Published in final edited form as:

Gender Issues. 2008 September 1; 25(3): 173–192. doi:10.1007/s12147-008-9057-5.

Subjective versus Objective Definitions of Homelessness: Are there Differences in Risk Factors among Heavy-Drinking Women?

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Abstract

Investigations with homeless populations have focused on those living on the streets or in shelters; few have examined phenomena based on respondents' self-definitions as homeless or not. This investigation examined similarities and differences among risk factors (including mental health, substance abuse, religion/spirituality, social support, and risky sexual behaviors) using two definitions of homelessness: one where place of residence defined individuals as homeless (the 'objective', or traditional, definition) and another where respondents defined themselves as homeless (the 'subjective' definition). Data come from the baseline survey of the NIAAA-funded "Sister-to-Sister" study (n=339) of heavy-drinking women. Subjectively-defined homelessness was associated with higher rates of mental health and substance use disorders, lower rates of condom use, higher rates of trading sex for food, and less social support. Objectively-defined homelessness was associated with higher rates of drinking in abandoned buildings, on the streets, and in public restrooms, more new sexual partners, and higher rates of trading sex for heroin and speedballs. Investigations failing to ask for subjective information may misattribute some factors to homelessness which may overestimate the effect of various factors on homelessness. Investigators should ask respondents to define their homelessness, or they lose an important dimension of the concept of homelessness.

Keywords

homelessness; women; alcohol; substance use; risky behaviors; methods

INTRODUCTION

According to the Merriam-Webster dictionary (2003), homelessness refers to "having no home or permanent place of residence." The misleadingly simple concept is challenging to operationalize. Many policies and social service programs define homelessness using the definition outlined in the "McKinney Act"—originally passed in 1983 and renamed to the Stewart B. McKinney Homeless Assistance Act in 1987. The McKinney Act defines a homeless person as: "(1) an individual who lacks a fixed, regular, and adequate nighttime

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residence and (2) an individual who has a primary nighttime residence that is (a) a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (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” (P.L. 100–77, sec 103(2)(1), 101 stat. 485).

Most commonly in the scientific literature homelessness is defined by either a request for (Cowan et al., 2002) or a stay at (Coll et al., 1998; Nyamathi et al., 2003) an overnight shelter. However, one night in a shelter may not be sufficient to classify someone as homeless, so this definition would capture only a segment of the homeless population.

Literal homelessness expands this definition by including individuals sleeping on the streets, in cars, abandoned buildings, tunnels, bus stations, parks, and similar places (Calsyn et al., 2005; North et al., 2004; Susser et al., 1997). Definitions of literal homelessness vary in duration by nights, weeks, or years. Rates based on literal homelessness are generally higher than those based on shelter stays alone because they are more likely to include those who have been homeless for longer periods of time.

Investigators sometimes use an even broader definition of homelessness, including individuals who are *marginally housed* (Link et al., 1995), which refers to individuals living in transitional living programs, living with relatives or friends (i.e., “doubled-up”), and living in cheap hotels and motels, or single room occupancy units (SROs). Others disagree and argue that individuals who are doubling-up or are renting rooms in hotels, motels, or SROs are not yet homeless because they currently have a place to stay even though they may be on the cusp of homelessness.

Only a few studies have taken the respondents' own perspectives of homelessness into account, counting someone as homeless if he/she self-identifies as experiencing homelessness. For instance, Link and colleagues (1995) classified respondents as being homeless if they ever considered themselves homeless. However, many individuals, especially in the beginning months of homelessness, do not identify themselves as homeless (Snow & Anderson, 1987). If investigators require individuals to subjectively rate themselves, a bias could result because these individuals may not be ready to “subjectively” label themselves as homeless. Interestingly, Herman and colleagues (1998) used a hybrid definition of homelessness, classifying individuals as homeless if they both considered themselves homeless *and* spent at least one night in a shelter or nonsleeping space because they had nowhere else to go.

The purpose of this investigation was to explore how differing definitions of homelessness are associated with various factors. To our knowledge, no one has examined this particular issue. We had the opportunity to explore definitions of homelessness with data from a study that was not focused on homelessness, in which respondents were not biased towards stating they were homeless.

