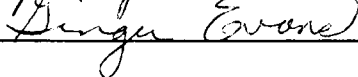


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**A STUDY OF SELF-CARE PRACTICES AND
DEFINITIONS OF HEALTH AND ILLNESS AMONG HOMELESS MEN**

**A Thesis
Presented for the
Master of Science
Degree
The University of Tennessee, Knoxville**

Roberta Ann Proffitt

May, 1991

DEDICATION

This thesis is dedicated to my parents

Mr. and Mrs. C. A. Proffitt

and

Mike Lavin

for their support and encouragement.

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ABSTRACT

This descriptive study was designed to identify common themes in definitions of health and illness and self-care practices of homeless males in Knoxville, Tennessee. Orem's self-care theory and Smith's four models of health were used as the conceptual framework. Further, attempts were made to determine if there was any relationship between the definitions of health and illness and self-care practices. Each subject provided demographic information and participated in an interview. Field notes made at the time of the interview were also used as a means of evaluation.

The most common definition of health and illness for this sample was related to the ability to perform expected roles. Frequently used self-care practices included the balance between rest and activity and the avoidance of hazards to human life. Commonly experienced self-care deficits were oppressive living conditions, abrupt changes in residence, and loss of personal items or job security. There appeared to be some association between demographic variables, such as race, and definitions of health and illness. There was also some association between self-care practices, such as the avoidance of hazards to human life, and deficits and definitions of health and illness. Subjects who had a clinical definitions of health and illness appeared to be more concerned with a desire to be normal and hygiene.

The study supported several changes in the way health care providers attend to the health care needs of the homeless population. Given the nature of the prevalent definitions of health and illness held by the homeless, health care providers must work to avoid ethnocentric biases in devising programs of education and care for the homeless. For example, a the commonly described role-performance definition of illness among the homeless made it less likely for them to seek timely care. Health care providers need to be

aware of this. Moreover, some routines of shelters, such as the dispensing and handling of medications for shelter residents, the provision of sound nutrition, and the basic health screening of shelter residents could be improvement. Since the sample size was small and the research was a descriptive study, further large scale studies would be appropriate to discover whether the relationships that appeared to exist hold for larger populations and whether other undiscerned relationships exist.

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CHAPTER I

INTRODUCTION

Homelessness is a growing problem that affects all strata of society across the country. It is not a new problem or one that is specific to the United States. It is, however, a problem that is becoming increasingly visible. As it becomes more visible, people are beginning to see the enormous health problems faced by the homeless on a daily basis. The more that is learned about this group of people, the more professionals realize that there is a paucity of knowledge about how the homeless define and care for their own health.

Little is known about how the homeless conceptualize health, even though the conceptualization of health is basic to the determination of self-care practices. Self-care is defined by Orem (1985) as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (p. 84). Self-care is not limited to care that persons provide for themselves. It may include care that is provided by others until impaired persons are able to care for themselves once again (p. 84). Self-care is considered to be a given in our society. However, there are considerable differences in the self-care practices of individuals. It is commonly accepted that self-care practices are diversified in both ethnic and socioeconomic groups. Despite these variances, we know little about the differences that characterize the self-care practices of the homeless.

The amount of research involving homelessness is growing. In the last ten years there has been a significant increase in the number of articles on homelessness in professional journals. Chris Raymond (1990) noted that there were 46 articles on homelessness listed in Psychological Abstracts in 1988 as compared to only 4 in 1980. The articles were primarily descriptive and were most frequently written by physicians, nurses,

sociologists, psychologists, and social workers. There is a plethora of demographic information in relation to the homeless population, but there is virtually no information on the beliefs of the homeless, especially as related to health. Connelly, Roderick, and Victor (1990) point out that the literature on the effects of homelessness on health is predominantly descriptive rather than analytical.

Although the homeless population is becoming increasingly heterogeneous, it is still predominantly composed of single white males, with a mean age of about 34 years (Lindsey, 1989; Maurin, Russel, & Memmott, 1989). It seems plausible that since these men share many of the same experiences, problems and environments, they might also have commonalities in their definitions of health and their self-care practices. These self-care practices include not only what homeless persons do for themselves, but the type of assistance they are likely to seek from health care professionals and others.

PURPOSE OF STUDY

The purpose of this research is to describe any commonalities homeless males may have in their health beliefs, definitions of health and illness, and their self-care practices. It is not the researcher's purpose to endorse a specific definition of health or illness. The study is descriptive and will fill some of the currently existing gaps in the research dealing with the health beliefs of the homeless population.

According to Hansen and Resick (1990) ethnocentric attitudes affect differences in health beliefs and vice versa. Ethnocentric attitudes are those dispositions, feelings and beliefs that are peculiar to one's own culture and that are taken by one with an ethnocentric attitude as the appropriate and superior standard for judging all other cultures. Ethnocentric attitudes affect not only the health care practices of the person seeking care, but also the

ways in which the health care provider treats and interacts with homeless clients. Hansen and Resick (1990) suggest that the differences in the value systems of health care providers and those individuals from different cultural backgrounds can be managed if the health care provider develops an attitude of cultural relativism. Cultural relativism attempts to interpret a situation based on another person's beliefs. Adopting an attitude of cultural relativism gives the health care provider the ability to see issues in the same way the clients see them. According to Dorothea Orem (1985) a patient's beliefs about health issues affect a nurse's ability to provide care. Therefore, the nurse's antecedent knowledge of a patient's health beliefs will help him or her to facilitate self-care better.

If health care providers are to adopt an attitude of cultural relativism in reference to the homeless population, they must first recognize the health care beliefs and self-care practices of homeless persons. Once this is done, attitudes can be modified in a manner that will allow for provision of appropriate health care services for the homeless. The initial step toward development of cultural relativism is to describe the health beliefs and self-care practices of the homeless. Since the homeless are a very diverse population, this research study will be limited in scope to identification of health beliefs and self-care practices of homeless males. Although homeless men are all in a similar situation and environment at the time they are homeless, they come from diverse cultural backgrounds. It is the researcher's intention to describe the health beliefs and resultant care practices they may have in common at the time of their homelessness.

CONCEPTUAL FRAMEWORK

Dorothea Orem's theory of self-care will be used as a theoretical framework for this research. The focus of her theory is "self-care" which she defines as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (Orem, 1985, p. 84). Self-care is not limited to care that persons provide for themselves, but may include care that is provided by others until impaired persons are able to care for themselves once again.

The purpose of self-care is achieved through action taken by a person that "contributes in specific ways to human structural integrity, human functioning, and human development" (Orem, 1985, p. 83). There are 3 types of self-care: universal, developmental, and health-deviation. These three types of self-care are called self-care requisites. According to Orem these self-care requisites must be known before one can use them as a basis of self-care.

According to Orem (1985) universal self-care requisites are those self-care practices that are basic to survival, such as taking in water and food. These requisites of self-care are common to all people at all stages of life. They do, however, change during the life cycle. There are 8 universal self-care requisites listed by Orem (1985) that include not only basic physical needs, but also those needs related to intervention and social acceptance. The universal self-care requisites will be discussed in greater detail in chapter 4.

Developmental self-care requisites are divided into 2 categories. The first category includes the maintenance and promotion of living conditions that aid in development. They are related to such times as intrauterine life, infancy and pregnancy. The second category deals with the provision of care to avoid or overcome conditions that may adversely affect

human development, such as educational deprivation, loss of significant relationships, and loss of possessions.

Health-deviation self-care requisites are those associated with physical, biological, or environmental problems that affect humans and the medical treatment that might be needed to correct the problem. These requisites exist in persons who are obviously ill. There are 6 health-deviation self-care requisites. The first involves seeking and securing medical assistance in the event that it is needed. The second involves being of aware of and attending to the effects of a pathological condition. The third involves effectively carrying out medical procedures and orders to improve one's condition. The fourth deals with being aware of and regulating adverse effects of medical care. The fifth necessitates modifying one's self-concept to make it congruent with one's state of health. The sixth requires learning to live with pathological states and medical treatments in a way that promotes development (Orem, 1985).

