

# **Homeless Persons Communicate their Meaning of Health**

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Une étude qualitative utilisant un échantillon de commodité de 29 personnes a été faite pour évaluer ce que les sans-abri entendent par le concept de santé. L'analyse a révélé que les sans-abri ont deux conceptions différentes de la santé : les caractéristiques décrivant la santé et une vue d'ensemble de la santé exprimée dans diverses combinaisons des dimensions de la santé. Un total de 10 caractéristiques décrivant l'essence de la santé ont été établies : satisfaire les besoins élémentaires de la personne, ne pas avoir de raisons de se plaindre liées à une maladie, faire l'effort de se maintenir en bonne santé, remplir un rôle fonctionnel, avoir une image de soi et une apparence positives, être en forme, avoir un réseau de soutien, s'abstenir de prendre des drogues, avoir une bonne hygiène et structurer sa journée. Quatre perceptions distinctes de la santé se sont révélées : les dimensions exclusivement physiques de la santé, les dimensions physiques et mentales/émotionnelles de la santé considérées séparément, les dimensions physiques et mentales/émotionnelles de la santé coexistantes, et la santé en tant que processus multidimensionnel de bien-être. Les répondants ont également indiqué que des événements graves associés à des sentiments de perte ont précédé leur état de sans-abri. En général, les répondants de cette étude se considéraient comme étant en bonne santé.

A qualitative study that utilized a convenience sample of 29 individuals was conducted to uncover the meaning of health as it is experienced by homeless persons. Analysis revealed that homeless persons have two distinct conceptions of health: the characteristics that describe health, and a comprehensive view of the totality of health expressed in different combinations of health dimensions. A total of 10 characteristics that described the essence of health were identified: satisfying basic human needs, having no illness-related complaints, doing the work of health, fulfilling a functional role, having a positive self-image and outlook, being fit, having a support network, eschewing the use of addictive drugs, having good hygiene, and structuring the day. Four distinct perceptions of health were revealed: physical dimensions of health exclusively, physical and mental/emotional dimensions of health considered separately, physical and mental/emotional dimensions of health coexistent, and health as a multidimensional process of well-being. Respondents also indicated that acute life events associated with feelings of loss preceded their state of homelessness. Generally, the respondents in this study considered themselves to be healthy.

Since the beginning of towns and cities people have been displaced from their homes for a variety of reasons, such as health and economic problems. It was believed that these homeless persons were mostly middle aged and elderly men who had demonstrated insufficient efforts on their own behalf and chosen this way of life.

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Homeless people tended to congregate for mutual acceptance of appearance and conduct that were otherwise not tolerated (Brickner, 1985). Mainstream society ignored the plight of these individuals even though their poor socioeconomic status adversely influenced health.

The recent dramatic increase in the number of homeless people, the heterogeneity of this population, and the inclusion of children has made homelessness more difficult for mainstream society to ignore. Nevertheless, the gap between these people and other societal groups has not diminished. Even health care providers who are trying to assist homeless individuals to promote their health have limited empirical evidence to describe this population and the meaning of health to them.

### Literature Review

In the United States, studies have estimated the annual rate of increase in homelessness to be 20-25% (Axelson & Dail, 1988; Francis, 1987). A survey conducted in Canada in 1987 estimated that more than 100,000 Canadians were homeless, and this number was expected to increase (McLaughlin, 1987). Further, it confirmed that homelessness in Canada was not limited to unemployed, middle aged, and elderly men, but included women, children, runaway youths, young adults and families. The heterogeneity of this population could no longer be ignored or disputed.

Health is related to socioeconomic status and is influenced by poverty, inadequate housing, and unemployment (Colantonio, 1988; Drennan & Stearn, 1986; Epp, 1987; Siler-Wells, 1988; Vladeck, 1991). The adverse effects of homelessness on health in relation to illness and disease have been well documented in the literature (Bowdler & Barrell, 1987; Boyer, 1986; Brickner, 1987; Damrosch & Strasser, 1988; Fischer, Shapiro, Breakey, Anthony & Kramer, 1986; Friedman, 1983; Kelly, 1985; Lenehan, McInnis, O'Donnell & Hennessey, 1985; Lindsey, 1989; Lovell, 1986; Pearson, 1988; Robertson & Cousineau, 1986; Ryder, 1982; Selby, 1985; Woolley, 1985; Young, 1985). Phillips (1985) stated that the perinatal mortality rate among unskilled workers was twice as high as that among professional couples. It would be expected that the perinatal mortality rate of babies born to homeless persons would be even higher.