METHODS

This investigation used baseline data from the NIAAA-funded “Sister to Sister” study, which tested a peer-delivered intervention based on holistic health concepts adapted from Cottler and colleagues' work (Cottler et al., 1998). For this study, which was aimed at reducing high risk HIV behaviors among heavy drinking women, eligibility criteria included (1) being female and over the age of 18, (2) reporting sexual activity in the past four months, (3) reporting problem use of alcohol (AUDIT score of 4+), (4) being drug negative for cocaine, heroin, and amphetamines, and (5) living in the St. Louis Area. This was one of the first community-based NIH NIAAA-funded HIV intervention studies.

Recruitment—Each area of St. Louis was mapped and coded for documentation of outreach efforts. Outreach personnel were assigned to recruit in these different geographic locations each day. Women were systematically approached in these geographic locations in grocery stores, laundromats, bus stops, and beauty salons and on the streets. Staff introduced themselves and the study and administered a five-item questionnaire to assess eligibility. Women were also asked to recruit friends from the same geographic locations. Referrals were also made to the study from the St. Louis City Female Drug Court. Women who met the eligibility criteria were given an identification code, indicating their recruitment source, and voucher and asked to call one of the study's two storefront offices within 30 days for further screening with the Alcohol Use Disorders Identification Test (AUDIT; Bohn et al., 1995). Those who scored a 4 or higher were invited to make an appointment to come to one of the study's storefront clinics, complete an informed consent, and provide a urine sample. Women with drug-negative urines were eligible to participate in the “Sister to Sister” study.

During the field period, 5,551 women were approached by study personnel; 2,272 women reported being at least 18 years old, sexually active in the prior 4 months, and using alcohol but not drugs in the past 30 days. Fifty-five percent of these women (n=1,012) later called for more information or came immediately to the office for an AUDIT; 98% (n=990) scored 4+ and were asked to make an appointment to participate in the study. Of these 990 women, 339 AUDIT+ women came to the site, consented to urine screens, were negative for drugs, were eligible for the study, and completed the baseline interviews. Because one of the aims of the study was to understand how feasible it was to use street-based methods for heavy drinking women, extensive baseline tracking of women was not allowed. Based on the minimal demographics women provided at the time of contact, it was determined that no significant differences were found between the women who enrolled and those who did not, other than transportation and other enrollment barriers.

Interview Protocol—Interviewers underwent two weeks of training and were permitted to conduct interviews only after becoming certified by the quality control manager. Ongoing quality control was conducted throughout the study for every interviewer via reviews of audiotaped interviews.

Baseline interviews for this study were conducted between May 2000 and September 2003. The baseline assessment was completed in two sessions. During the first session, a partial version of the Substance Abuse Module (SAM; Cottler, 2003; Horton et al., 2000) and the Washington University Risk Behavior Assessment for Women (RBA; Needle & Coyle, 1997) were administered. The SAM assesses lifetime and current patterns of substance use, abuse, and dependence (alcohol, amphetamines, cannabis, club drugs, cocaine, hallucinogens, inhalants, nicotine, opioids, PCP, and sedatives). These patterns are mapped to diagnostic criteria outlined in the DSM-III, DSM-III-R, DSM-IV, and ICD-10. The SAM has undergone psychometric testing in the United States and in other countries (Cottler et al., 1995). The RBA, originally developed by NIDA for use in its Cooperative Agreement Study in the 1990s, assesses lifetime and recent sexual activity and use of protection against HIV and other sexually transmitted diseases. The original version underwent extensive psychometric testing (Dowling-Guyer et al., 1994; Needle et al., 1995; Weatherby et al., 1994). It was modified to be more relevant to women and to cover additional risk and protective behaviors such as perceptions and attitudes towards sex, nutritional risk factors, medical illnesses, insurance status, recent use of health care services, and treatment history.

Two weeks later, in the second session, several sections of the Diagnostic Interview Schedule Version IV (DIS; Robins et al., 1997) were administered to assess DSM-IV depression, conduct disorder, antisocial personality disorder, post-traumatic stress disorder, and pathological gambling. The DIS assesses lifetime and current patterns of psychiatric symptoms and has been

used widely in psychiatric research since its creation in 1980. It, too, has undergone psychometric testing (Horton et al., 2000; Robins et al., 1997). Participants received \$10 remuneration for each of the two baseline interviews.

Variables

Residential Status—Residential status was defined in two ways: the self (or 'subjective') definition and the traditional (or 'objective') definition.

'Subjective' Self Definition: Women who responded affirmatively to the question, "Do you consider yourself to be homeless?" were classified as homeless (n=84; 25%). Those who responded negatively were classified as not homeless (n=255; 75%).