Through the use of Orem's self-care theory, the relationship of one's beliefs regarding health can be evaluated in terms of an individual's self-care practices. Understanding how an individual or group of individuals define health and knowing what self-care practices they utilize has two purposes. First, it furthers understanding of what these people can best do to help themselves. Second, it enables nurses to know what they can do to aid individuals in meeting their self-care requisites. The client's self-understanding of what health is and of what practices hurt, maintain, or improve it can serve as a baseline for nurses. Knowing what a client's self-understanding is permits nurses to present accurate information about health and self-care to their clients in a way that clients can easily understand and use.

According to Woods (1989) the concept of health needs to be discussed when characterizing self-care literature. There has been much disagreement on the definition of

health. Keller (1981) attempted to give a historical view of the meaning of health. Quite famously, the World Health Organization defined health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (cited in Keller, 1981, p. 45). Keller's review of the literature makes it is clear that there is no consensus on a correct definition of health.

Woods evaluates the current literature on self-care using Smith's four models of health. Smith (1981) attempted to clarify confusions over the meaning of health, a concept that plays a central role in nursing, even though there is no consensus about what the correct definition of health is. Smith's categorization of definitions of health will be used in this study to supplement Orem's self-care theory in the conceptual framework. She identified four categories of definitions of health which will be used as broad categories for examining and sorting the definitions of health and illness offered by the homeless men in this study.

The first category is the eudaimonistic model. This model views health as an idea of general well being and self-realization. That is, if a person is perfectly healthy, then that person has reached his full potential and is therefore self-actualizing.

The second model is the adaptive model. This idea was first conceived by Claude Bernard in the 19th century. Within this view, a healthy person is able to respond adaptively to shifts in his or her physical and social environment. If a person is unable to maintain physical and emotional homeostasis in the face of physical or social challenges, then that person is ill.

The third model is the role-performance model. This model holds that a healthy person is able to perform his prescribed roles. Consequently, if a person is unable to perform their daily task or roles, that person is ill.

The final model is the clinical model. In this model a person is healthy in the absence of any signs or symptoms of disease or disability. If there are such signs or symptoms, the person is ill.

Obviously these four models of health are not mutually exclusive, and are not exhaustive. Smith's work does, however, give an appreciation for the differences in the definitions that people attach to health. These models provide four broad categories into which differing definitions of health can be placed.

Woods points out that most of the currently existing self-care literature focuses on the "clinical model" of health. She further indicates that a researcher's conceptualization of health influences the research aims and methods. Finally, Woods points out that most self-care research deals with individuals rather than families or communities. Based on Woods (1989) findings, it is appropriate that the study of the health beliefs and self-care practices of homeless males use a conceptual framework that is a combination of Smith's four models of health and Orem's self-care theory.

RESEARCH QUESTIONS

1. What are the common themes in the definitions and beliefs regarding health and illness given by homeless males?
2. What are the most common self-care practices used by homeless males?
3. What are the most common self-care deficits of homeless males?

SUBSIDIARY QUESTIONS

1. Are certain demographic variables such as length of time homeless, educational level, and race associated with definitions and beliefs regarding health and illness?
2. Are specific types of self-care deficits associated with specific definitions of health and illness?
3. Are specific types of self-care practices associated with specific definitions of health and illness?

DEFINITION OF TERMS

Homeless: (1) an individual who lacks a fixed, regular and adequate nighttime residence; or (2) an individual who has a primary nighttime residence that is (a) a supervised or publicly operated shelter designed to provide temporary living accommodations; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (U.S. Congress, House, 1987).

Self-care: Orem (1985) defines self-care as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being," but is not limited to care that persons provide for themselves, and may include care that is provided by others until they are able to care for themselves once again (p.84).

Health: Orem (1985) defines health or healthy as "terms used to describe living things--plants, animals, human beings--when they are structurally and functionally whole or sound" (p. 173). For the purposes of this study, health will be viewed in terms of the four models proposed by Smith in 1981. Definitions of health offered by the subjects will be

categorized according to those definitions in Smith's four models. The four models are the eudaimonistic, adaptive, role-performance, and the clinical model.

Illness: Illness as defined by the subjects will be categorized in accordance with the definitions of illness given in Smith's four models.

CONCLUSION

It is important first to understand the homeless person's definition of health. If Spradley and McCurdy's (1972) belief that culture is equivalent to knowledge and knowledge is used to organize behavior is true, then the knowledge of health could be used by the homeless population to organize health self-care practices. Such definitions of health and knowledge of the self-care practices of homeless persons can be linked to Orem's calculation of self-care requisites, facilitating an understanding on the part of health care providers regarding the kind of information and practice that is likely to improve the quality of health care for the homeless.

CHAPTER II

LITERATURE REVIEW

INTRODUCTION

The small body of literature available on the health beliefs and practices of the homeless as well as the sizable body of research on the demographics of the homeless is surveyed in this chapter. This literature review makes it possible to develop some rough estimates about the number of people who are homeless, to draw tentative conclusions about the physical and mental health of the homeless, and to identify special health vulnerabilities of the homeless. By reviewing previous research on homelessness, this researcher hopes to put the present study in context, and to make the results of the study more useful.

DEMOGRAPHICS

As already indicated, there is a paucity of research into the health beliefs of the homeless. It was noted by the Institute of Medicine (1988) that the first book on health care for the homeless was published only five years prior. The research that is available is primarily concerned with the demographics of homelessness. Demographic studies are important, because at this time there is no reliable count of the number of homeless in this country, but demographic data alone does not assist health care providers in understanding how the homeless identify and cope with health problems.

Estimates of the number of homeless in this country range from 250,000 to 3,000,000 (Lockhead, 1988; U.S. Department of Housing and Urban Development, 1984), with the fastest growing segment of the homeless population being families (Alperstein,

Rappaport, & Flanigan, 1988). Lindsey (1989) reports that estimates of the homeless in Los Angeles alone range from 35,000 to 50,000. A study of fifty cities nationwide estimated the prevalence of homelessness at 0.6 to 15.9 persons per 1,000 (Tucker, 1987). The same survey estimated the median rate of homeless persons at 3.1 per 1,000 (Tucker, 1987). According to Vladeck (1990) the homeless are hard to count because the estimation of the number of homeless is a political issue regarding who should be counted, and because homelessness is not a permanent condition for many individuals.

Nooe and Lynch (1988) reported that the number of homeless in Knoxville was approximately 1,000 with 80% of those being male. It is estimated that about 74% of the males are white, 22.4% are black, and 2% are of other ethnic origin. In an informal survey, based on the registration cards of men who had stayed in a homeless shelter in Knoxville in the past year, this researcher found that 85% were white, 13% were black, 1% were hispanic, 0.5% were native American, and the rest belonged to other ethnic groups. The survey was accomplished by examining a file of information cards kept by the shelter on every man that signed up for a bed. Included in the information on the card is ethnic origin. Since this was only one of several local shelters for men, the percentages do not necessarily reflect the ethnic mix of the homeless population in the area, but the survey does give an accurate picture of the ethnic mix at one shelter for one period of time.

Maurin, Russell, and Memmott (1989) studied the gender differences in the homeless population in Utah. They found that 86.9% of the men were alone, compared to only 35.2% of the women. Men were less likely to have contact with their families. Men were also found to be less psychologically distressed by the situation they were in presently than were women. One thing that the men and women seemed to have in common was what they listed as their top 3 needs. These included a job, a permanent place to live, and financial assistance.

PHYSICAL HEALTH

The Institute of Medicine (1988) found that there were three ways in which homelessness and health interact: "(1) Some health problems precede and causally contribute to homelessness, (2) others are consequences of homelessness, and (3) homelessness complicates the treatment of many illnesses" (p. 39). Lack of a home itself has direct effects on a person's health risks. Vladeck (1990) points out that homelessness itself increases the risk of illnesses of exposure, malnutrition, and infectious diseases.

