The Yale Review

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WINTER 1988

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The editorial office of *The Yale Review* is located in the Whitney Humanities Center, Yale University, at 53 Wall Street. Mailing address: 1902A Yale Station, New Haven, Connecticut 06520. US ISSN 0044-0124. Advertising, sales, and subscription office: Yale University Press, 92A Yale Station, New Haven, Connecticut 06520. Subscription rates in U.S. dollars: individuals, $16.00 a year; institutions, $25.00 a year; postage to all foreign countries including Canada and Mexico $3.00 extra. Single copies $6.00 each, plus postage and handling. Subscribers who do not receive a copy will be sent a replacement free of charge on notification within three months following the month of publication. Back-issue prices available on request. Designed by Nancy Ovedovitz and printed by Capital City Press, Montpelier, Vermont. Published quarterly by Yale University Press.

Second-class postage paid at New Haven, Connecticut 06510 and Montpelier, Vermont 05602. Printed in U.S.A. Postmaster: Send form 3569 to Box Number 92A Yale Station, New Haven, CT 06520.

STATEMENT of ownership, management and circulation (Act of August 12, 1970; Section 3685, Title 39, United States Code). 1A. Title of publication: *The Yale Review*. 1B. Publication Number: 695200. 2. Date of filing: December, 1987. 3. Frequency of issue: Quarterly. 3A. Number of issues published annually: Four. 3B. Annual subscription price: $16 for individuals, $25 for institutions. 4. Complete mailing address of known office of publication: 92A Yale Station, New Haven, New Haven County, Connecticut 06520. 5. Complete mailing address of the headquarters or general business office of the publisher: Same as above. 6. Publisher, Yale University Press, 92A Yale Station, New Haven, Connecticut 06520; Editor, Kai T. Erikson, 1902A Yale Station, New Haven, Connecticut 06520; Managing Editor, Wendy Wippreche, 1902A Yale Station, New Haven, Connecticut 06520. 7. Owner: Yale University, New Haven, Connecticut 06520. 8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None. 9. The purpose, function and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during the preceding 12 months.

10. Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Single issue nearest filing date
A. Total no. copies printed (net press run)	5138	5200
B. Paid circulation		
1. Sales	413	240
2. Mail subscriptions	3245	3206
C. Total paid circulation	3658	3446
D. Free distribution	357	403
E. Total distribution	4015	3849
F. Copies not distributed		
1. Office use, left over, unaccounted, spoiled	1020	1351
2. Returns from news agents	103	—
G. Total	5138	5200

11. I certify that the statements made by me above are correct and complete. JOHN G. RYDEN, Director, Yale University Press.

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The Yale Review

Vol. 77 · Published in March 1988 · No. 2

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JONATHAN KOZOL

Distancing the Homeless

It is commonly believed by many journalists and politicians that the homeless of America are, in large part, former patients of large mental hospitals who were deinstitutionalized in the 1970s—the consequence, it is sometimes said, of misguided liberal opinion which favored the treatment of such persons in community-based centers. It is argued that this policy, and the subsequent failure of society to build such centers or to provide them in sufficient number, is the primary cause of homelessness in the United States.

Those who work among the homeless do not find that explanation satisfactory. While conceding that a certain number of the homeless are, or have been, mentally unwell, they believe that, in the case of most unsheltered people, the primary reason is economic rather than clinical. The cause of homelessness, they say with disarming logic, is the lack of homes and of income with which to rent or acquire them.

They point to the loss of traditional jobs in industry (two million every year since 1980) and to the fact that half of those who are laid off end up in work that pays a poverty-level wage. They point to the parallel growth of poverty in families with children, noting that children, who represent one quarter of our population, make up forty percent of the poor: since 1968, the number of children in poverty has grown by three million, while welfare benefits to families with children have declined by thirty-five percent.

And they note, too, that these developments have coincided with a time in which the shortage of low-income housing has intensified as the gentrification of our major cities has accelerated. Half a million units of low-income housing have been lost each year to condominium conversion as well as to arson, demo-

lition, or abandonment. Between 1978 and 1980, median rents climbed thirty percent for people in the lowest income sector, driving many of these families into the streets. After 1980, rents rose at even faster rates. In Boston, between 1982 and 1984, over eighty percent of the housing units renting below three hundred dollars disappeared, while the number of units renting above six hundred dollars nearly tripled.