'Objective' Traditional Definition: Women were also asked, "Where are you living or staying now?" Response categories were provided, including living on the streets or in a shelter. Women who reported staying on the streets or in a shelter were classified as literally homeless (n=31; 9%). Those who reported staying in a rooming/boarding house or halfway house or in someone else's apartment were classified as marginally housed (n=156; 46%). Those who reported staying in their own house or apartment were classified as not homeless (n=152; 45%).

Other Variables—Other demographic variables included age (a continuous variable), level of education (dichotomized into graduated from high school or attained a general equivalency diploma (GED) versus not), and race (dichotomized into Caucasian vs. of color). Level of education was dichotomized because a high school diploma or GED is a minimal requirement for many jobs. Race was dichotomized because three-quarters of the sample identified as African American, 21% identified as Caucasian, and 4% identified as other.

Psychiatric diagnostic variables included DSM-IV lifetime major depression, PTSD, adult antisocial behaviors, ASPD, and individual substance abuse/dependence disorders (alcohol, cannabis, amphetamine, sedative, cocaine, opioid, PCP, hallucinogen, and club drug). Substance use diagnoses were not calculated for women who never used because substance abuse and dependence are conditional on the substances used. Disorders were coded as met criteria vs. did not meet criteria, without exclusions. Abuse and dependence for each substance were combined for these analyses.

Religiosity/spirituality and social support were assessed by asking how often women attended religious services in the past 12 months, how important religion/spirituality is to them, and if they sought help from a traditional religious figure (i.e., "priest, minister, rabbi, or other member of the religious community") or from a nontraditional spiritual figure (i.e., "prophet, psychic, spiritual adviser, palmist, or tarot card reader"). Regarding other social support, women were asked if they had someone they could talk to about things that were important, to count on for understanding and advice, and to rely on for practical things. They were also asked how satisfied they were with this support. Because satisfaction with support is conditional on having support, women reporting no support were omitted from the analyses for the satisfaction variable.

Sexual risk-taking in the past four months was characterized by assessing the number of sexual partners, the number of new sexual partners, the gender of sexual partners, the number of IDU partners, the number of times respondents had vaginal, oral, and anal sex, and the percent of time it was protected by condoms. Sex trading in the past four months for alcohol/drugs, money, food, a place to stay, or clothing was assessed. During the initial screening, all women reported having sex in the past four months (which was a study inclusion criterion). However, a small number of women (n=48) reported not having sex in the past four months at the time of the interview; this scenario is plausible because some women were interviewed 30 days after their

initial screening. These women were coded zero for these sex questions. Additionally, because condom use is conditional on sexual activity, the percent of time sex was protected by condoms was calculated only for those reporting sexual activity. The number of days in the past month women spent drinking at a bar, in an abandoned building, on the streets, or in a public restroom were also elicited. Women who reported not drinking in any of these locations were coded zero.

Data Analysis

Data were analyzed using SAS 9.1 (SAS Institute, Inc., 1999). Descriptive data are summarized with percentage rates and means with standard deviations. Chi-square and Fisher's Exact tests were performed with categorical variables; t-tests and ANOVAs were used for continuous variables. McNemar's test for correlated proportions was used to compare respondents' subjective classification (as homeless vs. not homeless) with the objective classification (as literally homeless, marginally housed, or not homeless); this test was selected because the two variables (subjective and objective) were not independent (Everitt, 1992). Because multiple tests were run, the p-value for statistical significance was set at .01.

RESULTS

Respondent Classification vs. Traditional Classification as Homeless

To understand the overlap in classification status, we compared women who classified themselves as homeless with those who were classified as homeless by the traditional definition. As shown in Table 1, there was not a perfect agreement between the subjective and objective definitions of homelessness. Among the 31 persons who were objectively classified as literally homeless, 90% considered themselves homeless; only three respondents who were living in shelters or on the streets did not consider themselves homeless. Every respondent who was objectively defined as not homeless subjectively defined themselves as not homeless (i.e., perfect agreement). However, of those objectively classified as marginally housed, only 36% considered themselves to be homeless.

Sample Demographics

Over half (53%) of the sample had at least a high school education or GED. Seventy-nine percent of the sample identified as being of color. The average age was 31.95 ± 10.07 years. Almost three quarters (73%) of the sample had children. The personal incomes of these women were quite low, with 44% of the sample earning under \$3,999 and 87% earning under \$15,000 in the past 12 months.

Demographics are presented in Table 2 by definitions of homelessness. Those who labeled themselves as homeless were older than those who did not. No other significant differences were detected between the groups.