A British study found that the main health related problems associated with homelessness can be attributed to poor access to primary health care and overcrowded and unhygienic conditions. These lead to an increase in infections, childhood accidents, behavior problems in children, poor nutrition, and decreased compliance with immunization schedules (Connelly, Roderick, & Victor, 1990). This further illustrates that homelessness is a world wide problem.

Lindsey (1989) reported that in a clinic for homeless in Los Angeles, the top three "diagnoses" (sic) when the homeless sought treatment were acute nasopharyngitis, TB screening to rule out TB, and open wounds or lacerations, although it is anomalous that Lindsey counted TB screening as a diagnosis. Other common reasons for clinic visits were tinea, acute bronchitis, hypertension, acute pharyngitis, scabies, contact dermatitis, and eczema. Ninety percent of the clients at the clinic were men. Of these people 85.3% had no health care benefits of any kind. Further, Bassuk, Rubin, and Lauriat (1984) found that 45% of the group she studied reported serious physical illnesses. Roth and Bean (1986) found that approximately one third of the homeless persons they interviewed claimed to have some condition for which they felt they should see a physician.

According to the National Association of Community Health Centers (1990), 30-40% of homeless suffer from one or more chronic diseases. These diseases are typically longstanding, untreated, and more severe than in a domiciled population. Management of the diseases of the homeless is complicated by such factors as stress, exposure to the elements, poor nutrition, and the use of alcohol, drugs, and tobacco. The Association recommends that all homeless be screened for chronic disease, but also suggest that standard treatments on any discovered chronic disease may be impractical and unrealistic.

Hu, Covell, Horgan, & Arcia (1989) reported that the quality of health care received by the homeless was quite low. Thirty homeless families in San Diego, California were studied, and it was found that 56.7% had no regular source of health care and 46.6% were not covered by any public or private health insurance. Results of this study demonstrated a negative relationship between the duration of homelessness and one's health status. This may be due to lack of self-care measures or preventive measures available. Other studies have also confirmed that homelessness has adverse effects on one's health (Bassuk et al., 1984 & Rossi, Wright, Fisher, & Willis, 1987). According to the Institute of Medicine (1988) the homeless are less likely to seek and obtain access to health care than are the domiciled poor. This is partially due to the trouble that the homeless have getting into the Medicaid system. In Tennessee an individual income of more than \$117 a month renders the homeless person ineligible for benefits. The lack of benefits inevitably makes the homeless person an undesirable patient for most health care providers.

MENTAL HEALTH

Since the 1960s, when there was a large movement toward deinstitutionalization, the number of chronically mentally ill homeless has been growing and yet few alternatives to care have been established (Riesdorph-Ostrow, 1989). According to Levine and Rog (1990) the homeless mentally ill adults are defined as "individuals, age 18 years or older, who have long-term severe mental illnesses and no fixed place of residence (or who are at imminent risk of becoming homeless)" (p. 963). For a person to be considered as having a long-term severe mental illness he or she must have severe persistent mental or emotional problems that interfere with the ability to function daily in such areas as self-care, relationships, work, and school.

Estimates of the extent of psychiatric problems in the homeless population range from 30% to 90% (Bassuk, 1984; Susser, Struening, & Conover, 1989; Salem & Levine, 1989). In 1988 23% of Knoxville's homeless population were hospitalized for emotional illness and 11% were taking medication for mental health problems (Nooe & Lynch, 1988). In a grant proposal by Helen Ross McNabb Center, it was estimated that 30% of the homeless population in Knoxville reported having "bad nerves," and more than 50% stated they experienced depression several times a week (Blanton, 1988).

Roth and Bean (1986) studied 1000 homeless persons in Ohio and found that 30% of those interviewed had been hospitalized at least once for a psychiatric problem. Further, they found that 69% of those interviewed showed no symptoms on the Psychiatric Severity Index. These researchers identified 3 distinct types of homeless people. Street people were those who usually had no contact with shelters. Shelter people had regular contact with shelters and used other available resources. Resource people were those who did not use shelters, but had more available resources than the other groups and they were more likely to have an

income. Using the Psychiatric Severity Index they found that the street people had a higher proportion of psychiatric problems by about 5%.

Fischer, Shapiro, Breakey, Anthony, & Kramer (1986) identified characteristics that distinguished the homeless male from the domiciled male. They found that the homeless male was more alienated and had more psychopathology than did the domiciled male. The authors were unsure whether their subjects were alienated because of their psychopathology or for other reasons, but they concluded that it is likely, in any event that their alienation contributed to their becoming homeless. They further noted that approximately one third of the homeless men in their sample probably had psychiatric conditions.

Homeless individuals with psychiatric illnesses reportedly have greater difficulty obtaining housing and services. Speculations about the reasons for so many homeless persons with psychiatric illness being on the streets range from housing discrimination and decrease in the availability of affordable housing to deinstitutionalization and the lack of contact that shelters have with community based psychiatric programs (Carling, 1990). Lamb and Lamb (1990) interviewed 53 consecutive homeless persons admitted to a psychiatric hospital to determine what characteristics contributed to their lack of housing. Among the prominent characteristics they found were disorganized and poor problem-solving ability, paranoia, and depression. These deficits were judged to contribute to homelessness and it is surmised that the stress of homelessness intensified the deficits. Further, only 4% of the sample had either case managers or were involved in outpatient mental health treatment. Many mentally ill homeless, however, prefer the streets to the available options of places to stay. They feel that their freedom is restricted in many residential facilities.

Lipton, Nutt, and Sabatini (1988) placed an experimental group of chronically mentally ill homeless persons in St. Francis Residence. The control group either refused

discharge placement, was discharged to a shelter or an adult home, transferred to a state hospital, or discharged to a friend. At the end of a year it was found that the experimental subjects were homeless a mean of 6% of the nights while the control group was homeless 46% of the nights after discharge.

In order to avoid the expressed concern of restricted freedom Ryan (1989) suggest an alternative to the housing situation of the homeless mentally ill. Individuals with chronic illnesses are provided low rent efficiency apartments and supportive care provided they pay their rent and follow the rules. The residents are free to come and go as they please.

SUBSTANCE ABUSE

Typically when many people think of a homeless person they visualize a skid row alcoholic. According to Stark (1987) the percentage of homeless who are alcoholics has remained steady at about 30%, a prevalence rate perpetuating the stereotype of the homeless as skid row alcoholics. In a study by Linn, Gelberg, and Leake (1990) a comparison was made between poor and homeless who used the services of a Los Angeles County health center. They found that 46% of homeless patients, as compared to 34% of the domiciled poor, had used at least one of the psychoactive drugs about which they were questioned. For many of the included drugs it was found that there was no significant difference in amount of use in the 2 groups.

The studies report some variation in alcohol and drug use based on age, race and sex in the homeless population. Men were more than twice as likely than women to use alcohol. The highest rate of those who drank alcohol was between the ages of 30 to 64 years. Chronic alcoholics were found to be at greater risk for trauma, seizures, malnourishment, infectious diseases, and lung disorders (Wright, Knight, Weber-Burdin, & Lam, 1987).

Shandler and Shipley (1987) found that of 162 individuals brought to a detox unit in Philadelphia: 44% had symptoms of liver problems, 29% had evidence of other trauma, 27% had respiratory problems, 18% were malnourished, 10% had gastritis, 7% had high blood pressure and 6% had symptoms of heart problems. Overall, the homeless alcoholic is more likely to suffer from one or more illnesses needing treatment than is the person who is not a substance abuser.

DETERRENTS TO CARE

Many things keep homeless people from seeking health care. Among these deterrents are lack of financial ability to pay for services, lack of transportation, mental illness, inappropriate services to meet the needs of the homeless, and poor compliance (National Association of Community Health Centers, 1990). According to Berne, Dato, Mason, and Rafferty (1990) many mothers fail to seek help until they need emergency care, because they feel they are the least important family member. Others fail to seek help from fear or paranoia (Ryan, 1989). Many homeless families avoid health care because they are afraid the providers will think they are unfit parents and attempt to remove their children from parental custody. There are many reasons why the homeless do not seek care, but a critical factor for many is the lack of trust.

