Mental Homelessness: Locked Within, Locked Without

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SUMMARY. The concept of Mental Homelessness is presented and developed. This paper will provide a historical review of the connection between mental illness and housing and the changing approaches toward institutionalization and de-institutionalization over several centuries. Case illustrations from practice in Israel will be presented to highlight the theme of *home*, or rather the theme of *lacking a home* as an element which may be inherent to a mental illness.

More specifically, the paper argues that homelessness is a *state of mind* of which the actual, physical homelessness may be a manifested re-

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flection of. If so, even if a mental patient does initially own a home, he or she is at high risk to lose it somehow.

This work is a primary attempt at developing a new idea, stemming originally from the field of mental health, with an attempt to widen its theoretical scope to populations not usually defined as mentally ill. Clinical characteristics are presented, as well as an attempt at a theoretical formulation of this concept permitting the development of therapeutic implications. These are presented in relation to existing psychodynamic concepts and therapeutic approaches related to the phenomenon of homelessness.

KEYWORDS. Home, mental illness, homelessness, psychology of home, mental homelessness, institutionalization, de-institutionalization

. . . The idea of rounding up all the mad and mentally ill to live together under one and the same roof seemed in itself a symptom of madness [. . .] At the end of the seventh day, the fiestas were over. The town at last had a madhouse of its own. *Machado de Assis, O Alienista (translation ours, Melamed et al.)*

MENTAL ILLNESS AND HOMELESSNESS: A CHRONOLOGICAL REVIEW

Common belief has it that the conjunction of psychiatric disorder and homelessness is a contemporary phenomenon; however, historical antecedents are quite numerous, though poorly documented (Timms, 1996). In ancient times and in the Middle Ages, a communal approach to mental illness prevailed; treated or untreated, the local madman (as the proverbial village fool) was part and parcel of his community, as psychiatric institutions proper were yet to be invented.

The Inquisition turned mental patients of all kinds into outcasts, exiled or otherwise isolated, and 'psychiatry' was conceptualized as an instrument in the service of "healthy" society. It was this basic approach that eventually brought about the creation of dedicated psychiatric hospitals, the primary purpose of which was not to cure but to segregate the

"ill" from the "healthy." Putting its mental patients away in closed wards or in any other type of isolated living allowed society to feel safe, protected from its own "freaks." It was a variant of other methods of exclusion: "Leprosy disappeared, the leper vanished, or almost, from memory. These structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals and 'deranged' minds would take the part played by the leper [. . .] With an altogether new meaning and in a very different culture, the forms would remain–essentially that major form of a rigorous division which is social exclusion but spiritual reintegration [. . .] the *Narrenschiff* . . .–[the ship of fools] conveyed their insane cargo from town to town. Madmen then led an easy wandering existence. The towns drove them outside their limits; they were allowed to wonder in the open countryside, when not entrusted to a group of merchants and pilgrims" (Foucault, 1967, p. 7-8).

It was only later that therapists of all kinds started to become interested in the strange morbidity that had so far been treated only by means of containment and restraining. This was the beginning of the first psychiatric revolution–the medicalization of society's approach to mental illness, heralded by Pinel (ibid., p. 241), who built the first proper psychiatric institutions. "Freaks" were now seen as "patients" and received not confinement or isolation but therapy and treatment. This was the beginning of modern-day institutionalization, the flip-side being that it precluded, or at least severely impaired, patient's chances of reintegrating in the community.

Institutionalization was also greatly influenced by urbanization and its consequent reduction of individual physical space. Close in proximity and thus more evident, mental illness was no longer viewed as just a "lunatic" pattern of behavior but as something to be feared, a societal problem; it became society's task to provide the mentally ill with a shelter, a home. But the high and ever increasing cost of housing, the growing number of mentally ill, the outcry of antipsychiatry against mental institutions and the overall rise in the number of homeless turned the idea of providing a home for those who had to be taken out of their original homes into a financial impossibility (Gerhart, 1990).

This was the financial and social background out of which stemmed, somewhere in the 1960s and under President Kennedy, the notion of deinstitutionalization. It was in fact the beginning of the third psychiatric revolution-that of The Era of Community–in which the treatment of the mentally ill was perceived as belonging to the communal sphere. But since

none of the social, organizational, administrative, legal, or financial infrastructures was provided to support the move for deinstitutionalization, its unfortunate result was inadequate care for the mentally ill and an even bigger increase in the number of homeless (ibid.).