Psychiatric Diagnostics

Rates of psychiatric disorders by definitions of homelessness are presented in Table 3. Regardless of subjective or objective definition, rates of adult antisocial behaviors were higher among the homeless (and the marginally housed). Women who subjectively classified themselves as homeless were more likely to meet criteria for ASPD and PTSD than those who subjectively classified themselves as housed.

Rates of cocaine and opioid abuse/dependence were higher among the homeless regardless of subjective or objective definitions. Those who subjectively defined themselves as homeless had higher rates of alcohol and sedative abuse/dependence than those who defined themselves

as housed. Drinking in abandoned buildings, on the streets, and in public restrooms were reported more often by persons who were objectively defined as literally homeless.

Religion/Spirituality

No differences in religious/spiritual variables were detected by either subjective or objective definitions of homelessness (Table 4).

Social Support

Those who subjectively defined themselves as homeless had less social support in the form of having someone provide them with advice and understanding compared to those who did not define themselves as homeless, although both groups had considerably high rates of support. They also reported a lower rate of satisfaction with their social support. No differences were detected using the objective definition of homelessness.

Risky Sexual Behaviors

Regardless of subjective or objective definition, rates of ever trading sex for alcohol/drugs, money, and a place to stay were higher among the homeless (Table 5). Similarly, regardless of definition, rates of trading sex for alcohol and cocaine in the past four months were higher among the homeless. Women who considered themselves homeless also were less likely than those who did not consider themselves homeless to report always using a condom; they also reported higher rates of ever trading sex for a basic necessity of life—food. Literal homelessness was associated with more new sexual partners and higher rates of trading sex for heroin and speedballs in the past four months than the marginally housed and not homeless groups.

Additional Investigation

As previously noted, the key classification disagreement (subjective vs. objective) occurred among the marginally housed. Further analysis (Table 6) determined that the marginally housed who were staying in someone else's home were less likely than the marginally housed who were staying in a rooming/boarding home or halfway house to consider themselves homeless (33% vs. 59%). Because we thought this deserved further exploration, we examined differences between those staying in someone else's home and those staying in a rooming/boarding home or halfway house on all demographic, mental health and substance use, religion/spirituality and social support, and risky sexual behavior variables. Only 17 respondents reported staying in a rooming/boarding home or halfway house; therefore, we altered our threshold for statistical significance to $p \leq .05$ when examining the marginally housed subgroups to decrease the chance of making Type II errors.

We detected differences on seven variables (Table 7). Those staying in a rooming/boarding home or halfway house were older than those staying in someone else's home. Additionally, those staying in someone else's home were more likely than all other groups to identify as being of color. They were also more similar to the literally homeless than to the not homeless for adult antisocial behaviors; however, they were more similar to the not homeless than to the literally homeless on three variables: presence of cocaine use disorder, ever trading sex for alcohol/drugs, and trading sex for cocaine in the past four months. Women staying in a rooming/boarding home or halfway house were more similar to the literally homeless than to the not homeless on all variables: presence of major depression, adult antisocial behaviors, and cocaine use disorder as well as ever trading sex for alcohol/drugs and trading sex for cocaine in the past four months.

DISCUSSION

The purpose of this investigation was to examine differences in characteristics of persons defined as homeless either by themselves or based on traditional methods. Both the objective and subjective definitions captured differences in several risk factors. The homeless by both definitions had higher rates of adult antisocial behaviors, cocaine and opioid abuse/dependence, ever trading sex, and trading sex for alcohol and cocaine in the past four months. Thus, for these variables, it does not appear to matter which definition of homelessness investigators use in their studies.

The objective definition of homelessness captured some risk factors that were undetected using the subjective definition. This definition detected “undersirable behaviors,” among the literally homeless for drinking more in abandoned buildings, on the streets, and in public restrooms. This definition also detected higher numbers of new sexual partners and higher rates of trading sex for heroin and speedballs in the past four months among the homeless, indicating that investigators should continue using the objective method of defining homelessness when studying these risk factors.

The subjective definition of homelessness provided additional value; it captured some risk factors that were undetected using the objective definition. Specifically, those who thought they were homeless reported higher rates of psychiatric disorders (ASPD, PTSD, and alcohol and sedative abuse/dependence) than those who did not. Investigators should consider adding this one question of homelessness to their studies to avoid the risk of underestimating these conditions. Social support was also underreported when women self disclosed their homelessness. Because both social support and self defined homelessness are *perceived concepts*, it makes sense that they would be associated. Investigators studying social support should consider adding this definition to their studies as well. In general, increased rates of risky sexual behaviors were not found with the use of the subjective definition of homelessness. The self-defined homeless reported lower rates of always using condoms and higher rates of ever trading sex for food.

