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## EARLY LIFE EXPERIENCES AND RESIDENTIAL STABILITY: A Ten-Year Perspective on Sheltered Care

Steven P. Segal, Ph.D., Alice M. Hines, M.S.W., Victor Florian, Ph.D.

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*The effects of early family losses and disruptions on the ability of seriously mentally disabled individuals to achieve stable living arrangements were investigated. Factors found to predict instability were early losses, early disruptions, psychological symptoms, and youth. Among factors found to predict stability were increased age and a diagnosis of schizophrenia.*

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The provision of adequate housing, while the sine qua non for the success of community care efforts for the seriously mentally disabled (SMD), has increasingly been recognized as only a first step in ensuring that individuals will and can make use of such facilities. Although placements are made in sheltered-care facilities, it is frequently observed that individuals choose not to remain in them. With the capacity to house over 400,000 SMD individuals in sheltered-care facilities and the increasing problem of homelessness, it is important to understand those factors that enable or inhibit the settlement and stabilization of individuals in these supported living arrangements.

This article considers the hypothesis that early developmental disruptions and losses have a long-term influence on an individual's ability to settle into sheltered-care environments. The literature on the homeless mentally ill has reported replicated findings that early disruption of the social network, particularly of family ties, may increase

later vulnerability to residential instability (Fischer & Breakey, 1991; Piliavin, Sosin, & Westerfelt, 1988; Sosin, Colson, & Grossman, 1988; Susser, Struening, & Conover, 1987). This is particularly true for young adults in foster care who are forced out of their placement when their state financial support expires at age 18 and thus become homeless. For an older population, it must be considered whether early loss and disruption have become part of the individual's behavioral pattern.

### REVIEW OF THE LITERATURE

Much of the contemporary literature on ego psychology, object relations theory, developmental psychology, and related disciplines emphasizes the importance of early caregiving relationships for cognitive and affective development, which shapes later interpersonal experiences and emotional well-being (Kernberg, 1975, 1976; Kohut, 1971; Mahler, Pine, & Bergman, 1975). It is generally accepted that loss of or prolonged separation from a parent during child-

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hood or adolescence has immediate and long-term consequences that are dramatic, intense, and complex (Krupnick & Solomon, 1988; Lerner & Lerner, 1988).

In reviewing this literature, however, it is important to distinguish between studies that examine the relationship between early life disturbances and later pathology and personality impairment from those that explore subsequent problems with social functioning and adjustment. Research in both areas has been weak. Regarding the former, numerous studies have investigated the association between early losses and the development of different types of emotional disturbances and psychopathologies (Crook & Elliott, 1980; Lloyd, 1980; Pfohl, Stangl, & Tsuang, 1983; Tennant, Bebbington, & Hurry, 1980). An extensive review of the literature indicates that parental absence has most frequently been linked with subsequent affective illness (Breier *et al.*, 1988; Kennard & Birtchnell, 1982; Richman & Flaherty, 1985; Roy, 1981, 1985), suicide (Dorpat, Jackson, & Ripley, 1965; Lester, 1989), sociopathy (F. Brown & Epps, 1966), alcoholism (Dennehy, 1966), other psychiatric disorders (Stastny, Perlick, Zeavin, Empfield, & Mayer, 1984), and the genesis of emotional problems (Sklar & Harris, 1985).

Since the present study focuses on the SMD, the long-term effects of early loss and disruption on social functioning and adjustment, especially the capacity to form and maintain relationships and a stable life-style, were of particular interest. The notion that early loss or disruption of relationships has serious long-term consequences for social functioning and adjustment is rooted in psychodynamic theory and observation (Freud, 1917/1957, 1940/1964) and attachment theory (Bowlby, 1969, 1980). In the 1940s, psychologists observed negative effects in children who had experienced impoverished maternal contact through institutionalization, war-related separations, or other traumatic losses. Studies showed that early disruptions in maternal care impaired personal-