History therefore supports the coincidence of mental illness and homelessness. Indeed, this relation is plausible since it is logical to assume that the more deprived and incapacitated–and mentally ill individuals in particular–would find it harder to cope, to have a place of their own, and would require assistance in finding some sort of home.

INSTITUTIONALIZATION AND DE-INSTITUTIONALIZATION

This subject has been increasingly explored and dealt with in the last two decades. The growing public attention to the homeless phenomenon gave rise to a volume of academic literature focusing on the link between homelessness and mental illness. At least one social work publication (Community Mental Health Journal of October 1990) dedicated an entire issue to this particular link. Other publications carried articles that were addressing diverse aspects of this link: the particular needs of the combined mentally ill homeless population (Martin, 1990; Rife, First, Greenle, Miller and Feichter, 1991), clinical implications (Susser, Goldfinger and White, 1990), and social welfare implication (Hoff, Briar, Knighton and Van, 1992; Linhorst, 1992).

The cause-effect of this link was also brought up in several publications (e.g., Belcher and Rife, 1989; Linhorst, 1992; Pam, 1994). Regarding culture as a major determinant of personality and mental health, Pam (1994) discusses "the new schizophrenia," which is in fact a social type of schizophrenia, stemming from the cultural fragmentation of family bonds, rather than by enmeshed, dysfunctional, and a reclusive family ties that is traditionally regarded as a determinant of schizophrenia. Social intervention techniques are discussed in Hoff, Briar, Knighton and Van (1992). However, it is still unclear why the mentally ill would develop homelessness. Belcher and Rife (1989) introduce the Social Breakdown Syndrome (SBS), a chronic social deficit that some individuals with schizophrenic-type disorders often develop; indeed, the concept of SBS could be the missing link between homelessness and schizophrenia.

Various classifications of different "types" of homeless people have been suggested in the literature. Hoff et al. (1992) classifies the homeless as either victims of economic changes, or as victims of failed

de-institutionalization. Arce and Vergare (1984) suggests a threefold distinction: situational, episodic and chronic homelessness (in Gerhart, 1990, p. 29).

However, another classification, functional in essence, seems to arise. Some homeless people–i.e., situational–can be helped; if taken care of–arranged in some kind of housing project and so on–their homelessness problem is likely to be resolved. But there are others who seem to be totally "unhelpable"; giving them the key to a four-wall anything, handing them the solution to the physical problem, simply does not work. Beyond issues of narcissism, ego strengths or cognitive deficiency, beyond the vicissitudes of life and actual dire straits, these patients seem to be homelessness-prone or indeed, chronically homeless. What these people really seem to lack is not a house but a home and, more precisely, an inner home. A place that they can call their own; a locality which has a potential to give them a sense of inner security; a place in the sun that in some degree can give them a mirror of themselves; a place of rest. In these cases, it seems to us that mental illness is not a mere contributing factor to but, indeed, the primal and specific cause of homelessness. We therefore submit that homelessness may be viewed in some cases-the characteristics of which are brought below–as a distinct state of mind, that of *Mental Homelessness,* which gradually infiltrate the individual's behavior and may–or not–manifest as a prime symptom in his or her lifestyle.

CLINICAL VIGNETTES

Although still at a very primary stage of a new idea, as part of our attempt to understand and develop this concept we shall present three cases which seem to us to have recognizable behavioral and emotional characteristics suggestive of Mental Homelessness. These cases will help us to better understand the relevancy of the idea of Mental Homelessness and to help us develop its clinical ramifications.