It was surprising that a majority (64%) of women whom we classified as marginally housed classified themselves as housed. This is an area that has received little scientific attention (an exception is Link and colleagues (1995)). Should people who are living with others because they have nowhere else to stay be considered homeless? Should people who are living in single room occupancies, cheap hotels/motels, or in halfway houses be considered homeless? In this investigation, for mental health diagnoses, the marginally housed were more similar to the literally homeless than to the not homeless. However, they were more similar to the not homeless than to the literally homeless for location of drinking, substance use diagnoses, and risky sexual behaviors (number of sexual partners and trading sex). When the marginally housed group was broken into subgroups—those staying in someone else's home and those staying in rooming/boarding homes or halfway houses—very few differences emerged. Women staying in rooming/boarding homes or halfway houses were more similar to the literally homeless than to the not homeless. The data on women staying in someone else's apartment or home were more complicated—sometimes more similar to the literally homeless, sometimes more similar to the not homeless, and sometimes in between the two groups.

At first glance these data suggest that, in general, the marginally housed should not be considered a homeless group. Those studying mental health disorders, however, should consider including them. More than one-third of the marginally housed considered themselves homeless, and the self-defined homeless reported higher rates of psychiatric diagnoses and less social support than the self-defined not homeless. Because these two categories of factors are commonly hypothesized (both implicitly and explicitly) to be critical elements in the entry

into, maintenance of, and exit from the homeless condition (Calsyn et al., 2005; Herman et al., 1998; North et al., 2004; Nyamathi et al., 2003; Susser et al., 1997), investigators studying these elements should consider including the marginally housed as a homeless group as well. The next question is whether the marginally housed group should be subdivided. Although we had fairly little power (with only 17 participants in one subgroup), we suspect not. Too few differences emerged to warrant such bifurcation. Future studies could separate those who live in a halfway house from those who live in a rooming/boarding home, which could yield greater clarity on this issue.

Regardless of the reasons for the differences in self-perception, people who choose to consider themselves as homeless are different, in some ways, from those who do not choose this. When investigators classify individuals by where they live, they capture one dimension of the homeless condition. However, those studying psychiatric disorders and social support may be inadvertently misclassifying people and creating bias. Because most investigations to date have relied on objective measures of homelessness (number of nights on the streets or in shelters), investigators should continue to do so to compare results across studies in different cities. However, our data indicate that considerable data about psychiatric diagnoses and social support are lost without the additional question about perceived homelessness. In fact, over one-third (36%) of the women we classified as marginally housed with the traditional definition (whom are almost always omitted from homelessness studies) classified themselves as homeless.

Use of a subjective definition of homelessness may also prove more valuable for service providers working with this population. Psychiatrists, social workers, and other direct-service professionals may place more weight on clients' *perceptions* of their living arrangements than on the technicalities of their living arrangements. Thus, including this aspect of homeless self-definition in scientific investigations might extend more applicability to "real world practice."

Strengths and Limitations

Although the "Sister to Sister" study was not a study of homelessness and did not target homeless women, the investigators did ask the question, "Do you consider yourself to be homeless?" This question allowed us to examine results using two independent definitions of homelessness. Additionally, respondents had no reason to falsely report whether they were homeless or not; the interviews were not conducted by treatment providers who could assist them with accessing the shelter system or other services. Another strength of this study is that the women were recruited from the community (not from shelters or through service providers). These women are most likely underrepresented in the scientific literature in general.

The marginally housed group was not operationalized as precisely as was desirable. Regardless of who owned or leased the residence, women who considered themselves to be living in their own home were coded as such, and women who considered themselves to be living in someone else's home were coded accordingly. Thus, no explicit distinction could be made between the women who lived with others because they had nowhere else to stay (truly doubled-up) and the women who lived with others because they wanted to do so (e.g., caring for elders). However, even if one ignores the findings involving the marginally housed group (who are usually not included in homelessness studies), there are a substantial number of differences between those who were classified as literally homeless and not homeless.