CONCLUSION

Hansen and Resick (1990) believe that health beliefs and cultural values affect ethnocentric attitudes. The health beliefs are the result of the interaction of various forces. The ethnocentric attitudes of a subculture can work to damage the quality of health care if the health care providers are unaware of ethnocentric attitudes or are not sensitive to them.

Therefore, it is essential that those who provide health care to the homeless start to look at the health beliefs of the homeless.

In this chapter, the characteristics of the homeless population have been identified through a literature review. The homeless are a growing population in which men and people of color are disproportionately represented. Moreover, the physical health of the homeless is poor and is continuing to deteriorate, with the risk of infectious diseases and accidents being especially high, but with chronic diseases also being frequent. The mental health of the homeless is also poor. Dependency disorders are frequent, and the incidence of major mental illness and personality disorders is alarmingly high. All of these features of the homeless population are likely to have an influence on how the homeless define health and their ability to engage in and sustain self-care practices. In many cases, the presence of mental disease, which often involves withdrawal, is a deterrent to the homeless gaining access to facilities that will provide health care or that will teach the homeless how to provide their own health care. Physical problems can also have the same effect. In all, the foregoing provides the context in which the health care beliefs and practices of the homeless are to be understood. Just as importantly, it points to the need to sensitize health care providers to the special characteristics of the homeless population.

CHAPTER III

METHODOLOGY

INTRODUCTION

The methodology used to evaluate the data gathered from demographic sheets, interviews, and field notes is described in chapter 3. Support for using a qualitative study is offered. Finally, limitations of the study are enumerated.

DESIGN

This research was a qualitative study using interviews for data collection. According to Knafl and Howard (1984) qualitative research is appropriately used when sensitization or conceptualization is the purpose. This research was designed to be sensitizing and to bring health care providers into contact with a useful way of conceptualizing the health beliefs and practices of the homeless.

PROCEDURES

Site access. Access to sites where data was gathered was obtained by approaching directors of local homeless shelters with a research proposal and asking permission to use their facilities for data collection. Written letters of permission were obtained.

Subjects. The subjects consisted of 27 males between the ages of 20 and 50 who were currently homeless. The limitation on age was based on the literature review which indicated that the average age of homeless males was 34 years old. Further, males were chosen because they make up the largest percentage of the homeless. Participants were

selected from (a) persons spending the night at a homeless shelter, or (b) persons staying in a dayroom at a shelter. Demographic information on each subject was collected on a separate form by the interviewer (see Appendix A).

Ethical treatment of human subjects. Subjects were volunteers who were free from any physical or psychological coercion to participate. Their interview was to be terminated if it became apparent that it was causing the subject any emotional distress. All interviews were kept confidential. No names were on the tapes and tapes were erased as soon as they were transcribed, which was within one month of taping. All subjects were given a consent form to sign that explained that they had the right to discontinue the interview at any time (see Appendix B).

Instrument. Each subject first read and signed a consent form, then answered demographic questions which were recorded on a separate sheet of paper. Segovia, Bartlett, and Edwards (1988) reported that self-assessed health status is a valid indicator of health and certain health practices. If this is the case, then it might seem likely that self-assessed status would be predictive of self-care, and that one's definition of health might predict self-care behaviors. Each subject participated in a tape recorded interview that consisted of 2 questions relating to the definitions of health and illness and 7 questions relating to self-care practices (see Appendix C). Each interview lasted approximately 30 minutes. All interviews were conducted by the same interviewer.

The first 2 interview questions asked for definitions of health and illness. These questions were related to Smith's models. The last 7 questions were related to Orem's self-care requisites. The third and sixth questions asked about self-care practices during times of health and illness. Questions 4 and 5 were concerned with where the individual learned the self-care practice and whether they truly believed that it helped to keep the person healthy.

Question 7 inquired where the person would go for help if for some reason he could not take care of himself. Questions 6 and 7 were used jointly to attempt to determine if health-deviation self-care requisites were being met. Questions 8 and 9 were used to compare the universal self-care requisite of the maintenance of balance between solitude and social interaction.

Pilot project. A pilot study was done approximately 4 weeks before the actual study, using the same instrument. Subjects consisted of 3 volunteers who were homeless men employed by Volunteer Ministries Center. Participants signed consent forms, provided demographic information, and participated in the interview. The pilot study helped to determine if clarification or changes were necessary in the interview protocol.

Following the pilot study it was not necessary to make any changes in the interview protocol. Feedback was obtained from the participants on the interview technique and language used.

Constancy of conditions. Subjects for the study were all currently residing in Knoxville. They were all homeless at the time of the interview.

All interviews were conducted by the researcher. All interviews took place in public areas during the afternoon or early evening. All subjects were asked the same set of questions. The recorder was turned on after the demographic information was gathered. All interviews took place during the month of January 1991.

Analysis of data. Determining that there was a need for sensitization in the area of health beliefs and self-care practices of homeless males required a review of the literature to indicate that there was a lack of research in the area. This was accomplished by exploring such areas as demographics, physical health, mental health, substance abuse, and

deterrents to care of the homeless. There was no research found that dealt with the health beliefs and self-care practices of homeless males.

Orem's theory of self-care and Smith's four models of health were used as a conceptual framework for the study. Orem provided the basis of self-care theory and the categorization of self-care practices. Orem's theory indicated the necessity of recognizing self-care requisites and their impact on health.

Smith's models of health were used as a means of categorizing the definitions of health offered by homeless males. These categories were then evaluated and compared to the self-care practices of the homeless males in an attempt to identify patterns of belief and practice. For example, what bearing do such variables as length of homelessness, education, race, area of origin, and health status have on definitions of health and health care practices? And what relationship do specific styles of self-care have to specific definitions of health and illness?

Each tape recorded interview was transcribed. All answers were individually coded with a number to identify the respondent that answered the question. Once transcribed, the answers to the questions were color coded based on the model of health they best fit. The color coded answers were placed in one of Smith's 4 different categories of definitions of health and illness: eudaimonistic, adaptive, role performance, and clinical. Once subjects's responses were all coded, they were reviewed to identify any subcategories.

Self-care practices were evaluated in terms of Orem's three categories of self-care: universal, developmental, and health deviation. These categories formed the rows of a twelve cell matrix, with Smith's four models of health and illness forming the columns. A subject's responses were placed on the matrix accordingly. For example, a subject whose responses were coded as eudaimonistic for health and illness and universal, developmental, and health

deviation for health care practices would have his responses entered in the eudaimonistic and universal cell of the matrix, the eudaimonistic and developmental cell of the matrix, and the eudaimonistic and health deviancy cell of the matrix. Assessments were made to determine if any correlation existed between the definition of health and illness given and the self-care practices performed by the individual. For example, did most subjects with a eudaimonistic conception of health and illness also have entries on all three of the self-care cells under the eudaimonistic column? A key comparison involved whether subjects who had differing conceptions of health were as likely to have the same self-care practices. This could be verified by inspecting the cells of the column under that definition of health and comparing it to the cells of another column, adjusting the comparison for demographic variables and response rates.

LIMITATIONS

Limitations on any research on the homeless population are many. The first and most noticeable limitation is that researchers use different definitions of homelessness. There is much disagreement on just who should be considered homeless. The definition of homeless that was used for this research was the same as that in P.L. 100-77, the Stewart B. McKinney Homeless Assistance Act, which is the same definition used by the Institute of Medicine (1988).

The second limitation of this research is that a convenience sample was selected. The sample was taken entirely from the Knoxville area. Further, the sample was small which made comparison between groups difficult. This will limit the generalizability of the data.

The third limitation is that only males were studied. Although they do make up the largest segment of the homeless population, the study excludes women and children, a part of the homeless population that is increasing in number daily.