Hard numbers, in this instance, would appear to be of greater help than psychiatric labels in telling us why so many people become homeless. Eight million American families now pay half or more of their income for rent or a mortgage. Six million more, unable to pay rent at all, live doubled up with others. At the same time, federal support for low-income housing dropped from $30 billion (1980) to $9 billion (1986). Under Presidents Ford and Carter, five hundred thousand subsidized private housing units were constructed. By President Reagan's second term, the number had dropped to twenty-five thousand. "We're getting out of the housing business, period," said a deputy assistant secretary of the Department of Housing and Urban Development in 1985.

One year later, the *Washington Post* reported that the number of homeless families in Washington, D.C., had grown by five hundred percent over the previous twelve months. In New York City, the waiting list for public housing now contains two hundred thousand names. The waiting time is eighteen years.

Why, in the face of these statistics, are we impelled to find a psychiatric explanation for the growth of homelessness in the United States?

A misconception, once it is implanted in the popular imagination, is not easy to uproot, particularly when it serves a useful social role. The notion that the homeless are largely psychotics who belong in institutions, rather than victims of displacement at the hands of enterprising realtors, spares us from the need to offer realistic solutions to the fact of deep and widening extremes of wealth and poverty in the United States. It also enables us to tell ourselves that the despair of homeless people bears no inti-

mate connection to the privileged existence we enjoy—when, for example, we rent or purchase one of those restored townhouses that once provided shelter for people now huddled in the street.

But there may be another reason to assign labels to the destitute. Terming economic victims "psychotic" or "disordered" helps to place them at a distance. It says that they aren't quite like us—and, more important, that we could not be like them. The plight of homeless families is a nightmare. It may not seem natural to try to banish human beings from our midst, but it *is* natural to try to banish nightmares from our minds.

So the rituals of clinical contamination proceed uninterrupted by the economic facts described above. Research that addresses homelessness as an *injustice* rather than as a medical *misfortune* does not win the funding of foundations. And the research which *is* funded, defining the narrowed borders of permissible debate, diverts our attention from the antecedent to the secondary cause of homelessness. Thus it is that perfectly ordinary women whom I know in New York City—people whose depression or anxiety is a realistic consequence of months and even years in crowded shelters or the streets—are interrogated by invasive research scholars in an effort to decode their poverty, to find clinical categories for their despair and terror, to identify the secret failing that lies hidden in their psyche.

Many pregnant women without homes are denied prenatal care because they constantly travel from one shelter to another. Many are anemic. Many are denied essential dietary supplements by recent federal cuts. As a consequence, some of their children do not live to see their second year of life. Do these mothers sometimes show signs of stress? Do they appear disorganized, depressed, disordered? Frequently. They are immobilized by pain, traumatized by fear. So it is no surprise that when researchers enter the scene to ask them how they "feel," the resulting reports tell us that the homeless are emotionally unwell. The reports do not tell us we have *made* these people ill. They do not tell us that illness is a natural response to intolerable conditions. Nor do they tell us of the strength and the resilience that so many of these people still retain despite the miseries they

must endure. They set these men and women apart in capsules labeled "personality disorder" or "psychotic," where they no longer threaten our complacence.

I visited Haiti not many years ago, when the Duvalier family was still in power. If an American scholar were to have made a psychological study of the homeless families living in the streets of Port-au-Prince—sleeping amidst rotten garbage, bathing in open sewers—and if he were to return to the United States to tell us that the reasons for their destitution were "behavioral problems" or "a lack of mental health," we would be properly suspicious. Knowledgeable Haitians would not merely be suspicious. They would be enraged. Even to initiate such research when economic and political explanations present themselves so starkly would appear grotesque. It is no less so in the United States.

One of the more influential studies of this nature was carried out in 1985 by Ellen Bassuk, a psychiatrist at Harvard University. Drawing upon interviews with eighty homeless parents, Dr. Bassuk contends, according to the *Boston Globe*, that "90 percent [of these people] have problems other than housing and poverty that are so acute they would be unable to live successfully on their own." She also precludes the possibility that illness, where it does exist, may be provoked by destitution. "Our data," she writes, "suggest that mental illness tends to precede homelessness." She concedes that living in the streets can make a homeless person's mental illness worse; but she insists upon the fact of prior illness.