The findings of this study should be generalized with some caution. The "Sister to Sister" study was conducted in one city, among a sample of women who were asked to report to a research site. Transportation barriers were real. Women were recruited because they were heavy drinkers and did not use cocaine, heroin, or amphetamines; results could be different for women who urine-test positive for drugs, for men, and for other populations. However, demographics

of the homeless women in this study are not unlike those of homeless women other studies (Kushel et al., 2003; Nyamathi et al., 1999, 2003; Surratt & Inciardi, 2004; Toohey et al., 2004).

Conclusions

Researchers conducting investigations with homeless individuals—especially those studying psychiatric disorders and social support—should consider including one simple question about self-disclosed homelessness in addition to the usual questions on housing status. The addition of one question could provide investigators with more useful information about the histories of individuals who live in unstable conditions. Such data could be useful for assessment, identification, and treatment of the homeless condition.

Acknowledgments

Research supported by NIAAA, Grant #AA12111.

The authors would like to thank Dr. Nick Garg for assistance with the conceptualization of this manuscript and Ms. Susan Bradford for assistance with the data analysis.

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Table 1

Residential Classification

`Subjective' Self Definition of Homelessness	`Objective' Traditional Definition of Homeless					
	Literally Homeless (n=31)		Marginally Housed (n=156)		Not Homeless (n=152)	
	n	%	n	%	n	%
Homeless (n=84)	28	90%	56	36%	0	0%
Not Homeless (n=255)	3	10%	100	64%	152	100%

(McNemar=179.20, df=1, p<.0001)

Table 2

Demographics

	`Subjective' Self Definition			`Objective' Traditional Definition					
Item	Homeless (A)	Not Homeless (B)	p-value	Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value	p-value	
			A vs. B				C vs. D	C vs. E	D vs. E
N	84	255	ns	31	156	152	ns	ns	
Age	34.40±9.27 ^B	31.14±10.20 ^A	p=.0098	34.32±8.70	31.23±10.42	32.20±9.92	ns	ns	
% Nonwhite	83	77	ns	67	83	76	ns	ns	
% HS Grad	50	57	ns	42	50	64	ns	ns	
% with Children	83	69	ns	77	76	69	ns	ns	
# Children	3.47±2.50	2.94±1.89	ns	3.58±3.20	2.93±2.00	3.15±1.87	ns	ns	
# Days Living at Current Place	650.30±2072.13	937.87±1798.84	ns	60.29±135.58	1057.06±2287.87	835.60±1513.01	ns	ns	

Table 3

Mental Health and Substance Use

		`Subjective' Self Definition			`Objective' Traditional Definition				
Item		Homeless (A)	Not Homeless (B)	p-value	Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value	p-value
				A vs. B				C vs. D	C vs. E
% with DSM IV:									
Depression		52	39	ns	48	18	43	ns	ns
SPD		27 ^B	12 ^A	p=.0006	29	17	11	ns	ns
Adult Antisocial Behaviors		92 ^B	71 ^A	p<.0001	90 ^E	83 ^E	66 ^{C,D}	ns	p=.0004
PTSD		35 ^B	20 ^A	p=.0072	35	22	23	ns	ns
Of those using the substance, % with:									
Alcohol Abuse/Dependence		89 ^B	74 ^A	p=.0037	87	79	75	ns	ns
Cannabis Abuse/Dependence		36	31	ns	39	33	30	ns	ns
Amphetamine Abuse/Dependence		8	9	ns	13	6	11	ns	ns
Medative Abuse/Dependence		14 ^B	4 ^A	p=.0016	19	6	5	ns	ns
Cocaine Abuse/Dependence		48 ^B	2 ^A	p=.0003	61 ^{D,E}	31 ^C	26 ^C	p=.0005	ns
Opioid Abuse/Dependence		18 ^B	6 ^A	p=.0014	29 ^{D,E}	6 ^C	8 ^C	p=.0003	ns
BCP Abuse/Dependence		8	4	ns	3	7	3	ns	ns
Hallucinogen Abuse/Dependence		1	6	ns	3	3	7	ns	ns
Club Drug Abuse/Dependence		1	3	ns	3	1	4	ns	ns
Mostly Drinks with:									
Partner		34	29	ns	27	34	26	ns	ns
Relative/Friend		35	47	ns	42	42	47	ns	ns
Stranger/Acquaintance		3	4	ns	9	3	4	ns	ns
Alone		20	19	ns	14	18	22	ns	ns
In Past Month:									
% Drank at Bar		30	40	ns	23	33	45	ns	ns
# Days Drank at Bar		1.94±5.73 ^B	2.23±4.84 ^A	ns	0.64±1.43	2.07±5.31	2.49±5.10	ns	ns
% Drank in Abandoned Building		4	<1	ns	9 ^{D,E}	1 ^C	1 ^C	p=.0020	ns