Health problems of the homeless have been identified and categorized (Bassuk, Rubin & Lauriat, 1986; Drennan & Stearn, 1986; Maurin, Russell & Memmott, 1989; Mealey, 1981; Sebastien, 1985; Thompson, 1986; Wadsworth, 1984). The self-reported health status of homeless people has also been documented (Bowdler & Barrell, 1987; Fischer *et al.*, 1986; Robertson & Cousineau, 1986); as has their limited access to health care (Burke-Masters, 1986; Lenehan *et al.*, 1985; Lewis,

1986; Lovell, 1986; Young, 1985); and the difficulties they encounter when attempting to adhere to medical regimens (Maurin *et al.*, 1989; Slavinsky & Cousins, 1982; Strasser, 1978). It has also been reported that their vulnerability to disease is magnified by their lack of protection from the elements, their inadequate sleeping accommodations, and the alienation of life on the streets (Brickner, 1985; Lindsey, 1989; Sebastian, 1985).

Various nursing interventions have been attempted to promote the health of homeless clients, including assisting them to access available resources, and developing health education programs to promote their self-care (Atkinson, 1987; Lenehan *et al.*, 1985; Malloy, Christ & Hohloch, 1990; Marquis, 1986; Pearson, 1988; Young, 1985). Since the individual's conception of health influences the adopting of health-promoting behaviours (Baumann, 1961; Colantonio, 1988; Laffrey, 1985a; Way, 1990), it is important to understand what that conception is.

The authors found only one study that addressed this subject. In 1978, Strasser studied 34 homeless women to learn how they viewed their health. It was discovered that health was attributed to independence and related to the individual's resources and knowledge. These women expressed their beliefs about health through discussing illness, "...what caused illness, what prevented it, and how to take care of it" (p. 2079). Causes of illness were linked to dependence and events that they could not control.

## Method

### *Purpose*

The purpose of the current study was to investigate the meaning of health as it is experienced by homeless persons. Three factors prompted the decision to conduct this study: (a) Canadian policy makers have stated that the health inequities between people of different economic status must be reduced and self-care and individual responsibility for health maintenance promoted (Epp, 1986). (b) The increasing homeless population in Canada is highly susceptible to health deficits (Siler-Wells, 1988). (c) The concept of health is central to nursing, yet nurses have limited empirical knowledge of the meaning of health to homeless persons.

### *Research Questions*

The following research questions were explored:

- 1) How do homeless persons perceive the meaning of health?
- 2) How do homeless persons perceive their own health status?

### ***Design***

This qualitative study followed a phenomenological approach which examines the underlying structure of a particular phenomenon (in this case, health) as it is experienced by respondents in the context of their environment. In this way the implicit experience of health can be made explicit. Respondents communicated their lived experiences concerning the phenomenon of health.

### ***Procedure***

The researcher gained entry into three facilities that offered homeless individuals overnight accommodations and a meal service, and a fourth facility that offered a meal service only. The director of each facility provided a private area for interviewing, and asked the program coordinator to select potential participants and introduce the researcher to them.

The inclusion criteria specified that all participants would: (a) speak functional English; (b) be at least 16 years of age, the age at which children do not require parental consent for medical treatment in the province of Ontario; (c) be able to articulate their experiences; and (d) agree to a tape recorded interview. Program coordinators were guided by these criteria. Thus a sample of convenience evolved. Participants readily agreed to be interviewed, and some were anxious to volunteer.

The guided interview technique employing open-ended questions was used to focus on the interview so that the information collected was relevant to the research questions or useful in describing the sample. The effectiveness of the interview guide in eliciting appropriate information was verified in a pilot study comprised of eight respondents. Immediately following each interview, the researcher tape recorded all personal observations and inferences. All recordings were subsequently transcribed verbatim. These transcripts constituted the data base.