CONCLUSION

The methodology employed in this study was presented in this chapter. The study is a qualitative investigation of definitions of health and self-care practices of the homeless. To conduct the research a nonrandom sampling of homeless individuals was undertaken, using as an instrument a questionnaire inspired by the work of Smith on definitions of health and of Orem on self-care. Appropriate measures were undertaken to assure confidentiality of the respondents. Since the study is qualitative, standard statistical techniques suitable for a quantitative study were not appropriate.

CHAPTER IV

RESULTS

INTRODUCTION

The demographic information provided by the 27 men in the study is described and presented in chart form in chapter 4. The research and subsidiary questions are answered. Tables are provided to facilitate an understanding of the findings.

DEMOGRAPHICS

Twenty-seven homeless males participated in the study. Their average age was 33 years, with a range of 22 to 50 years. The majority (66.7%) of the men had spent the previous night at Knoxville Union Rescue Mission (KURM). Only one person had spent the previous night on the street (see Table 1).

Fifteen of the men were white (55.6%) and 12 (44.6%) were black. These men originated from 13 states in the United States and had been in Knoxville from 1.5 months to their entire life. The average length of time homeless was 15.9 months with a range of 1 week to 7 years. The majority (88.9%) did not intend to move in the next 2 to 3 weeks.

The backgrounds of the men varied. Sixteen (59.3%) were single and eleven (40.7%) were divorced. The average number of children was 1 per homeless male with a range of 0 to 8. Eighteen (66.7%) of the men were employed at least part time. The average length of time since a man was last employed full time was 29 weeks. Seventeen (63%) of the men claimed to have a trade. The average level of education was eleventh grade, with a range from seventh grade to a college graduate.

Table 1. Sociodemographic Data of Subjects (N = 27)

	No.	%
Race		
Black	12	44.4
White	15	55.6
Marital Status		
Divorced	11	40.7
Single	16	59.3
1st time homeless	16	59.3
Employment status		
employed	18	66.7
unemployed	9	33.3
Move in 2-3 wks.		
yes	3	11.1
no	24	88.9
Taking medication	13	48.1
Hospitalization	20	74.1
Alcohol	21	77.8
Cigarettes	21	77.8
Illegal drugs	6	29.0

Table 1. (cont.)

	No.	%
Education level		
7 - 9	4	14.8
10 - 12	18	66.7
> 12	5	18.5
Slept last night		
KURM	18	66.7
Salvation Army	2	7.4
Volunteer Min.	4	14.8
Street	1	3.7
Other	2	7.4
Length of time in Knoxville		
< 1 year	13	48.1
> 1 year	14	51.9
Trade		
yes	17	63.0
no	10	37.0

The health status of the men also varied. Thirteen (48.1%) of the men were currently taking medication for either chronic or acute conditions. Twenty (74.1%) had been hospitalized at some time in their life, with some being hospitalized more than once yielding a total of 27 hospitalizations. Fifteen visits were for injuries, 6 were for mental illness, and 6 were for other reasons. Twenty-one (77.8%) of the men drank alcohol at least occasionally. Twenty-one (77.8%) smoked cigarettes and 6 (29%) used illegal drugs.

FINDINGS

Research question one: themes of definitions. Question one was employed to determine whether the definitions of health and illness given by homeless males had common themes. To answer this question homeless males were asked to give their definition of health and their definition of illness. This question was phrased, "What do you think of when you think of yourself or others as being sick?" These definitions were evaluated using Smith's 4 models of definitions of health and illness. It was found that the themes of the definitions of health and illness offered by homeless males could be assigned to one of the four categories. Three participants had eudaimonistic definitions, 2 had adaptive definitions, 15 had role-performance definitions, and 7 had clinical definitions (see Table 2). A couple of examples of definitions of health or illness in each of Smith's 4 models will help to clarify how the homeless men in the study conceptualize health.

In the eudaimonistic model one man offered a definition of health as an "Excellent condition. Feeling good about yourself. Nothing wrong with you at all. Really, just feeling good about yourself, I guess." Another subject defined illness as "Someone being sick when they are physically bothered with sickness or mentally. Not having a house or something to go to, or a job. It'd make anybody sick."

Table 2. Themes in Definitions (N = 40)

	No.	%
Eudaimonistic	3	11.1
Adaptive	2	7.4
Role-performance	15	55.6
Clinical	7	25.9

There were only 2 subjects with adaptive definitions of health and illness. Illness was defined by one subject as "Not being able to adjust to society. Not being able to cope with everyday life." Health was defined by another subject as "Being able to cope with life. Getting along with life's problems. Accepting life as it really is and not as you really want it to be, but you are going to have bad days and good days."

The role-performance model was the most common in the population studied. One subject defined illness as "When you're not able to get up out of bed and go to your job. That's a big one. You can be mentally sick or physically sick too. It is not being able to perform too. Being able to get out, when you have a cold or the flu or something. To me being sick means not being able to perform your job, or things around the house or whatever." Similarly health was defined by another subject as "Someone that could take care of himself real good, hold a job down and work."

The final model was the clinical model. Illness as defined by one subject was "A person in need of medications for aches and pains or a person I guess a person that's got

physical disease like AIDS or hepatitis or something like that." Healthy was defined by a subject as "A person that has no body diseases, external or internal. Eats well, eats the right foods, exercises."

Research question two: Common self-care practices. To answer this question participants were asked two questions: (1) "What do you do on a regular basis to keep yourself healthy?"; (2) "Tell me about a time when you were sick and how you cared for yourself?" Themes in the answers were established using Orem's universal self-care requisites as a model (see Table 3). All items in table 3 are self-explanatory with the exception of "hazards" and "development." In Orem's theory, a hazard is anything that has a detrimental influence on human life, human functioning or human well-being. Development, according to Orem, involves whatever promotes human functioning and development within a social group relative to human potential, limitations, and the desire to be normal. It was found that the most common self-care practices were the balance of rest and activity (70.4%), sufficient intake of food (55.6%), and the prevention of hazards to human life (57.9%). Both races shared these common self-care practices, but the percentages differed noticeably in the categories of need for sufficient intake of water and the need for sufficient intake of food. Black subjects listed the sufficient intake of water 21.7% more than white subjects. Further, black subjects listed the sufficient intake of food 20% more often than white subjects. All other categories had less than a 10% difference between the races. Considering the small number of subjects it is difficult to establish any relationship between self-care practice and race, but some differences were noted.

Table 3. Common Self-care Practices (N = 27)

	Black (n = 12)		White (n = 15)		Total (n = 27)	
	No.	%	No.	%	No.	%
Air	0	0.0	0	0.0	0	0.0
Water	5	41.7	3	20.0	8	29.6
Food	8	66.7	7	46.7	15	55.6
Elimination	1	8.3	0	0.0	1	3.7
Activity	8	66.7	11	73.3	19	70.4
Solitude	0	0.0	0	0.0	0	0.0
Hazards	7	58.3	7	46.7	14	57.9
Development	1	8.3	0	0.0	1	3.7

Research question three: Self care deficits. To answer this question demographic sheets were assessed for health related issues. Interviews were coded based on themes that were related to universal, developmental, and health-deviation self-care requisites. Field notes were evaluated for the researcher's impressions of personal hygiene and mental status of participants. It was found that the most common self-care deficits were developmental, with the major deficits being those of oppressive living conditions (92.6%), abrupt changes in residence (81.5%), and loss of possessions or occupational security (74.1%) (see Table 4). Universal self-care deficits were experienced by all subjects. The most common universal self-care deficit was related to the "maintenance of a balance between solitude and social interaction." No participants had universal self-care deficits of air, food, or water. The fewest participants had deficits that were in the health-deviation self-care requisites. The deficits in Table 4 are easily explained. Under developmental deficits, for example, Orem's theory includes the subcategories education, social adjustment, loss of people, jobs, or possessions, changes in residence, status, health, and living conditions. These subcategories are intuitively understandable. A respondent might lack an adequate education, or have lacked the ability to adjust to social demands, or have lost a loved one, a job, or a personal possession. Likewise, a respondent might have had an abrupt change to an unfamiliar environment, and so on. It is noticeable that some differences in self-care deficits do exist between the races. In the category of developmental self-care, black subjects experienced educational deprivation 26.6% more often than did white subjects. The most noticeable difference however is in the category of health-deviation self-care where no black subjects experienced deficits. All other self-care requisites had less than a 20% difference between the races.