The Executive Director of the Massachusetts Commission on Children and Youth believes that Dr. Bassuk's estimate is far too high. The staff of Massachusetts Human Services Secretary Phillip Johnston believes the appropriate number is closer to ten percent.

In defending her research, Bassuk challenges such critics by claiming that they do not have data to refute her. This may be true. Advocates for the homeless do not receive funds to defend the sanity of the people they represent. In placing the burden of proof upon them, Dr. Bassuk has created an extraordinary

dialectic: How does one prove that people aren't unwell? What homeless mother would consent to enter a procedure that might "prove" her mental health? What overburdened shelter operator would divert scarce funds to such an exercise? It is an unnatural, offensive, and dehumanizing challenge.

Dr. Bassuk's work, however, isn't the issue I want to raise here; the issue is the use or misuse of that work by critics of the poor. For example, in a widely syndicated essay published in 1986, the newspaper columnist Charles Krauthammer argued that the homeless are essentially a deranged segment of the population and that we must find the "political will" to isolate them from society. We must do this, he said, "whether they like it or not." Arguing even against the marginal benefits of homeless shelters, Krauthammer wrote: "There is a better alternative, however, though no one dares speak its name." Krauthammer dares: that better alternative, he said, is "asylum."

One of Mr. Krauthammer's colleagues at the *Washington Post*, the columnist George Will, perceives the homeless as a threat to public cleanliness and argues that they ought to be consigned to places where we need not see them. "It is," he says, "simply a matter of public hygiene" to put them out of sight. Another journalist, Charles Murray, writing from the vantage point of a social Darwinist, recommends the restoration of the almshouses of the 1800s. "Granted Dickensian horror stories about almshouses," he begins, there were nonetheless "good almshouses"; he proposes "a good correctional 'halfway house'" as a proper shelter for a mother and child with no means of self-support.

In the face of such declarations, the voices of those who work with and know the poor are harder to hear.

Manhattan Borough President David Dinkins made the following observation on the basis of a study commissioned in 1986: "No facts support the belief that addiction or behavioral problems occur with more frequency in the homeless family population than in a similar socioeconomic population. Homeless families are not demographically different from other public assistance families when they enter the shelter system. . . . Family homelessness is typically a housing and income problem:

the unavailability of affordable housing and the inadequacy of public assistance income."

In a "hypothetical world," write James Wright and Julie Lam of the University of Massachusetts, "where there were no alcoholics, no drug addicts, no mentally ill, no deinstitutionalization, . . . indeed, no personal social pathologies at all, there would still be a formidable homelessness problem, simply because at this stage in American history, there is not enough low-income housing" to accommodate the poor.

New York State's respected Commissioner of Social Services, Cesar Perales, makes the point in fewer words: "Homelessness is less and less a result of personal failure, and more and more is caused by larger forces. There is no longer affordable housing in New York City for people of poor and modest means."

Even the words of medical practitioners who care for homeless people have been curiously ignored. A study published by the Massachusetts Medical Society, for instance, has noted that the most frequent illnesses among a sample of the homeless population, after alcohol and drug use, are trauma (31 percent), upper respiratory disorders (28 percent), limb disorders (19 percent), mental illness (16 percent), skin diseases (15 percent), hypertension (14 percent), and neurological illnesses (12 percent). (Excluded from this tabulation are lead poisoning, malnutrition, acute diarrhea, and other illnesses especially common among homeless infants and small children.) Why, we may ask, of all these calamities, does mental illness command so much political and press attention? The answer may be that the label of mental illness places the destitute outside the sphere of ordinary life. It personalizes an anguish that is public in its genesis; it individualizes a misery that is both general in cause and general in application.

The rate of tuberculosis among the homeless is believed to be ten times that of the general population. Asthma, I have learned in countless interviews, is one of the most common causes of discomfort in the shelters. Compulsive smoking, exacerbated by the crowding and the tension, is more common in the shelters than

in any place that I have visited except prison. Infected and untreated sores, scabies, diarrhea, poorly set limbs, protruding elbows, awkwardly distorted wrists, bleeding gums, impacted teeth, and other untreated dental problems are so common among children in the shelters that one rapidly forgets their presence. Hunger and emaciation are everywhere. Children as well as adults can bring to mind the photographs of people found in camps for refugees of war in 1945. But these miseries bear no stigma, and mental illness does. It conveys a stigma in the Soviet Union. It conveys a stigma in the United States. In both nations the label is used, whether as a matter of deliberate policy or not, to isolate and treat as special cases those who, by deed or word or by sheer presence, represent a threat to national complacence. The two situations are obviously not identical, but they are enough alike to give Americans reason for concern.