			'Subjective' Self Definition			'Objective' Traditional Definition				
Item	Homeless (A)	Not Homeless (B)	p-value A vs. B	Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value C vs. D	p-value C vs. E	p-value D vs. E	
# Days Drank in Abandoned Building	0.15±0.79	0.01±0.19	ns	0.41±1.33 ^{D,E}	0.03±0.30 ^C	0.00±0.00 ^C	P<.0001	p=<.0001	ns	
% Drank on Streets	28	20	ns	32 ^E	28 ^E	14 ^{C,D}	ns	p=.0058	p=.0058	
# Days Drank on Streets	1.96±5.12 ^B	1.33±4.26 ^A	ns	4.27±8.41 ^E	1.93±4.97	0.59±2.44 ^C	ns	p=.0003	ns	
% Drank in Public Restroom	7	2	ns	9	3	2	ns	ns	ns	
# Days Drank in Public Restroom	0.24±1.19	0.05±0.40	ns	0.64±2.08 ^{D,E}	0.03±0.22 ^C	0.07±0.48 ^C	p=.0003	p=.0003	ns	

Table 4

Religion/Spirituality & Social Support

	`Subjective' Self Definition				`Objective' Traditional Definition				
Item	Homeless (A)	Not Homeless (B)	p-value		Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value	
			A vs. B					C vs. D	C vs. E
% Attended Religious Services:									
Never	30	32	ns		23	31	34	ns	ns
Rarely	20	29	ns		32	27	26	ns	ns
1-2 times per month	26	23	ns		26	25	22	ns	ns
1+ times per week	24	16	ns		19	17	18	ns	ns
% Religion/Spirituality Important:									
Not at all	6	9	ns		6	8	9	ns	ns
Somewhat	17	26	ns		23	24	24	ns	ns
Very	77	65	ns		71	69	67	ns	ns
% with Someone to Tell about Important Things	87	91	ns		94	89	89	ns	ns
% with Someone who Provides Understanding & Advice	80 ^B	92 ^A	p=.0016		90	85	93	ns	ns
% with Someone to Rely on for Practical Things (Favors)	76	85	ns		77	84	84	ns	ns
% Satisfied with Current Support:									
% Very Satisfied	53 ^B	74 ^A	p=.0073		54	67	75	ns	ns
% Somewhat Satisfied	39 ^B	22 ^A	p=.0073		42	28	21	ns	ns
% Somewhat Dissatisfied	5	3	ns		0	4	4	ns	ns
% Very Dissatisfied	3	<1	ns		4	2	0	ns	ns
% Sought Help from Religious Community	36	25	ns		35	25	29	ns	ns
% Sought Help from Spiritual Person	7	14	ns		6	11	24	ns	ns

Table 5

Risky Sexual Behaviors

	'Subjective' Self Definition			'Objective' Traditional Definition					
Item	Homeless (A)	Not Homeless (B)	p-value	Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value	p-value	p-value
			A vs. B				C vs. D	C vs. E	D vs. E
% Consented to Sex First Time	77	77	ns	71	81	74			
In Past 4 Months:									
% Had Sex	86	90	ns	81	88	91	ns	ns	ns
% Always Used Condom	5 ^B	18 ^A	p=.0029	0	17	16	ns	ns	ns
# Sexual Partners	2.82±5.86	1.85±4.75	ns	3.84±8.29	2.26±6.21	1.56±1.76	ns	ns	ns
# New Sexual Partners	1.79±5.56	0.65±1.94	ns	3.21±8.23 ^{D,E}	0.83±2.65 ^C	0.58±1.39 ^C	p=.0005	p=.0005	ns
# Female Sexual Partners	0.17±0.41	0.09±0.33	ns	0.17±0.38	0.10±0.34	0.11±0.36	ns	ns	ns
# Male Sexual Partners	2.57±5.86	1.76±4.75	ns	3.45±8.27	2.16±6.22	1.45±1.74	ns	ns	ns
# Sex Partners who Probably Inject Drugs	0.65±4.51	0.22±1.94	ns	1.71±7.33	0.29±2.46	0.09±0.33	ns	ns	ns
# Times Vaginal Sex	37.4±68.83	30.01±67.77	ns	47.22±97.93	36.25±81.66	24.22±39.44	ns	ns	ns
% Times Used Male Condom during Vaginal Sex	28	40	ns	24	39	37	ns	ns	ns
# Times Performed Oral Sex	14.17±53.89	8.70±47.64	ns	30.74±87.50	10.51±59.28	5.56±16.28	ns	ns	ns
% Times Used Male Condom Performing Oral Sex	12	15	ns	4	19	13	ns	ns	ns
# Times Anal Sex	0.49±2.43	0.75±8.99	ns	1.22±3.95	1.10±11.51	0.17±0.83	ns	ns	ns
% Times Used Male Condom during Anal Sex	11	28	ns	14	18	32	ns	ns	ns
Ever Traded Sex:									
% for Alcohol/Drugs	36 ^B	17 ^A	p=.0003	55 ^{D,E}	22 ^C	14 ^C	p=.0002	p<.0001	ns
% for Money	48 ^B	24 ^A	p<.0001	58 ^{D,E}	31 ^C	22 ^C	p=.0047	p<.0001	ns