Table 4. Self-care Deficits

	Black (n = 12)		White (n = 15)		Total (n = 27)	
	No.	%	No.	%	No.	%
Universal						
Air	0	0.0	0	0.0	0	0.0
Water	0	0.0	0	0.0	0	0.0
Food	0	0.0	0	0.0	0	0.0
Elimination	0	0.0	1	6.7	1	3.7
Activity	1	8.3	1	6.7	2	7.4
Solitude	8	66.7	10	66.7	18	66.7
Hazards	5	50.0	6	40.0	12	44.4
Development	3	25.0	4	26.7	7	25.9
Developmental						
Educational	8	66.6	6	40.0	14	51.9
Social	4	33.3	5	33.3	9	33.3
Loss of people	7	58.3	10	66.7	17	63.0
Loss of job or items	10	83.3	10	66.7	20	74.1
Changes	10	83.3	12	80.0	22	81.5
Status	5	41.7	5	33.3	10	37.0
Health	4	33.3	7	46.7	11	40.7
Living cond.	12	100.0	13	86.7	25	92.6
Health-deviation						
Seeking care	0	0.0	2	13.3	2	7.4
Being aware	0	0.0	2	13.3	2	7.4
Following tx	0	0.0	3	20.0	3	11.1
Aware of bad effects of tx	0	0.0	1	6.7	1	3.7
Self-concept	0	0.0	1	6.7	1	3.7
Living with effects of dx	0	0.0	1	6.7	1	3.7

Subsidiary question one: Association of demographic variables and self-definitions of health and illness. To answer this question information was drawn from the demographic sheet and the 12 square matrix. Length of time homeless was averaged for each self-described category of health: eudaimonistic, adaptive, role-performance, and clinical. The average length of time homeless for all categories combined was 15.92 months with a range of 1 week to 7 years. The average length of time homeless for the individual categories was quite varied (see Table 5). Educational level was also averaged for category of health using the highest grade completed (see Table 6). The combined average of the four categories was eleventh grade. Association of race to category of health was examined, but since few subjects were in the eudaimonistic, adaptive and clinical models of definitions of health and illness, racial associations were difficult to evaluate. The role-performance model had the largest number of subjects with 15. Of those subjects 6 were black and 9 were white. For further discussion of racial differences in this study, refer to research questions 2 and 3.

Table 5. Length of Time Homeless with Self-defined Category of Health.

	No.	Avg in mths	Range
Eudaimonistic	3	11.0	6 - 24
Adaptive	2	3.5	1 - 6
Role-performance	15	23.6	.23 - 82
Clinical	7	13.7	3 - 30

Table 6. Educational Level with Category of Health.

	Avg.	Range
Eudaimonistic	9th	9 - 11
Adaptive	12th	12 - 14
Role-performance	11th	8 - 13
Clinical	11th	7 - 16

Subsidiary question two: Association of self-care deficits and definitions of health and illness. Subjects whose definitions of health and illness were either eudaimonistic or adaptive showed the fewest self-care deficits. Specifically, they had only one universal self-care deficit each and no health-deviation self-care deficits. There were only 6 subjects that did have health-deviation self-care deficits and of those 5 of 6 were either taking medication for a mental illness or had been hospitalized in the past for a mental illness. Subjects with definitions of health and illness that were clinical showed the greatest number of self-care deficits (see Table 7).

Subsidiary question three: Association of self-care practices and definitions of health and illness. To answer this question self-reported self-care practices were charted on a 12 square matrix as described in chapter 3. The self-care practices used most commonly by all groups were sufficient intake of fluids and foods, balance between activity and rest, and prevention of hazards to human life. Subjects with clinical definitions of health and illness also were concerned with such self-care practices as providing for hygiene and the desire to be normal (see Table 8).

Table 7. Association of Self-care Deficits and Definitions of Health and Illness.

	Euda	Adap	Role	Clin
Universal				
Air	0%	0%	0%	0%
Food	0	0	0	0
Water	0	0	0	0
Elimination	0	0	0	14.3
Activity	0	0	6.6	14.3
Solitude	66.6	100.0	73.3	42.9
Hazards	0	0	53.3	57.1
Development	0	0	26.6	42.9
Developmental				
Education	100.0	50.0	40.0	42.9
Social	0	0	50.0	42.9
Loss of people	66.6	100.0	66.6	42.9
Loss of job or items	33.3	100.0	80.0	71.4
Changes	66.6	100.0	86.6	71.4
Status	0	50.0	46.6	28.6
Health	66.6	50.0	26.6	57.1
Living cond.	66.6	100.0	100.0	100.0
Health-deviation				
Seeking care	0	0	6.6	42.9
Being aware	0	0	6.6	28.6
Following tx	0	0	20.0	28.6
Aware of bad effects of tx	0	0	6.6	28.6
Self-concept	0	0	6.6	28.6
Living with effects of dx	0	0	6.6	28.6

Table 8. Association of Self-care Practices and Definitions of Health and Illness.

	Euda	Adap	Role	Clin
Universal				
Air	0%	0%	0%	0%
Water	66.6	50.0	20.0	14.3
Food	66.6	50.0	46.7	71.4
Elimination	0	0	0	14.3
Activity	66.6	50.0	80.0	57.1
Solitude	0	0	0	0
Hazard	66.6	50.0	40.0	57.1
Development	0	0	0	14.3

CONCLUSION

The findings of this study were summarized in this chapter. The demographics of the study's population were explained, and it was noted that black males were, in relation to the general population, overrepresented among the homeless. The majority of respondents also had less than a high school education. The average age was 33. The health status of the subjects varied. The demographic details are given in Table 1.

The study answered 3 research questions and 3 subsidiary questions. The 3 research questions concerned how the homeless define health and illness, whether there were any commonalities in their definitions, and what the self-care practices of the homeless are, with an eye to identifying strengths and weaknesses in the self-care of the homeless. The 3 subsidiary questions concerned the influence of variables such as duration of homelessness and educational level on definitions of health and illness; the relation that

specific definitions of health and illness have on self-care deficits; the association, if any, between specific definitions of health and illness and specific types of self-care practices. The findings are summarized in Tables 2 through 8. The most striking finding was that the majority of respondents had a role-performance definition of health and illness. It was also noted that respondents who had eudaimonistic or adaptive health care models had vastly fewer self-care deficits.

CHAPTER V

CONCLUSION AND IMPLICATIONS

INTRODUCTION

The findings of the study are summarized in chapter 5. Implications for nursing practice are discussed and suggestions for future research are offered.

DISCUSSION OF RESEARCH FINDINGS AND IMPLICATIONS

Findings of this research suggest that the definitions of health and illness, as offered by homeless males, have common themes. Those common themes are consistent with Smith's four models of definitions of health. The majority (55.6%) of the subjects interviewed had role-performance definitions. Of the remaining subjects, 25.9% had clinical definitions, 11.1% had eudaimonistic definitions, and 7.4% had adaptive definitions.

Having a role-performance conceptualization of health and illness is a deterrent to care, since it causes a delay in seeking care until the person is no longer able to perform his daily activities. Since the majority of the homeless in this study had role-performance definitions of health and illness, nurses should concentrate on the need to educate homeless individuals in such areas as preventive health and early treatment prior to the need for hospitalization. Education in these areas could be accomplished by stressing that compliance with preventive care measures allows clients to experience fewer days of non-performance of their daily tasks. Areas of education could include the need for annual flu vaccines, TB screening, and the need to follow prescribed routines, even after they begin to feel well and are able to perform their daily tasks again. In addition to educating the homeless person,

nurses also need to be educated. Nurses should be familiar with the agencies that provide services for the homeless. Nurses should further understand the importance of follow-up to make sure that appointments are kept. The last group that needs to be educated is shelter staff and volunteers. By providing education to shelter staff on the health needs of the homeless, nurses may be able to convince staff and volunteers to refer the homeless for care before illnesses become serious.