David[1]

Diagnosed as suffering from schizophrenia and a personality disorder, David–a "hip" looking, smartly dressed, fashionable, angry, get-into-trouble-type man in his thirties–has a record of repeated hospitalizations, the most recent of which lasted almost a year. Handsome, tall, and well groomed, he conveys an erroneous and overrated image of his abilities. His good looks are deceiving;

everyone consequently seems to expect him to get hold of himself: "why don't you do something with your life already." When David met his therapist for the first time-in the corridors of the psychiatric rehabilitation ward where he was hospitalized–he said, in a very agitated tone of voice: "I have nowhere to go and I feel that they want me out of the hospital." David had no direction he felt he wanted to pursue in his life and had nowhere to go. His mother and stepfather did not want him at home, nor did they offer to help him in any way. He had been referred to several vocational training programs which he never completed. He also applied to an Israeli non-profit organization managing sheltered work programs and group homes for the mentally disabled, but failed to comply with their rules. David also tried to work outside of the hospital, in sheltered programs offered by his social worker and even in work places he found for himself. In spite of his manifest wish to find work, he never managed to keep a job for more than a week, and even the most elaborate and promising rehabilitation programs offered to him invariably failed. He seemed to have gotten himself into a true catch-22 situation: Without work he could not find a place to live, but with nowhere to live he could not find a job. Not eligible for financial assistance–he had misused money he received in the past–David had turned himself into a persona non grata for most help agencies; to them, he was "burnt."

Getting David to agree to actually attend therapy sessions was no easy task. During many weeks David simply refused to meet with his therapist. Even when he did agree, he still could not commit himself to an ordinary therapeutic setting; he preferred to meet "occasionally," without any fixed day and time. In the first few weeks, his therapist met him "informally"; Some sessions–a more appropriate term would be "encounters"–took place in the corridor. And no matter where the encounters were held, they were almost always about exchanging cooking recipes. A former chef, David took great pride in his knowledge of cooking secrets.

In the first proper session David said, "I have no home." He accepted the suggestion that he was in fact referring not only to an external, but also to an inner home. Other home-related themes that were mentioned, besides cooking and cooking recipes, were "opening a door-closing a door" and "a stable home" (with regard to his ambivalence about keeping a regular therapeutic setting).

The theme of "homelessness" was present throughout David's sessions. In fact, it sometimes served as an indicator to David's rehabilitation effort and readiness. When he spoke of the things he had to do in order to settle in a group home–e.g., claim his disability allowance from

Social Security–or expressed his pain and grief over his homelessness, it was regarded as signs of increased responsibility and self care.

At a certain point, David asked to be accepted to the ward's rehabilitation workshop, a long-term intervention program designed to provide rehabilitating patients with basic work-related skills. Since this was considered a costly and complex intervention, only good prospects–that is, patients who seemed likely to be able to truly benefit from the program–were admitted. With his poor employment record David was not welcome there. Nevertheless, his therapist persuaded the program administrators that David should be accepted, were it only for the sole purpose of providing him, once in his life, with an unconditional experience of success. Against all odds, David seemed to thrive in the program. He not only succeeded in keeping a steady occupational setting for a relatively long period of time but also greatly improved his ability to adhere to external schedules and even developed other working habits. This happy stage, however, did not last long. After six months David quit the workshop, left the hospital and was not seen again.

Jack

Jack is a male patient in his fifties, diagnosed with adjustment disorder, after a long and gradual decline in his marital relationship and economic situation. In the last few years he was hospitalized several times, in psychiatric as well as in a general hospitals.

People who meet Jack in everyday life often mention his preoccupation with issues related to a "home"; for example, when he travels abroad he always carries in his bag some hot green peppers, to give "alien food"–during flights or in foreign restaurants–a familiar taste of home. But in fact Jack has no home.

In the relatively recent past he used to be a successful businessman. He was married, had children, built a home, acquired property and belongings and traveled around the world. But he left his wife and his children, left them all his material belongings, tried in vain to start a new family and got increasingly entangled, taken by what seemed to be a spiraling vicious circle of financial and personal deterioration, until he felt that everything was collapsing "like a house of cards."

Jack's use of the term "house of cards" is far from being incidental. In fact, "house of cards" seems to be a strikingly adequate oxymoron: a "house" (and even more in the Hebrew idiom: a tower)–an architectural structure supposedly having a clear and massive presence and author-

ity–that is made of cards–a flimsy, shaky, unreliable structure unable to withstand any pressure or threat due to its internal basic instability; a structure that is *inherently* unstable and unreliable.

