. Permanent Eligibility *(Check all that apply)*
☐ A. One six month stay in an inpatient psychiatric unit.
☐ B. Two stays of any length in an inpatient psychiatric unit in the preceding two years.
☐ C. Client is Chapter 620/621 Eligible.
☐ D. Three or more admissions to an Office of Mental Health operated or licensed certified mental health outpatient program or a forensic satellite unit operated by the Office of Mental Health within the preceding 18 months; or three or more contacts with crisis or emergency mental health services within the preceding 18 months; or a combination of three admissions or contacts within the preceding 18 months.
☐ E. SSI/SSDI recipient due to mental illness.
☐ F. Twelve months active enrollment as a waived client.
☐ G. Six months consecutive residency in a designated adult home.
☐ H. Six months consecutive residency in a community residence.
☐ I. Six months consecutive residency in a Residential Care Center for Adults (RCCA).
☐ J. Six months consecutive residency in a family care home.
☐ K. Six months consecutive residency in a Residential Treatment Facility (RTF).

16. Categorical Eligibility
☐ A. Resident in a designated adult home, less than six months.
☐ B. Resident in a designated shelter for the homeless.
☐ C. Resident in a designated single room occupancy hotel (SRO).
☐ D. Resident in a community residence, less than six months.
☐ E. Resident in a family care home, less than six months.
☐ F. Resident in a Residential Care Center for Adults (RCCA), less than six months.
☐ G. Inpatient in a state-operated psychiatric facility and scheduled for placement within ninety days to a community residence, Residential Care Center for Adults (RCCA), or Family Care.

17. Initial Date of Residency MO. DAY YEAR

18. Waiver Request *(Attach Form OMH-143b)*

A. Waiver Requested by:	Name (Last) PRINT (First) (M.I.)	Title
B. Regional Office Action ☐ 1. Approved ☐ 2. Disapproved	Name (Last) PRINT (First) (M.I.)	Title
C. Date Waiver Approved MO. DAY YEAR		

19. I certify that this client, who is eighteen years of age or older, functionally disabled due to mental illness, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the permanent or categorical eligibility requirements or a request has been submitted to waive such criteria or no determination of eligibility has been made and the client is receiving on-site rehabilitation or outreach services.

Signature | Name signed (Print)

Title | Today's Date MO. DAY YEAR

COMMUNITY SUPPORT SERVICES
FUNCTIONAL ASSESSMENT WORKSHEET

APPENDIX - B

1. SELF-CARE

___ Needs assistance in maintaining personal hygiene.

___ Needs assistance in gathering information re: proper health care.

___ Puts self at continual risk of injury.

___ Needs assistance in securing proper health care, or complying with prescriptions or other medical procedures.

___ Needs assistance in learning about medication and its administration.

___ Needs assistance in learning about and maintaining proper nutrition.

2. ACTIVITIES OF DAILY LIVING

___ Needs assistance in utilizing public transportation on familiar or unfamiliar routes.

___ Needs assistance with basic housekeeping chores.

___ Needs assistance with day-to-day meal planning and preparation.

___ Needs assistance with day-to-day money management.

___ Needs assistance in fully accessing community resources, i.e., senior citizen services, libraries, recreational facilities, etc.

___ Needs assistance in developing and maintaining social and recreational activities outside the home.

___ Needs assistance in day-to-day self-administration of medication.

3. SELF-DIRECTION

___ Needs assistance in making own appointments for doctors, services, etc.

___ Needs assistance in advocating for one's own interest with landlords, homeowners and/or service providers, doctors.

___ Needs assistance in establishing and maintaining personal goals.

___ Needs assistance in organizing and scheduling personal activities.

___ Needs assistance in taking initiative/seeking others for assistance with problems.

___ Needs assistance in using the phone for personal or business needs.

4. SOCIAL FUNCTIONING

___ Lacks the skills to effectively and appropriately communicate with family and friends.

___ Does not respond appropriately to individuals in authority.

___ Repeatedly violates rules at home, work or school.

___ Is not fully aware of the array of legal rights available, including Constitutional and relevant resident/tenant rights and regulations.

___ Does not willingly participate in social or recreational activities.

___ Does not organize group activities with friends.

___ Needs assistance in forming contacts with potential friends or interacting with strangers.

___ Needs assistance in confronting criticism or other stressful situations.

5. ECONOMIC SELF-SUFFICIENCY

___ Lacks adequate literacy skills necessary to obtain economic self-sufficiency.

___ Needs assistance from others to obtain or retain entitlements, i.e., SSI, food stamps, etc.

___ Is not fully employed or is underemployed.

___ Needs assistance in budgeting and paying for recurring monthly expenses: occasionally runs out of money before the end of the month.

___ Needs assistance in finding appropriate and affordable housing.

___ Lacks the vocational skills and/or education to obtain economic self-sufficiency.

6. ABILITY TO CONCENTRATE

___ Medication and/or mental illness interferes with the person's ability to focus or concentrate.

___ Needs assistance in completing tasks and following through on personal goals and social activities.

___ Lacks stability and proper support groups in his/her environment which would otherwise enforce clear thinking and concentration.

___ Lacks adequate literacy skills which subsequently interfere with his/her ability to concentrate.

APPENDIX-C

Informed Consent Statement
(to be read by Candidate)

You are invited to participate in a group program that involves group discussion with other women who are living at your residence. This group is part of a study. The purpose is to help participants strengthen their supportive relationships. Your participation in this study is completely voluntary and will involve attending 20 weekly group sessions, each lasting for 1 1/2 hours. You can discontinue coming to the group at anytime.

The sessions are confidential. When the project is completed, only anonymous information will be described; no names will be used nor any other information that might identify participants. This project is part of the requirements for the doctoral program at the Hunter College School of Social Work.

I have had an opportunity to ask questions before being asked to sign this form and before the group begins.

Signed_____Date_____

Martha A. Sullivan, CSW APPENDIX - D
Women's Group

As part of my project I am interested in your opinion of how the Women's group has fit into the total E49 program. Please share your impressions in response to the following questions. (There's no need to sign this form.)

1. What impact do you feel the women's group has had upon the total program?

2. Have you observed any impact the group may have had upon group members? Please describe. Feel free to relate your response to any group member, not just women on your caseload.

Thanks so much for your cooperation, I'll pick up the forms from Josie when come I come in.

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