Using Orem's Self-care theory, self-care practices used on a regular basis by homeless males and self-care deficits were evaluated. The most common self-care practices were the universal self-care requisites of balance of rest and activity (70.4%), sufficient intake of food (55.6%), and the prevention of hazards to human life (57.9%).

Knowing that homeless men frequently use these self-care practices provides the nurse with a basis for education. Nurses can provide patients and shelter staff with information related to these three self-care practices while simultaneously reinforcing positive behaviors. For example, a nurse can provide information to the homeless about shelter services, such as lodging, meals, showers, and lockers in which to store personal possessions. Nurses may know of other resources for the homeless, such as, those for recreational activities. For example, one Knoxville area church has a gym and equipment which it encourages the homeless to use. Frequently, one of the church's ministers is present and plays basketball with the men. Basketball was one of the most frequently listed social activities that the homeless men in the study identified as something they like to do when they are with other people. Playing basketball at the gym provides the homeless person with not only a place for recreational activity, but access to a concerned member of the community that is available to help meet spiritual needs. The other aspect of a balance between rest and activity involves an adequate amount of rest. For a homeless person this is controlled largely

by shelter policy. One Knoxville area shelter requires that the men be in by 9:30 pm or risk losing their bed. If the person showers and is in bed by 11:00 pm they have only 7 hours to sleep before having to get up in the morning. This is slightly less than 8 hours, but is less than is recommended. The sleep deficit is compounded, since there is little opportunity for a homeless person to rest during the day. This is especially so during nice weather when most shelters insist that the homeless leave the shelter. Consideration of the amount of energy that is expended when a man rises at 6 a.m., eats breakfast, packs up his belongings, and lugs them with him wherever he goes during the day would be appropriate in planning the use of the shelter. This alone is a physically demanding routine, but the homeless person is additionally allowed less sleep in a strange, frequently unsafe, environment than most health care professionals and shelter staff allow themselves.

An adequate intake of food was listed by 55.6% of the men in the study as a self-care practice used on a daily basis. Positive nutritional behaviors should be reinforced with the understanding that the homeless have limited control over their diets. Ordinarily, the homeless person eats whatever the shelters happen to be serving that day. If the menu at a shelter is nutritionally unbalanced, then the diet of the homeless person is bound to be unbalanced. It would be more effective to attempt to improve the diet of the homeless by interacting directly with shelter staff responsible for planning meals than to encourage homeless persons with no control over what they were served to eat responsibly. Providing instruction to shelter staff on nutrition would be helpful. The ideal alternative would be to help local shelters utilize a nutritionist for balancing meals while using available resources.

Another self-care practice used frequently by the homeless men in the study was the prevention of hazards to human life. For most men this included staying out of inclement weather and avoiding injury by others. The best way to help a homeless person avoid these

hazards is through the provision of adequate shelter. Sleeping on the street is dangerous and is something that no person should have to endure. Any person who presents to a clinic without a place to sleep should be given assistance in finding shelter. If the person leaves the clinic without the care provider arranging alternative shelter, that care provider has failed to help that homeless person meet a basic universal self-care requisite. If a person has no shelter, he or she will probably be unable to follow whatever treatment was prescribed, not even such basics as "Get plenty of rest" or "Drink lots of fluids."

The most common self-care deficits were developmental, with the major deficits being related to oppressive living conditions (92.6%), abrupt changes in residence (81.5%), and loss of possessions or occupational security (74.1%). Further, it was noted that all participants had some developmental self-care deficits. No participants had deficits of air, food, or water in the universal category and only 6 participants had health-deviation self-care deficits. Before nurses can help meet these self-care requisites they must first understand the culture of the homeless.

Nursing must now develop an attitude of cultural relativism. It is important to understand what the population being served considers to be sickness and how they care for themselves. To impose one's own values on such a vulnerable population is impractical and arrogant. Health care must be adapted to fit the unique needs of the homeless, but to do that, health care professionals first must understand what those needs are. Knowing the most frequently experienced self-care deficits facilitates understanding the needs of the homeless population. Some suggestions for providing appropriate care include locating clinics in areas where the homeless congregate, providing transportation to and from medical appointments, and even going out to the shelters where the homeless live to provide basic screening services.

Nurses must realize that their care does not end with the physical person. Housing is essential to a person's health. Inadequate housing is the most common self-care deficit experienced by the homeless males in this study. One individual interviewed summed it up best by saying, "Not having house or something to go to, a job, that would make anybody sick." Nurses often believe that housing is a problem for social workers, yet frequently there is no funding for social workers or they are too few in number to care for the growing homeless population. Further, if a trusting relationship is developed between the individual being served and the nurse, then the nurse is better positioned to offer advice and help. Lack of housing is not only a deterrent to care, but oppressive living conditions put the homeless person at greater risk of disease and injury. To escape oppressive living conditions a person must either secure a job or community aid. It is a frequent complaint from the public that the homeless should get a job. Even former President Ronald Reagan claimed that homeless are homeless by choice. Unfortunately, few consider the difficulties of getting a job when a person must go to an interview carrying all of their possessions, has no phone number, no means of transportation, and typically few occupational skills. Nurses that deal with the homeless need to know enough about the available resources in their community to instruct a person where to find training and help in securing employment. Often shelters are equipped to deal with the problems homeless individuals face when seeking employment, but before those services are of use, the homeless person must be made aware of them.

When comparing variables of length of time homeless, educational level, and race with models of health and illness, it was found that the range of the variables of length of time homeless and educational level were large in all 4 models; therefore, no discernible relationship existed between these variables. The one exception concerned the role-performance model in which there were 6 black subjects and 9 white subjects. In evaluating

the variable of race, no specific statement could be confirmed because of the small number of subjects in all categories.

Subjects with either eudiamonistic or adaptive definitions of health and illness showed the fewest self-care deficits. There were only 6 subjects that had health-deviation self-care deficits and it is notable that 5 of the 6 had either been treated for mental illness in the past or were currently taking medication for a mental illness. Finally, those individuals with clinical definitions of health and illness showed the greatest number of self-care deficits.

Knowing that those with a history of mental illness showed the greatest number of health-deviation self-care deficits should suggest to nurses that these individuals should receive special follow-up and referral if they present to a clinic for care. If at all possible, all homeless mentally ill persons should have a case worker; however, financial constraints often prevent this or the case workers may have too many clients to follow them well. This is one area where nurses should use whatever influence they have in the community to implement change. Without enough case workers to provide close follow-up of the homeless mentally ill, these clients frequently receive inadequate medical attention, since their illness tends to lead to poor health seeking behaviors. If a mentally ill homeless person is given a prescription or future appointments, the help of shelter staff should be enlisted, if at all possible, to help assure that the medical regime is completed. Further, it should be known that the the mentally ill homeless are at special risk of hazards to human life. One of the participants in this study who had a history of mental illness received a monthly check which he cashed at a bank the first of each month. If he went without the company of shelter staff to cash his check, he was usually robbed within a few blocks of the bank or conned out of his money by others who knew about his illness. Additionally, mentally ill persons are at special risk of having their medications taken from them by other shelter residents. Therefore, it would be

ideal if their medication could be stored by the shelter in a safe place and dispensed to them as needed. If this is impossible, clinics should provide only a few days medication at a time and have the individuals return to the clinic for more medication.

There appeared to be little association between definition of health and illness and self-care practices used by the participants. The most commonly used self-care practices included sufficient intake of fluids and foods, balance between activity and rest, and prevention of hazards to human life. The only association appeared to be that those individuals with clinical definitions of health and illness were also concerned with such self-care practices as providing for hygiene and the desire to be normal.