With no higher education, Jack has nevertheless acquired a great deal of "street wisdom," which must have helped him a great deal in his business. He exerts most of his efforts and energy on clinging to people, and especially women, persuading them to take him home with them. Money is not the object here. Although Jack lives on a small social security disability pension, he is quite lavish in his spending and likes to bring expensive presents to everyone he is in contact with. He buys clothes as presents to his lady-friends and he always seems to want to give. He seems to be driven by the need not to be left with anything that belongs to him, to give away everything he owns so that he would not own anything himself. He does not have a permanent address. He is constantly on the move, never settling anywhere and always being thrown away, on his way to somewhere else.

Jack's problem is not a lack of support systems, either. Different Israeli welfare authorities have been unsuccessfully trying to help him find a place to live. There are in fact two female social workers working on his case, and somehow he still has nowhere to live. It seems that what Jack is looking for is not merely a place to live but a home.

Despite many years as a nomad, and although in others areas his capacities seem to be intact, Jack systematically refuses to learn how to cook, and can't even make his own cup of coffee. He explains that "the art of making coffee somehow eludes him . . . "; when it comes to finding solutions to his own way of life, he seems to be in a state of total helplessness.

Both his parents are still alive but Jack hardly ever mentions them. He is not wanted in their home and he has virtually no contact with them–or with his many siblings. He always carries a backpack containing papers and documents, newspaper excerpts and photographs from the time he had a family and owned his own company. The image of a successful man, which he tries to convey, includes bragging about his financial successes and about his fatherhood–although in fact he has hardly maintained any contact with any of his children.

On his last day at the hospital he came in late, breathing hard and carrying grocery bags. He looked like he was coming back home from the market. He brought tomatoes, cucumbers, grapes, soft drinks . . . In the group he described the hospital ward as "an escape hatch," "a haven." He explained: "you showed a personal attitude, you related to every little thing very seriously and respectfully," "you cared." He compared the

ward's staff to parental figures: the chief psychiatrist was "a father," the nurse "a mother" and concluded: "if one understands that, one can nurse, suckle and feed on what you can offer him."

Maurice

Maurice, too, seems to be unable to settle down anywhere. But his itinerary is much more widespread, in fact encompassing the entire planet. He was born a wanderer. "I never went to the same school for more than a year, and I don't have any friends left from any school I ever went to. I have traveled so much that there is no language that I truly master." His parents kept moving, looking for the ultimate location, but did not know how to feed, contain, hold, and support their children, and particularly this child, whose development was fraught with difficulties. Maurice's first episode of asthma occurred at birth, and as an infant he suffered not only from asthma but also from digestive, dermatological, and other problems. Maurice does not remember all this but only tells, with a great deal of pain and anger, about the experiences of abandonment he had as a child.

A child with learning and conduct problems, Maurice was thrown away from one place after the other; his parents could not find an educational framework that would suit his needs.

Maurice learned to survive. He has been wandering in the world for many years. He restlessly moves from place to place, trying to start something of his own. He tried to get as far away from his father as he could, and found a place in another continent. He acquired a profession in which he was successful (his profession is not very different from that of his father's). He tried to ignore and repress the pain and almost cut all of his contacts with his family of origin. But in his heart he still yearned for his father. For a while he felt that he was doing OK, but his angry outbursts and temper tantrums became more frequent and more powerful, and he felt he was getting into more and more trouble.

When he finally collapsed he called his parents, who arranged for him to fly back to their home and sought treatment for him. For a while he lived in their home, where they had occasional quibbles and angry outbursts, always followed by a "Returning of the Key" ceremony (or, more accurately, a "Throwing Away of the Key" to his parents' home). Being without a key probably has to do with more than just this particular home where his parents currently live. More than just a sort of concrete behavior–he throws away the key to their home and in fact remains without any key–this act symbolizes Maurice's lack of key to an *inner*

home. He throws away the key, concretely as well as emotionally, and returns to his familiar inner experience of homelessness.

Maurice also has many plans in which he always envisages traveling. "Ill go there and then I'll travel here." From his parents' home, he uses the Internet to find occupation around the world. He makes deals and transactions related to his profession, in various relevant workplaces all over the globe. He promises to leave "in February, March and April next year." This search is also indicative of his changing mental state. When he is stressed and in a poor emotional state, he finds several jobs in parallel. When he stabilizes, he hardly looks for work at all.