ity development as well as social functioning and adjustment (Bowlby, 1940, 1944; Burlingham & A. Freud, 1942; Sptiz, 1945). Goldfarb's (1943, 1944, 1945) investigations of the immediate and long-term consequences of institutional child-rearing found deficits in intellectual and social development and highlighted problems in the development of relationships with caregivers and later disturbances in the ability to form relationships with peers. Studies in the 1950s and 1960s suggested an association between early loss and impairment in sexual identity, development of autonomy, and capacity for intimacy of adults (Archibald, Bell, Miller, & Tuddenham, 1962; D. Brown, 1958; Remus-Araico, 1965).

The study of early loss and separation pursues the core problem of human existence. Freud (1905/1953) suggested that anxiety in childhood is essentially a reaction to the loss of a person the child loved. Bowlby (1980) referred to James's (1890/1983) observation that "the greatest source of terror in infancy is solitude" (p. 1036). The "developmental interference" (Nagera, 1970, p. 362) caused by the loss of a primary caretaking relationship may be even more pronounced for the SMD, who are particularly vulnerable to emotional disturbance and have problems forming and maintaining interpersonal relationships (Kernberg, 1975, 1976; Sugarman & Jaffe, 1988). In an attempt to function more effectively, the SMD, especially those suffering from schizophrenic disorders, may create interpersonal and emotional distance between themselves and others, walling off any sense of human neediness and interaction (Blatt & Wild, 1976). This impairment in the ability to form attachments because of psychological disturbance may be exacerbated by loss or disruption early in life, which makes it even more difficult to establish lasting relationships and a stable life-style.

Some support for this assumption can be found in the study by Stastny, Perlick,

Zeavin, Empfield, and Mayer (1984), who found that the prevalence of early parental absence was twice as high for long-term hospitalized schizophrenic patients than for a sample of "successful" outpatients in the community. Parental absence before age 16 in preschizophrenic children appears to be associated with subsequent long-term hospitalization. Conversely, an uninterrupted marital bond in parents with schizophrenic offspring covaries with shorter hospitalizations and prolonged outpatient status. These authors suggest that patient status and dischargeability may be predetermined, in part, by the nature of the parental bond during the patient's childhood.

In light of this review, it seems reasonable to suggest that the long-term impact of early losses and disruptions may have repercussions on various life domains, particularly for people with diagnoses of chronic psychiatric disturbance. It is the authors' hypothesis that, irrespective of the quality of the facility and the nature of support available to people, early losses and disruption in the childhood of SMDs will have a significant effect on their ability to settle into and maintain a stable residential situation.

## METHOD

### *Sample*

The data used in this study were collected as part of a 12-year longitudinal study of mentally ill adults living in sheltered-care facilities in California in 1973. The sample included 393 individuals from 211 facilities located in 157 census tracts in California. Geographic areas and facilities were sampled with a probability in proportion to the size of their estimated bed capacities; systematic random sampling was used for residents within facilities. This probability sample was representative of all 12,430 sheltered-care residents aged 18–65 with a history of mental illness in the state of California. Sheltered-care facilities were defined as board and care, family care, halfway houses, and psychosocial rehabilitation facilities, as well as any other supported hous-

ing arrangement claiming to provide 24-hour supervision to the mentally disabled (Segal & Aviram, 1978).

Of the 393 residents who were interviewed in 1973, 360 (91.6%) were traced ten years later, 270 (68.7%) were found to be alive, and 253 (64%) consented to be reinterviewed; 19 (4.8% of the original sample) of the 253 interviews were deleted because the extreme disability of the participants made their response validity questionable. Thus, this article reports on data collected from the 234 sheltered-care residents (59.5% of the original sample) who completed valid interviews in both 1973 and 1983.