ADDITIONAL CONCLUSIONS AND IMPLICATIONS

Most health professionals realize that individuals seek care when they believe themselves to be sick. However, in the homeless population many things can prevent an individual from seeking care. Examples of deterrents to care found in this study include lack of a fixed address which is required to receive Medicaid, lack of financial ability to pay, and a role-performance conceptualization of health and illness that causes a delay in seeking care until the person is no longer able to perform their daily activities.

When providing care to a homeless individual with acute or chronic illness, it is important to have a good understanding of where the person is staying and what resources are available to the person before treatment is rendered. If a person is sent home to elevate a swollen ankle and put ice on it, the care provider must first know that this is a practical option. Or if insulin is prescribed for a newly diagnosed diabetic, it is important to know if they have a place to store their insulin and syringes. Treatment plans must be individualized for the situations of each client. Medications need to be given to the client at the clinic, if the person

does not have Medicaid, and in small enough quantities to permit the clinic to replace them if they are lost or stolen. Prescribing a medication is pointless if the client cannot afford to buy it. In summary, special attention needs to be given to an individual's ability to follow a treatment plan.

SUGGESTIONS FOR FUTURE RESEARCH

Replication of this research on a larger scale within a clinic setting where homeless individuals are served would better identify health seeking behaviors of the homeless population. Further, during an illness is a better time to evaluate health-deviation self-care requisites than in retrospect. Future research should also include women and children.

Development of an instrument for measuring self-care deficits would be useful for future research. The instrument should be on a Likert type scale using Orem's self-care theory as a basis. Such a tool would provide a means to do analytical research, which is a deficient area in research involving the homeless population. Further, funding from community agencies is often easier to obtain if quantitative data is available.

Finally, research addressing the differences in self-care practices of portions of the homeless who use available resources, such as, shelters and clinics, and that portion of the homeless population that chooses not to use available resources needs to be undertaken. It would be useful to know how to address the health care needs of the homeless who choose not to use shelters or clinics.

CONCLUSION

The study's findings and the identification of some of its implications have been reviewed in this chapter. The findings suggest that the definitions of health and illness do have

commonalities and that these can be usefully situated through the use of Smith's 4 models for definitions of health and illness. In terms of her model, the majority of respondents had role-performance definitions of health and illness. The holding of this model was positively related with self-care deficits. Respondents who had adaptive or eudaimonistic models of health and illness were less likely to suffer from self-care deficits. Identification of deficits in self-care was made possible through the use of Orem's models for self-care. However, for the most part, with the exception of the relationship between a role-performance model of health and illness and certain self-care deficits, there were few associations between definitions of health and illness and self-care practices.

The study shows that further research in the area of definitions of health and illness and self-care practices may be needed. Moreover, the study has implications for nursing practice. In particular, the study indicates that health care providers should be aware of and seek to minimize their ethnocentric biases. In addition, an awareness of the definitions of health and illness that the homeless are likely to have should enable health care providers to have a better opportunity of devising programs of self-care education that have a reasonable chance of securing the compliance of the clients for whom these programs are devised.

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APPENDICES

APPENDIX A

Demographic Questions

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APPENDIX B

Informed Consent Statement

You are invited to be part of a research study for a master's thesis in nursing about health and sickness in people who do not have a home right now. You will be asked questions about being well and sick. The interview will be tape recorded. If for any reason you want me to turn the recorder off, I will be glad to do so. It will help us to understand the needs for health care of those without homes. The questions will take about 30 minutes.

Nothing bad should result from your answering the questions. Your answers will help us understand your needs better. There are no benefits other than the knowledge you may have helped other people.

The tape of the questions and answers and the information that is written down will not have your name on it. A typed copy will be made in one month and the tape will be erased. The answers are private and no one else will listen to your tape. Faculty who are working with me will not ever know your name.

Answering the questions is voluntary and you may quit at any time. If you decide not to answer the questions it is alright.

If you have any questions feel free to contact the researcher listed below.

Thank you,

Roberta Proffitt, R.N.
1200 Volunteer Blvd.
Knoxville, TN 37996
(615) 974-4049

I understand the above statement. I freely agree to take part in this research under the above conditions.

Signed_____

Date_____

APPENDIX C

Interview Protocol

Introduction:

I'm glad you agreed to answer some questions for me for the research study.

Remember that if for any reason you want me to turn the recorder off, I will be glad to do so.

If you have any questions to ask me, we can do that after our 30 minute time limit.

I would like to assure you again that no one but you and I will know what you said.

Your name will not be on the tape. I will only have a number on it and will type it within one month of the recording, then I will erase the tape.

Do you have any questions about what I have either the research or the interview?

Question: Why did you choose me?

Answer: You are a homeless man in the age group I am studying.

Question: I'm not sure I want to be recorded.

Answer: If you find that the recorder makes you uncomfortable, tell me and I will be glad to turn it off.

Questions: What if I decide I want to quit in the middle of the interview?

Answer: You can quit at any time you want to. I will understand.

Question: Do I get anything for doing this?

Answer: You will have helped to improve the understanding of the health care needs of the homeless.

Interview question # 1

If you are ready we will begin. (Turn on tape recorder). Knowing that people have different ideas about being sick what do you think of when you think of yourself and other people as being sick or ill?

I expect a lot of different answers, but the biggest problem might be if the person says , "I don't understand". I will respond by saying, "Think of a time when you thought of yourself or someone else as unhealthy and tell me what it meant to you". If I get no response I will ask if he understands the question. If he does not, I will ask him to tell me about a time when he considered himself the sickest he has ever been.

Interview question # 2

When you think of yourself and other people being healthy, what do you think?

Again I expect a wide variety of answers and some of the same problems. I will use the same type of responses to get at what I want to know. One further problem that might arise is that he may get off the subject or continue to talk about illnesses. If this occurs, I will tell him that I have several more question to ask, but we can talk more about this after we have finished taping.

Interview question #3

Tell me what you do regularly to keep yourself from getting sick?

Some people may simply answer that they do not do anything to this question. If this happens, I will prompt them by giving an example like, "What kinds of things do you do to

keep Blue (the shelters pet dog) from getting sick? If they respond, then I will ask them to tell me some similar things they do to stay healthy. The questions will vary depending on the answers they give.

Interview question #4

Where did you learn these self care practices?

He may not understand what I mean. If not, I will say, "Who taught you the things you should do to stay healthy and the things you should do if you are sick?"

Interview question #5

Do you think these practices help to keep you healthy?

This will probably get a yes, no or I don't know. This is acceptable.

Interview question #6

Tell me about a time when you were sick and how you cared for yourself. Where did you go for help?

This is a request that may lead to a long answer. If I am not getting the information I need, I will be a little more specific. For example, when you were last sick did you have any home remedies that you found useful?

Interview question #7

If for some reason you couldn't take care of yourself, say you were too sick, who would you go to for help?

I might expect the person to say I don't know. I will prompt them by saying would you go to a friend, a family member, the shelter, or a clinic if you felt like you needed help because you were too sick to take care of yourself?

Interview question #8

Where do you go when you want to be alone?

The person might say they don't like to be alone. I would ask if they ever find themselves alone and if he says yes I will ask where that usually happens.

Interview question #9

When you are with other people what kinds of things do you do?

I expect a wide range of answers. Some serious and some not, but it will give a feel for social activities.

Conclusion

These are the all the questions I have to ask you. I would like to thank you for you participation. Do you have anything you would like to talk to me about?

VITA

Roberta Ann Proffitt was born in Knoxville, Tennessee on May 23, 1962. She attended elementary school in Knoxville and graduated from Norris High School in May, 1980. A Bachelor of Arts in Psychology was received in March, 1986 from the University of Tennessee. In June, 1987 she reentered the University of Tennessee and in May, 1991 received a Master of Science degree in Nursing.

She is presently employed as a Nurse Practitioner with the United States Public Health Service, at St. Elizabeth's Hospital in Washington, D.C.