	'Subjective' Self Definition			'Objective' Traditional Definition					
Item	Homeless (A)	Not Homeless (B)	p-value A vs. B	Literally Homeless (C)	Marginally Housed (D)	Not Homeless (E)	p-value C vs. D	p-value C vs. E	p-value D vs. E
% for Food	20 ^B	8 ^A	p=.0016	19	12	9	ns	ns	ns
% for Place to Stay	19 ^B	8 ^A	p=.0038	29 ^E	12	6 ^C	ns	p<.0001	ns
% for Clothing	7	3	ns	10	3	4	ns	ns	ns
In the Past Four Months:									
# Times Traded Sex for Money, Food, Place to Stay, Clothing	13.67±68.51	1.76±12.55	ns	21.03±90.80	4.94±32.77	1.09±8.46	ns	ns	ns
# Times Traded Sex for Alcohol/Drugs	8.39±42.45	1.51±14.74	ns	6.35±20.61	5.49±35.20	0.24±1.74	ns	ns	ns
% Traded Sex for:									
Alcohol	9 ^B	1 ^A	p=.0017	20 ^{D,E}	3 ^C	1 ^C	p=.0012	p<.0001	ns
Cannabis	0	<1	ns	0	0	1	ns	ns	ns
Cocaine	16 ^B	5 ^A	p=.0020	25 ^E	9	4 ^C	ns	p=.0003	ns
Heroin	1	0	ns	5 ^{D,E}	0 ^C	0 ^C	p=.0089	p=.0086	ns
Speedball	1	0	ns	5 ^{D,E}	0 ^C	0 ^C	p=.0089	p=.0086	ns
Amphetamines	0	<1	ns	0	1	0	ns	ns	ns
Club Drugs	1	<1	ns	5	1	0	ns	ns	ns
Other Drugs	0	<1	ns	0	1	0	ns	ns	ns

Table 6

Breakdown of Marginally Housed Classification

	Where are you living or staying now?			
'Subjective' Self Definition of Homelessness	In Someone Else's Home (n=139)		In Rooming/Boarding Home or Hotel (n=17)	
	n	%	n	%
Homeless	46	33%	10	59%
Not Homeless	93	67%	7	41%

(McNemar=28.70, df=1, p<.001)

Table 7

Variables with Significant Differences between Marginally Housed Subgroups

	Literally Homeless (A)	Staying in Someone Else's Home (B)	Staying in Rooming/Boarding Home or Halfway House (C)	Not Homeless (D)	A vs B	A vs C	A vs D	B vs C	B vs D	C vs D
Demographics										
Age	34.32±8.70	30.40±10.18	38.06±10.46	32.20±9.92	ns	ns	ns	p=.0095	ns	ns
% Nonwhite	67	84	59	76	p=.0012	ns	ns	p=.0112	p=.0053	ns
Mental Health & Substance Use										
% with DSM IV Major Depression	48	36	71	43	ns	ns	ns	p=.0064	ns	p=.0307
% with Adult Antisocial Behaviors	90	80	100	66	ns	ns	p=.0067	p=.0448	p=.0054	p=.0038
Of those using cocaine, % with cocaine abuse/dependence	61	35	85	26	p<.0001	ns	p<.0001	p=.0005	ns	p=.0005
Risky Sexual Behaviors										
% Ever Traded Sex for Alcohol/Drugs	55	19	47	14	p<.0001	ns	p<.0001	p=.0075	ns	p=.0009
% Traded Sex for Cocaine in Past 4 Months	25	7	31	4	p=.0076	ns	p=.0003	p=.0034	ns	p<.0001