It should be noted that the 90 (22.9%) members of the original cohort who had died during the follow-up period did so at a rate 2.85 times higher than that of a comparable sample of the general population and 1.82 times higher than that of a comparable sample of poor people (Segal & Kotler, 1991). In addition, an analysis of possible sampling biases showed that there were no significant demographic differences between those who were located and those who were not. African Americans, however, were more likely to refuse to be interviewed ( $\chi^2 = 10.3$ ,  $p < .006$ ) or to be too ill to complete an interview ( $\chi^2 = 10.9$ ,  $p < .01$ ).

### *Measures*

*Residential stability.* Two measures of residential stability were used in the study. The first was the *number of times* a resident had been in sheltered care from 1973 through the follow-up interview. Information obtained as part of the general residential history of each respondent was used to construct this continuous variable; see Segal and Choi (1991) for further details on this measure. The dates of arrival at and departure from a new living arrangement were used to define residential "episodes." The initial residential episode for each subject was represented by the sheltered-care facility in which the respondent was interviewed in 1973. This episode terminated at

the time of departure from the 1973 facility or at the time of the follow-up interview for those residents who remained in the same facility. It was hypothesized that residents who had experienced the loss of a parent or surrogate parent, or the disruption of family life through divorce or growing up in a foster home, would have a greater number of sheltered-care episodes, denoting greater instability.

The second measure of residential stability addressed the issue of settling into a supervised living arrangement, that is, the total *number of days* spent in sheltered-care facilities from 1973 through the follow-up interview in 1983. This information was included as a continuous variable in the analysis. The total number of days in sheltered care was derived from the subject's residential history during the follow-up period. It was hypothesized that residents with early loss or disruption would have spent fewer days in sheltered care because of their inability to settle into a given environment for an extended period.

*Factors related to instability.* The purpose of this study was to determine which factors might be related to greater residential instability. A conceptual-theoretical framework was developed that included the probability that developmental factors, in the form of early family losses and disruptions, and the extent of psychological disability were primary contributors. The model also accounted for important control factors, including the amount of available social support and individual demographic characteristics, such as age and sex, that are most likely to be related to residential stability. An additional control factor was the quality of the facility, as rated by social work interviewers. It was believed that a person could not be expected to remain in a facility if the quality of the environment was poor.

To measure *developmental factors*, early developmental history was gathered by asking residents whether they had experienced specific developmental events before age

18. The variable *early loss* was constructed by combining answers to three items: "Did your father die?" "Did your mother die?" and "Did anyone else acting as a parent to you die?" This measure was conceptualized as a dichotomy of either no early loss or at least one experience of early loss. *Early disruption* was constructed by combining two items: "Were your parents separated or divorced?" and "Did you grow up outside your parents' home?" Again, this measure was conceptualized as a dichotomy of either no early disruptions or at least one disruption. According to the conceptual framework, residents who had early losses or disruptions would be more likely to experience instability later in life.

Brown and Birley (1968) found that life crises were likely to lead to rehospitalization of the SMD. A hypothesis of this study was that such readmissions to a mental hospital might contribute to subsequent residential instability. Since this would confound the results related to early losses and disruptions, those individuals with recent losses were eliminated from the analysis of predictors of residential stability if they were found to be more likely to move than were other members of the sample during the period in which they experienced the recent loss. A recent loss was defined as the death of a close relative or friend within the last six months.

Two measures of *psychological disability* were used. The first used clinical assessments on the Brief Psychiatric Rating Scale (BPRS), initially developed to rate the severity of 16 discrete psychiatric symptoms and later used extensively in drug trials with psychiatric patients (Overall & Gorham, 1962; Rhoades & Overall, 1988). The BPRS score is the summation of ratings on all 16 symptoms and was used as a continuous variable in this analysis. All the interviewers were clinical social workers with a minimum of one year of experience with this population. The interrater reliability of joint interviews with a psychiatrist and an interviewer in 1973 was  $r = .9$  (Segal & Avi-

ram, 1978). The internal consistency for the BPRS rating was  $\alpha = .79$  for 1973 and  $\alpha = .86$  for 1983 (Segal, Cohen, & Marder, 1992).