Categories were inductively derived from the data to describe the essence of health as it was reported by the respondents. Each respondent was identified as a unit of analysis and could only be coded into a given category once even if they repeatedly described the same category. Therefore, the total possible score for any one category was 29, the total number of respondents. This initial examination led to the unfolding of the characteristics of the phenomenon. To ascertain whether the

categories were mutually exclusive, random portions of the data were coded by two independent coders. Where difference occurred between coders, the categories were more precisely defined.

When the boundaries of the characteristics of health were examined, general perceptions of health were revealed. This, in turn, led to a more thorough examination of the characteristics of health, the internal relationships, and the specific features of each. Only features that further developed the meaning of a characteristic were included.

Subsequent examination of the data more precisely defined the characteristics of the phenomenon and confirmed that respondents had also revealed their perceptions of the totality of health. Distinct perceptions of health emerged from the data. The meaning of health as experienced by these respondents could now be understood and articulated. Random portions of the data were coded by two independent coders to determine the extent of agreement; the inter-rater reliability was 0.90.

### *Sample*

The target population included all homeless persons living in a non-industrial city in the province of Ontario with a population of 600,000. The accessible population was comprised of those homeless persons who utilized shelters and hostels as a place to rest or to obtain food. All participating facilities were located within the central core of the city.

Twenty male and 10 female respondents were interviewed, a ratio in keeping with the gender composition of the homeless population reported in other studies (Robertson & Cousineau, 1986; Sergi, Murray & Cotanch, 1989). One interview with a female respondent was excluded from analysis because of inconsistencies in her response. During data collection four interviews were terminated by the researcher: one respondent refused to be tape recorded, two did not speak functional English, and one was agitated and unable to concentrate.

## **Results**

### *Sample Characteristics*

The age range of respondents was 18 to 62 years and the education profiles disclosed that two people had no high school education, 11 had some, and 15 had graduated from high school. Of these 15, nine had some post secondary education



and four were graduates of a post secondary course of study. One respondent did not relate level of education. These figures for age distribution and education are in agreement with results from other studies of the homeless (Axelson & Dial, 1988; Kelly, 1985; Malloy *et al.*, 1990; Maurin *et al.*, 1989).

Results indicate that the length of time respondents spent in shelters or without permanent accommodations was related to gender. For female respondents the amount of time spent in shelters ranged from 1 week to 3 years, and for male respondents, 3 weeks to 35 years. One other study also reported that women had been homeless for a shorter period of time than had men (Maurin *et al.*, 1989).

As in other studies of the homeless population (Cohen, Teresi, Holmes & Roth, 1988; Maurin *et al.*, 1989), this study also demonstrated that most homeless persons had worked. All respondents except one woman had work experience. The number of years worked ranged from zero to 29 years for females, and 3.5 months to 45 years for males.

According to Canadian voting regulations, individuals who live in the same geographic location for one year or longer are considered residents. Since society assumes that homeless people are transient, the geographic mobility of respondents is of interest. Twenty of the respondents (69%) had been living in the same geographic location for one year or longer and could not be considered transients. This finding is also in keeping with that of other studies (Action Consulting, 1987; Bassuk *et al.* 1986; Francis, 1987; Fischer *et al.* 1986; McGrath, 1986; Slavinsky & Cousins, 1982).

### **The Meaning of Health**

In response to the first research question, regarding how homeless persons perceive the meaning of health, two distinct conceptions of health evolved from the respondents' descriptions: (a) the characteristics that describe the phenomenon, and (b) a comprehensive totality of the phenomenon expressed through various combinations of health dimensions.

#### ***Characteristics of health***

Ten core characteristics of health were inductively derived from the data. Each contained related features that put forth the same notion of health. Three other features that were unrelated but strongly emphasized were included in the analysis as "other." The characteristics are presented in order of most to least commonly described.

*Satisfying basic human needs.* In their descriptions, 23 respondents related that “satisfying basic human needs” is essential to health. These needs include sufficient food, a place to rest, and a permanent shelter.