Although Maurice is an energetic and charismatic professional, he does not succeed in finding work "here." *Prima facia*, there are many good reasons for that. "Here I'm offered insultingly small and miserable sums of money," "here people want to take advantage of me and steal my professional secrets." Although he was self-employed for many years, succeeded in his work and made a good living, when he is here, in his father's turf, he is again a child yearning for his father's attention and care. He cannot succeed without him. He also refuses to even listen to the possibility of receiving support from mental health authorities, and rejects with contempt all attempts to rehabilitate him and help him find work or a place to live. He therefore remains a workless professional, a young, handsome, and talented homeless.

CLINICAL CHARACTERISTICS

The above mentioned three cases as well as other examples are telling of the emotional and behavioral characteristics of Mental Homelessness. As an attempt to conceptualize these narratives into a clinical framework that will allow at some point to be empirically studied, we present a number of clinical characteristics. Although these characteristics concur with the DSM-IV classification of Narcissistic personality disorder, these patients were not necessarily diagnosed as such. We suggest that another common denominator may account for the joint presence of these characteristics in these individuals. These points are further discussed below.

1. *Unexplained inability to find a home:* these patients' inability to find, rent, settle down in, or hold to a home does not seem to be related to the availability of financial *or mental* resources. Highly intelligent and quite capable of handling various tasks in everyday

life, the specific task of finding a place to live and holding to it seems to be an insurmountable challenge for them.

2. *Unawareness to one's homelessness:* although these individuals have neither a home nor a place to live, they are usually unaware to their homelessness. Using the most basic defense mechanisms of denial and projection, they tend to account for their situation by pointing at the circumstances, other people, or just by saying "it happens."
3. *No suffering:* they do not express any experience of mental suffering with regard to the fact that they have no home. Their wish for the inaccessible and unobtainable home is not accompanied by mental pain. When they do experience distress, it seems to be more related to immediate and concrete matters (e.g., no place to put one's belongings for tonight), rather than to more general emotional concerns.
4. *Inability to establish a long-lasting relationship:* personal, professional, geographical or other relationships all seem to be doomed to failure from the start (this applies even to their hospitalization periods, which are often rather short and tend to end abruptly). Another facet of this handicap is the lack of any long-lasting experience of success.
5. *Narcissistic vulnerability:* these patients all seem to have experienced some form of severe abandonment and have a basic experience of rejection.
6. *Flashy self-presentation:* they try to create a successful image of themselves; they are extremely particular in the way they dress or speak (e.g., using pompous language).
7. *The predominance of home-related ideation:* home and home-related words, terms and concepts ooze out of these patients' verbalization and behavior: they frequently mention home or home-related concepts, or engage in home or home-related activities (i.e., cooking, shopping, food).

AN ATTEMPT TO DYNAMIC THEORETICAL CONCEPTUALIZATION

This paper started with a historical view of a special population: homeless people who are also mentally ill. Several cases in our clinical practice–three of which are brought here–suggest that underlying actual homelessness there could exist a particular state of mind. In the follow-

ing section we shall attempt to explore this concept, as well as some possible clinical applications and explanations of these particular patients' choice of symptom.

The three cases brought here were conspicuous in our clinical work, because of their extremeness and their apparent common traits. First and foremost, their homelessness was more than just mere "placelessness," as they demonstrated a seemingly constant tendency to become homeless. We hypothesize that this is reflective of a weakened or failing inner structure, a state we refer to as Mental Homelessness. We suggest that this notion may serve tentatively as a paradigmatic conceptual model describing at least some aspects of human behavior

Viewed in this light, it is interesting to explore these patients' choice of actual homelessness as chief manifested symptom. Presumably, traumatic situations from childhood, in which the child was not contained, lead the child to create his own solutions, such as the lack of mental pain, common to all these patients. This is a mechanism of self sufficiency (Gerzi, 2000), in which the individual seems to state: "I'm not needy, I can fill my voids all by myself." On a practical level, such an individual creates a golden fantasy (ibid.) for himself, an imaginary wonder-world in which everything is perfect and there is neither pain nor lack or want. For example, by becoming–and remaining–homeless, the individual is put in such a strenuous situation that requires all of his being to be invested in one and only thing–survival. In such conditions there is hardly any mental room left for any other experience. The feeling of neediness is therefore efficiently muffled, obstructed, obliterated. Homelessness would be a highly efficient, though extreme, type of distraction.