The second measure of psychological disability was based on the residents' psychiatric diagnoses, gathered from inpatient records obtained from all 119 psychiatric hospitals in which the respondents indicated they had been inpatients and searched in all state hospital facilities in California. Primary discharge diagnoses for all episodes of inpatient care were obtained from the psychiatric records of 201 subjects for 1,038 (89.5%) of 1,159 episodes (Segal, Cohen, & Marder, 1992). A modal lifetime diagnosis for each respondent was obtained. This original measure was recoded to form a dichotomous measure with either no diagnosis within the schizophrenic spectrum of disorders or a schizophrenic diagnosis. It was hypothesized that a higher score on the BPRS and a schizophrenic diagnosis would be related to greater residential instability.

### Control Variables

Two demographic characteristics, age and sex, were used as control variables. The age of each respondent in 1973 was included as a continuous variable in the analysis. The sex of each respondent was coded as a dummy variable with male = 1 and female = 2. These demographic variables were hypothesized to have the most significant effect on residential stability.

Two measures of social support were also selected as control variables. These measures assess support from family and friends, respectively, at the 1973 baseline assessment. The Family Access and Participation Subscale of the External Social Integration Scale (Segal & Aviram, 1978) is a six-item continuous measure that reflects the ease and frequency of contact with one's family by phone calls or visits. Possible responses range from "very difficult/never" to "very easy/very often." Internal consistency was  $\alpha = .83$ . Results from previous analyses in-

dicated that relationships with immediate family are generally confined to providing basic needs and social contact of an obligatory nature, which are not necessarily indicative of true social interaction (Segal & Aviram, 1978).

The Friendship Access and Participation Subscale, also a subscale of the External Social Integration Scale, is a continuous measure of six items that are similar to those of the family subscale, but pertain to "close friends" and "acquaintances," rather than to "immediate family" and "more distant relatives." Again, response categories range from "very difficult/never" to "very easy/very often." Access to friends and acquaintances through phone calls and visits implies social interaction. This subscale measures how often and with what ease residents interact with close friends and acquaintances. Its internal consistency was  $\alpha = .87$ . The hypothesis was that more social support of either kind would be related to greater residential stability.

A variable measuring the quality of the facility was also included as a control. It was based on the interviewers' ratings of the facility on a five-point scale from low to high.

### Analysis

Descriptive statistics were obtained on all the variables included in the multivariate model already described. Of the 234 individuals included in the panel, the demographic, clinical, and residential-career characteristics of the 23 who had experienced a recent loss were compared with those of the 211 who had not experienced one. A difference-of-proportions test was used to determine whether those with recent losses were more likely to experience residential instability at the time of their loss than were other members of the sample.

An ordinary least-squares (OLS) regression model was used to analyze the individual and joint effects of the group of predictor variables on the two measures of

residential stability (number of times in residential care and number of days in residential care) during the study period. The log form of the dependent variables was used in the analysis to correct the severe skewedness of the distribution.

## RESULTS

### *Characteristics of the Sample*

The typical resident in 1973 was male and aged 43 (see TABLE 1). He was more likely to have never married, to have failed to complete high school, and to have a diagnosis of schizophrenia. No significant differences were observed between the members of the sample with recent losses and other members on these more stable demographic and clinical characteristics.

TABLES 2 and 3 present the results for differences in the residential stability of those with and without recent losses and considers

Table 1

CHARACTERISTICS OF MENTALLY ILL RESIDENTS LIVING IN SHELTERED-CARE FACILITIES IN 1973 (N = 234)

CHARACTERISTICS	TOTAL SAMPLE (%)
Age (yrs)	
18-35	33.8
36-45	17.5
46-55	31.2
56-65	17.5
<i>X</i> = 42.9 <i>SD</i> = 12.5	
Sex	
Male	53.0
Female	47.0
Marital Status	
Single	53.6
Married	5.6
Formerly married	40.7
Education (yrs)	
0-6	8.8
7-12	62.6
13 or more	28.5
<i>X</i> = 11.3 <i>SD</i> = 2.9	
Ethnic Group	
Black	8.2
White	78.9
Other	12.9
Schizophrenia Diagnosis	
No	23.3
Yes	76.7

Note: No significant differences were found between sample members with recent losses (N = 23) and others (N = 211).