Being healthy is...to have, basically what you feel as a comfortable home or a place to rest. Sufficient, not an abundant amount of food. (R10, male)

Being healthy....for you to *get all* your vitamins, get your proper sleep, and all your nutrients. (P1, male)

*Having no illness-related complaints.* This characteristic, referred to by 23 respondents, included freedom from illness and medical treatment. Illness encompassed symptomatic or asymptomatic chronic and acute ailments. Treatment was described as either the continued use of medication or hospitalization.

Being healthy....not being ill. (R21, male)

A lot of people my age are, are not [healthy] you know. They're on medication every day of the week. (R14, male)

*Doing the work of health.* Twenty respondents referred to the work of health as promoting health and preventing health deficits. They spoke of taking care of themselves and assuming responsibility for, and participating in, the development of their own health.

Health means...you have to be careful about yourself, and you have to be considerate about yourself, and you have to know what is good for you and what is bad for you. And avoid the bad things and,...try to achieve the good things. (R15, female)

No, I'm not healthy....I'm not looking after myself and I'm not taking my medication. (R1, male)

*Fulfilling a functional role.* Nineteen respondents linked productive working and doing with health. They described the ability to work and/or the capacity to function in society as influencing health.

Well, being healthy, you are able to get up and go to work and do whatever you want to do and get out. (P6, male)

Being healthy?...Being a functioning part of society. (R3, male)

*Having a positive self-image and outlook.* Nineteen respondents indicated that feeling good about oneself, having control over one's activities, and receiving recognition from others contribute to health. Features of this characteristic included having self-esteem, a sense of control over stressful events that could create worry and tension, a positive outlook on life, self-confidence, and pride in accomplishments.

But to be healthy...I feel that you have to feel very good about yourself. Number one, be happy. You cannot be down on yourself. (R11, female)

Being healthy means...if you need something, you have the means and the ways to get it, without going through a big hassle....you have the means to change something that is doing you harm....there's something that starting to affect you, you can't change it because you have no means of changing it. (R9, male)

But it means a lot to me...To have my health back, ...and do the things that I can do....I can do it....and I'm proud of myself. (R5, male)

*Being fit.* Seventeen respondents connected health with being physiologically stable and physically fit without speaking of the work required to attain and maintain fitness. Physical fitness, physiological stability, the importance of regulated body weight, and quick recovery from infection were described.

'Cause my heart is strong and I got [sic] a good pulse and I breathe OK....I can work all day and I can work hard....my heart rate doesn't increase that much. And I don't get dizzy or light headed when I do a lot of heavy lifting or stuff like that. That's how I see myself, as pretty healthy. (R3, male)

I must be fairly healthy because I was sick with the flu last night and I'm up and around again today. So I must be in good shape. (P5, male)

...lost over ten pounds in one week. That's not healthy. (R17, female)

*Having a support network.* Eleven respondents indicated that "having a support network" contributes to health, or not having a support network adversely affects health. Respondents' feelings of self-worth and belonging were fostered by nurturing relationships with friends and family.



If you were married, a close family, immediate, that's healthy. If you're single, having good friends is healthy. (R9, male)

...I had to rely on myself too much and I wasn't ready to be independent. I wanted to be dependent on somebody but that somebody was me...emotionally, it screwed me up. (R3, male)

*Eschewing the use of addictive drugs.* Abstinence from addictive substances was considered a requirement for health by 10 of the respondents. They denounced the use of chemically addictive substances that lead to adverse effects on health, including the smoking of tobacco products, and the use of non-prescription drugs and alcohol.

...being free of this nicotine, would be healthy for me. (R2, male)

...made me more susceptible to disease. Alcohol and drugs do weaken you very much....malnutrition, I wouldn't eat when I was drinkin'. (R7, male)

*Having good hygiene.* Nine respondents referred to this characteristic of health, identifying the features of personal cleanliness and sanitary conditions in the environment.

Well, have a clean home to come in [*sic*], have clean clothes and everything like that....You gotta [*sic*] be clean. No dirt. (R1, male)

*Structuring the day.* Nine respondents described the observing of routines and the planning of daily activities as being important to health. Having structure in the day gave respondents a sense of direction and control in their lives.