Homelessness is also a state of ultimate neediness, accompanied in these patients by a seemingly paradoxical lack of subjective mental pain. The symptom is carefully designed so as to hide but at the same time also point out the huge void, the hole in the psyche. Kohut (1986) explains that "A patient whose self has been damaged [. . .] reactivates the specific needs that had remained unanswered by the specific faulty interactions between the nascent self and the self objects of early life" (p. 177). Winnicott, in "Fear of Breakdown" (1989), writes: " . . . The patient needs to 'remember' [. . .] but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to. The only way to 'remember' in this case is for the patient to experience this past thing [. . .] " (p. 92).

One might speculate that the place where mental disorder develops is at one's inner home. This seems to mainly refer to the function of home–containment, holding, mirroring and so on–which is a maternal, self object's

function (Kohut, 1986). When a failure occurs in the relations with figures serving as self objects, then the home function–the maternal environment–is impaired, as is the potential for the development of an independent self.[2]

THERAPEUTIC IMPLICATIONS

What is the scope of Mental Homelessness? Is this a new concept? Does it suggest a modified diagnosis? Does it offer a new work methodology? Within what boundaries can it be applied? How does it relate to other concepts? Originally developed in the therapy room, the idea offers a working concept in the field of mental health, and seems to fit well within existing psychodynamic conceptual frameworks. At the same time however, it seems that the idea has a potential to be looked inspiring in other everyday sociological fields as well.

Mentally ill homeless people have always represented a very unique problem for the various help agencies. But as was also described above, the existence of an inner Mental Homelessness has never been taken into consideration and most attempts to deal with this so particularly mixed population therefore focused merely on these clients' concrete problems of everyday life.

The perspective of Mental Homelessness is a descriptive-paradigmatic model that may also affect the therapeutic approach. This approach may lead to increasing the therapeutic leverage towards developing, or/and consolidating the mental home of those whose 'inner sanctuary' has been either absent or seriously incapacitated. The theme of home is familiar, well-known and non-threatening to the patient. The metaphor of homelessness may serve a non-threatening space of dialogue and interpretation, an intermediate domain functioning as a translation space, in which the therapeutic dyad speaks of place but refers to home, and speaks of home but refers to the self.

CONCLUSION AND SUGGESTION FOR FURTHER DEVELOPMENT

In our efforts to re-create and narrate our patients' personal stories and pathogenesis we found the conceptual framework of inner homelessness to be an efficient tool–even when there was no external manifestation in the form of actual homelessness–one that aided us in our

attempts to understand a little better the patient's life history, and most important, his or her everyday experience.

The cases described above illustrate the difference between "home" and "place," or between homelessness and the "mere" lack of place, or "placelessness." There can be no home without a place, and no inner home without an inner place to place it in.

Major territories for future investigation may include the psychodynamics of the perception of space. This will inevitably be related to our perception of the world, the constitution of our inner place and therefore affect the very way in which we conceive of family, community, city, state and country.

These thoughts and observations also stress the need to develop new tools, as we are currently undertaking, for assessing and measuring Mental Homelessness, both in mentally ill populations as well as in the population at large and even in micro and macro societal frameworks such as the workplace or the nation.

The collapse of the old space-related concepts–home, nation–and, on the other hand, the emerging and omnipresent cyberspace, emphasize the importance of investigating the psychological and metaphorical meanings of the concept of place (Harvey, 1986); such investigation is sure to produce new practices, new meanings and new definitions to what humans regard as (their) place and home in the world. Understanding the suggested concept of Mental Homelessness may lead to a further understanding of larger social and societal questions.

NOTES

1. All names and identifying details have been altered.

2. In his explanation of Winnicott's concept of "the capacity to be alone," Ogden (1986) writes: "What is internalized [. . .] is not the mother as an object, but the mother as environment. The premature objectification (discovery of the mother as object), and internalization of the object-mother lead to the establishment of an omnipotent internal-object-mother. This internalization of mother as omnipotent object is quite different from the establishment of the capacity to be alone (the former process is often a defensive substitute for the latter)" (pp. 181-182).

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