Table 2

RESIDENTIAL STABILITY AND THEORETICALLY RELATED FACTORS

FACTORS	% WITHOUT RECENT LOSSES (N = 211)	% WITH RECENT LOSSES (N = 23)	<i>p</i> <sup>a</sup>
Early Loss			
None	62.1	100	
At least 1	37.9	0	.0003 <sup>a</sup>
Early Disruption			
None	62.6	100	
At least 1	37.4	0	.0003 <sup>a</sup>
Family Access & Participation (1973)			
Support	44.1	65.2	
Rare or no support	55.9	34.8	.040 <sup>a</sup>
Friendship Access & Participation (1973)			
Support	47.4	65.2	
Rare or no support	52.6	34.8	.026 <sup>a</sup>
Quality-of-Facility Rating (1973)			
Low	17.1	8.7	
Medium	42.9	47.8	
High	40.0	43.5	NS <sup>a</sup>
Residence Changed w/n Period of Recent Loss	19.9	34.7	.05 <sup>a</sup>

<sup>a</sup> Values for  $\chi^2$  or z-test.

factors theoretically related to the experience of a recent loss. Those with recent losses had experienced no disruption or loss in their early lives and were likely in 1973 both to have the support of friends and family and to be more severely symptomatic. Those with recent losses had also been in sheltered care a greater number of times (counting their most recent episode) during their residential careers and were more likely to have moved during the period of recent loss than were other members of the sample. Given these differences, the 23 who had experienced a recent loss were removed from the multivariate analysis. Of the remaining 211 subjects, 38% experienced an early loss and 37% experienced an early disruption.

### *Early Loss and Disruption*

Because some of the variables included missing values, 170 subjects were included in the multivariate analysis. The first equa-

Table 3

## MEANS AND STANDARD DEVIATIONS FOR RESIDENTIAL STABILITY AND THEORETICALLY RELATED FACTORS

FACTORS	WITHOUT RECENT LOSS (N=211)		WITH RECENT LOSS (N=23)		$p^a$
	X	SD	X	SD	
Times in sheltered care	2.12	1.69	2.91	2.74	.047
Days in sheltered care	2515.50	1374.19	2266.78	1563.31	NS
Brief Psychiatric Rating Scale (1973)	-.111	1.044	.650	.743	.017

<sup>a</sup> Values for *t*-test of differences in Means.

tion in TABLE 4 depicts the findings on the influence of early loss and disruption on residential stability, as indicated by the number of times an individual had been in residential care during the follow-up period. Early disruption (i.e., out-of-home placement) before the age of 18 was second only to age in predicting the number of times an individual had been in sheltered care during the follow-up period. The older the person, the fewer the episodes in sheltered care. Those whose childhood was disrupted, those who had experienced an early loss, and those with BPRS symptoms of greater severity

all tended to have experienced more numerous episodes in sheltered care. These factors were significant when gender, social support, and the overall quality of the facility, as rated by an independent observer, were taken into account.

The second measure of residential stability addressed the issue of settling into a supervised living arrangement. The dependent variable was the number of days in sheltered care. Only a diagnosis of schizophrenia and increased age were associated with increased time in sheltered care during the follow-up period, when the following were taken into account: psychopathology, early loss, disruption, gender, social support, and the quality of the facility at the beginning of the follow-up period. Pearson product moment correlation coefficients indicated that the dependent variables for each equation (number of times in residential care and number of days in residential care) are unrelated.