You have to live every day....You got to have a plan and...it works out....You got to have direction of what you're going to do. (R4, male)

They know a basic routine...gives them their diet....When they leave the shelter at seven-thirty in the morning, they'll go...to the churches and things....They have their walk routine. (R10, male)

*"Other" characteristic.* Additional features of health that were reported and emphasized by up to three respondents included compliance with prescribed treatment, negotiating access to health services, and being motivated.

And that's why a lot of times these people that are in the hostels here are always down-and-out on their luck. They're unhealthy

because they...can't afford the proper medicine or the proper diets. (R12, male)

First I start getting diarrhea, then I start throwing up, and its my nerves. And I know its my nerves. And if you go to a doctor, a GP, anywhere; they're gonna tell you it's your nerves and that's all they're gonna do for you. See your shrink; and your shrink says go to a GP. (R17, female)

You got to get motivated....If anyone around here takes sick...you got to get motivated....Do things...even if its little things. (R5, male)

*Perceptions of Health: A Synthesis of Health Dimensions*

The second conception of health to evolve described respondents' perceptions of the totality of health. These were derived from four different combinations of the following health dimensions: physical, mental, emotional, spiritual, social, and environmental (Figure 1).

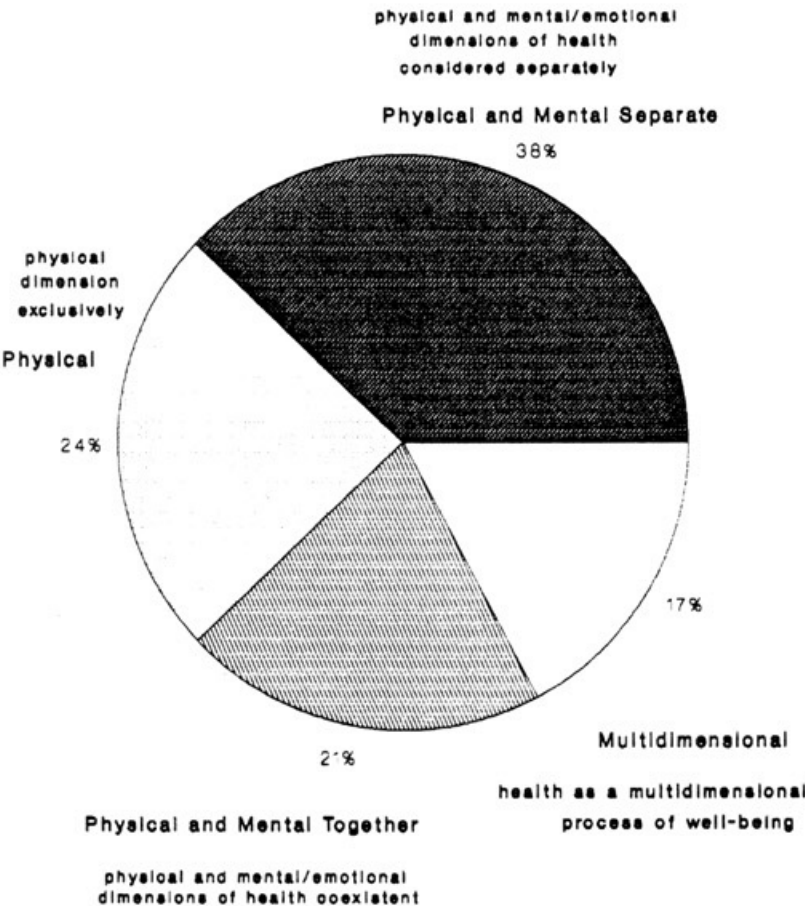


Figure 1: Respondents' perceptions of health.

*Physical dimension of health exclusively.* Seven respondents directly related health to the physical body. Health was linked to ability to engage in activities that require either strength or endurance to do physical work, fight and/or participate in sporting events. Respondents identified the physical perception of health by referring to images of famous personalities.