Table 4

## EARLY LOSS AND DISRUPTION AND SHELTERED-CARE RESIDENTIAL EXPERIENCES: OLS REGRESSION RESULTS

VARIABLE	OUTCOME VARIABLES	
	TIMES IN SHELTERED CARE <sup>a</sup>	DAYS IN SHELTERED CARE <sup>a</sup>
Predictors		
Early loss	.167*	.115
Early disruption	.206*	.014
Schizophrenia diagnosis	.106	.224*
BPRS (1973)	.160*	.078
Controls		
Sex	-.023	-.024
Family access & participation	-.127	-.021
Age	-.234*	.203*
Friendship access & participation	-.029	-.128
Quality of facility	-.072	.104
Adj. R <sup>2</sup>	.1527	.0831
F-ratio (N = 170)	4.404*	2.7124*
		169

<sup>a</sup> Log form of the dependent variable used in each equation to correct for skew (one-tailed significance level).

\*  $p < .01$  (one-tailed significance level).

## DISCUSSION

There is agreement in the literature that the results of studies of early life experiences and later symptomatology are inconclusive (*Bifulco, Brown, & Harris, 1987*). While some studies (*Lloyd, 1980; Nelson, 1982*) found the expected relationships between early losses and later symptomatology (e.g., depression), others that employed a more rigorous methodology failed to do so (*Crook & Elliott, 1980; Tennant, Bebbington, & Hurry, 1980*).

One major reason for these different findings may be related to the populations in-



cluded in the studies, specifically, community samples (Bifulco, Brown, & Harris, 1987; Dietrich, 1984) versus specific populations of patients (Pfohl, Stangl, & Tsuang, 1983). In his extensive review, Tennant (1988) reported that although the connection between early losses and adult psychopathology was unclear and the data were inconclusive in studies that used community samples, research conducted on samples of inpatients depicted stronger relationships.

The results of the present study reveal an unexpectedly high occurrence of early disruptive events among SMDs, with 38% ( $N=80$ ) having experienced an early loss and 37% ( $N=79$ ) an early disruption. These figures, which are higher than those found in the general population, point to the need for further attention to the possible influence of early life events on the later stability of this population.

The results also seem to indicate that stability in living arrangements and settling into sheltered care are two different phenomena. Clearly, early losses and disruptions were very much related to ability to stabilize living arrangements. Although age was expected to predominate in predicting stability, given the tendency of younger individuals to move more often, early loss and disruption were clear indicators that early experiences are likely to contribute to residential pattern over the life cycle. This effect holds true even when the factors of social support from family and friends and the quality of the facility, which are generally considered to be important indicators for remaining in a residential facility, are controlled.

Supervised living arrangements seemed to fit the life-styles of older schizophrenic patients more than they did other members of the sample, so that older patients were likely to spend more time in such environments. It is possible that greater residential stability is a function of aging itself. Alternatively, the protected low-stress environment of the sheltered-care facility may be

more attractive to the elderly schizophrenic population.

The results of this study also confirm the hypothesis that immediate life crises may disrupt the residential stability of the SMD, especially of those with recent losses who had been highly supported by both family members and friends and who were more disturbed at the outset of the study. In an era with few options available for inexpensive housing, such life crises may pose an increasing risk of homelessness for this population.

### CONCLUSION

The conceptual-theoretical framework used in this study proved helpful in identifying factors that are likely to predict residential instability among the SMD. Early loss and disruption seem to contribute to the establishment of a residential pattern throughout the life cycle. Although their influence may be mediated by psychological disturbance and increasing age, recent losses tend to exacerbate residential instability.

The findings, together with the fact that a large percentage of the sample reported an early loss or disruption, indicate the importance of taking early life experiences into account when making long-term care arrangements for the SMD. Interventions that emphasize the relationship between sheltered care and supportive services, including more extended case management, outreach, and intensive supervision and support, hold promise for maintaining the residential stability of those with early life disruptions. However, additional research is necessary to document the effectiveness of such interventions.

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