...gettin' strong and being strong. The first man that came into my mind was Arnold Schwarzenegger. Muscle man, see. I think that's healthy. (R2, male)

A healthy person like an athlete. Very healthful, eating the proper diet of food....maintaining their body, keepin' good, exercising all the time. (R12, male)

*Separate physical and mental/emotional dimensions of health.* Reported by 11 respondents, this is the perception most often disclosed. Consistent with the traditional reductionist view that health has two separate realities, respondents described physical and mental/emotional health as two independent dimensions of health. Health was assessed by examining each dimension separately. One could be either healthy or unhealthy, in one or both dimensions, at any given time.

...physical health is the most important health for most people, that's my opinion. And your mental health has to be in shape too. I've got the mental health, I think. The physical part, I haven't got too much going for me that way. (P3, male)

Not physically...not emotionally. But I tend to think the emotional thing is a time factor. You know, with time I'll be OK. My physical health, I worry about that a lot. (R22, female)

*Coexistent physical and mental dimensions of health.* Six respondents communicated that the physical and mental/emotional dimensions of health are interdependent and together comprise the health phenomenon. When either the physical or the mental/emotional dimension is challenged or further developed, health is influenced.

...there's your physical health and your mental health. That's what comes in my mind...one goes hand in hand with the other. If you're not physically well, sometimes it plays on your mental health....They both go together, cause if you allow yourself to go down physically, your mental health is not going to be good. (R11, female)

I think you can't be physically healthy if you're not mentally healthy. Just as you can't be mentally healthy if you are not physically healthy....They're just tangled in there together. (R17, female)

*Multidimensional process of health and well-being.* Five respondents related this perception of health. Health included many coexisting dimensions that contribute to the phenomenon in its entirety. This perception encompassed the notion of general well-being that emerges from the totality of life processes.

There's a lot of different healths. Health is not just physical. It's emotional, spiritual, it's, you know, it's what's around you. (R3, male)

### *Additional Findings*

Other findings that relate to health emerged when respondents related why it was necessary for them to leave permanent living arrangements. They indicated that the homeless state had been created by having no place to go, being unemployed, experiencing family difficulties, participating in substance abuse, being evicted from affordable housing, having health deficits, and/or dealing with wanderlust. These responses are consistent with what has been reported in other studies (Bassuk, 1984; Boyer, 1986; Damrosch & Strasser, 1988; Damrosch, Sullivan, Scholler & Gaines, 1988; Fischer *et al.*, 1986; Francis, 1987; Friedman, 1983; Hodnicki, 1990; Malloy *et al.*, 1990; McDonald, 1986; Reuler, Bax & Sampson, 1986; Rosenthal, 1989; Roth, Bean & Hyde 1986).

Further examination of the data revealed that in 79% of all interviews, homelessness was preceded by the occurrence of an acute life event such as marriage breakdown, death of a parent or spouse, unemployment, business collapse, the necessity of placing a child for adoption, impaired body function, relocation or abuse. Many respondents had several acute life events occur simultaneously, and several related that ineffective coping strategies had prevented them from effectively dealing with these events.

...emotionally I'm not equipped with very good coping skills for dealing with a rough situation. (R19, female)

What upsets me is that I'm handling that, and I'm handling everything else that is happening in my life. But when upcoming pressures come, I've got no room to handle it. (R13, female)

### Personal Assessments of Health

In response to the second research question, regarding how homeless persons rate their own health status, 76% of the respondents considered themselves to be healthy; 14% unhealthy; and 7% both healthy and unhealthy; and 3% did not answer. Results were similar when the data were separated by gender (Figure 2). The two respondents claiming to be both healthy and unhealthy viewed physical and mental/emotional dimensions of health as being separate, perceiving themselves to be physically healthy but mentally unhealthy.

The findings of this study do not concur with previous reports that 30 to 39% of homeless adults perceived their health status as being poor (Bowdler & Barrell, 1987; Fischer *et al.*, 1986; Robertson & Cousineau, 1986). In the current study several of the respondents with chronic illnesses and/or disabilities perceived themselves as healthy, indicating that their definition of health entailed more than the absence of disease. For them, the perceived assessment of health was a reflection of the individual's conception of health.



Figure 2: Self assessment of health by homeless people.



## Discussion and Nursing Implications

One of the primary concerns or goals of nursing is to assist clients in attaining, maintaining or regaining health (Schlotfeldt, 1972). Nurses have a responsibility to identify the health challenges that a community, family or individual may be experiencing, and assist clients in developing effective coping strategies.

The literature indicates that nurses should address the challenge of making health care accessible to the homeless population (Abdellah, Chamberlain & Levine, 1986; Atkinson, 1987; Lenehan *et al.*, 1985; Marquis, 1986; Pearson, 1988; Sebastian, 1985; Young, 1985). Homeless people encounter difficulties when attempting to gain access to health care (Bowdler & Barrell, 1987; Burke-Master, 1986; Lenehan *et al.*, 1985; Lewis, 1986; Lovell, 1986; Young, 1985). In Canada, a country with a national health insurance plan, this difficulty is often related to lack of acceptance by health care providers.

Homelessness arises from complex precipitating factors that may be related to an inability to cope with acute life events. This is essential information for nurses who work with homeless individuals. Understanding the precipitating events that lead to homelessness and recognizing the barriers that prevent reentry into mainstream society will help nurses to develop innovative strategies for coping. This would subsequently increase the effectiveness of nursing interventions and help nurses and other health care providers to overcome their own reluctance to work with homeless persons.

Koegel (1992) had noted that homeless persons have negative attitudes towards traditional health care delivery services. The respondents in this study revealed that interventions that are not compatible with their lifestyle are difficult to observe. It is critical that health interventions be acceptable and appropriate. Furthermore, the characteristics of health identified by homeless people in this study indicate that they view health in much the same way as "housed" people do (Baumann, 1961; Colantonio, 1988). Since homelessness is usually a temporary state most homeless people have lived in homes and undergone a socialization process similar to that of mainstream society. Therefore, many of the nursing interventions developed to address the health needs of the homeless population will also be applicable to mainstream society and vice versa. As well, evidence from this and other studies indicates that homeless people are a part of the community in which they live, therefore, community programs must be developed to promote the health of this population.

The current analysis reveals that not all respondents cited the same characteristics of health, nor did they hold the same overall perception of health. This finding that perceptions of health are diverse is consistent with the literature (Baumann, 1961;

Colantonio, 1988; Keller, 1981; Laffrey, 1986; Morse, 1987; Payne, 1983; Smith, 1981; Tripp-Reimer, 1984; Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor & Cowan, 1988).

In this analysis homeless persons combined the physical, mental-emotional, spiritual, social, and environmental health dimensions in unique ways to formulate four distinct perceptions of health. Conceptions of health are inherent in values and beliefs (Laffrey, 1985b; Parse, 1981), reinforce a specific world view, and influence many choices, including those concerning health.

Nurses who are aware that their clients' perceptions of health may differ from their own will focus on gaining an understanding of these differences. Only then can the nurse guide the client in the use of appropriate interventions to improve his/her health. Likewise, health programs that are designed to accommodate different perceptions of health may more effectively convey health information and meet the needs of diverse consumers. As Susser (1974) stated, the meaning of health depends on the person defining it. Therefore any definition of health should be concise, yet flexible enough that the whole and its integral parts can be understood.

### **Future Research Recommendations**

Qualitative studies are needed to explore how health conceptions influence health behaviour. The results of these studies would impact upon the nurse-client relationship and influence how the business of nursing is conducted.

Secondly, the information from this study could be used to design an instrument for measuring health conceptions of homeless persons, which in turn could be used in a quantitative study of large sample size. This would help to establish a data base to describe current demographics and health related issues of the homeless population.

Lastly, this study indicates that acute life events may precipitate homelessness. Therefore, a qualitative study to investigate the underlying causes of homelessness is needed. The findings would guide nurses who are assisting people in learning to cope effectively with life experiences.

In conclusion, this study reflects the views of 29 homeless persons who accessed facilities for the homeless. All but one of the interviews were included in the analysis of these data. As Koegel (1992) pointed out, there is no reason to suspect that the information reported by homeless persons is any less accurate than that reported by "housed" people when responding to sensitive issues. The findings from this study are consistent with those found in the literature. However, observation and other

empirical evidence would further validate the meaning of health for homeless persons.

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