Last summer, some twenty-eight thousand homeless people were afforded shelter by the city of New York. Of this number, twelve thousand were children and six thousand were parents living together in families. The average child was six years old, the average parent twenty-seven. A typical homeless family included a mother with two or three children, but in about one-fifth of these families two parents were present. Roughly ten thousand single persons, then, made up the remainder of the population of the city's shelters.

These proportions vary somewhat from one area of the nation to another. In all areas, however, families are the fastest-growing sector of the homeless population, and in the Northeast they are by far the largest sector already. In Massachusetts, three-fourths of the homeless now are families with children; in certain parts of Massachusetts—Attleboro and Northhampton, for example—the proportion reaches ninety percent. Two-thirds of the homeless children studied recently in Boston were less than five years old.

Of an estimated two to three million homeless people nationwide, about 500,000 are dependent children, according to

Robert Hayes, counsel to the National Coalition for the Homeless. Including their parents, at least 750,000 homeless people in America are family members.

What is to be made, then, of the supposition that the homeless are primarily the former residents of mental hospitals, persons who were carelessly released during the 1970s? Many of them are, to be sure. Among the older men and women in the streets and shelters, as many as one-third (some believe as many as one-half) may be chronically disturbed, and a number of these people were deinstitutionalized during the 1970s. But in a city like New York, where nearly half the homeless are small children with an average age of six, to operate on the basis of such a supposition makes no sense. Their parents, with an average age of twenty-seven, are not likely to have been hospitalized in the 1970s, either.

Nor is it easy to assume, as was once the case, that single men—those who come closer to fitting the stereotype of the homeless vagrant, the drifting alcoholic of an earlier age—are the former residents of mental hospitals. The age of homeless men has dropped in recent years; many of them are only twenty-one to twenty-eight years old. Fifty percent of homeless men in New York City shelters in 1984 were there for the first time. Most had previously had homes and jobs. Many had never before needed public aid.

A frequently cited set of figures tells us that in 1955, the average daily census of nonfederal psychiatric institutions was 677,000, and that by 1984, the number had dropped to 151,000. Subtract the second number from the first, conventional logic tells us, and we have an explanation for the homelessness of half a million people. A closer look at the same numbers offers us a different lesson.

The sharpest decline in the average daily census of these institutions occurred prior to 1978, and the largest part of that decline, in fact, appeared at least a decade earlier. From 677,000 in 1955, the census dropped to 378,000 in 1972. The 1974 census was 307,000. In 1976 it was 230,000; in 1977 it was 211,000; and in 1978 it was 190,000. In no year since 1978 has the average daily

census dropped by more than 9,000 persons, and in the six-year period from 1978 to 1984, the total decline was 39,000 persons. Compared with a decline of 300,000 from 1955 to 1972, and of nearly 200,000 more from 1972 to 1978, the number is small. But the years since 1980 are the period in which the present homeless crisis surfaced. Only since 1983 have homeless individuals overflowed the shelters.

If the large numbers of the homeless lived in hospitals before they reappeared in subway stations and in public shelters, we need to ask where they were and what they had been doing from 1972 to 1980. Were they living under bridges? Were they waiting out the decade in the basements of deserted buildings?

No. The bulk of those who had been psychiatric patients and were released from hospitals during the 1960s and early 1970s had been living in the meantime in low-income housing, many in skid-row hotels or boarding houses. Such housing—commonly known as SRO (single-room occupancy) units—was drastically diminished by the gentrification of our cities that began in 1970. Almost fifty percent of SRO housing was replaced by luxury apartments or by office buildings between 1970 and 1980, and the remaining units have been disappearing at even faster rates. As recently as 1986, after New York City had issued a prohibition against conversion of such housing, a well-known developer hired a demolition team to destroy a building in Times Square that had previously been home to indigent people. The demolition took place in the middle of the night. In order to avoid imprisonment, the developer was allowed to make a philanthropic gift to homeless people as a token of atonement. This incident, bizarre as it appears, reminds us that the profit motive for displacement of the poor is very great in every major city. It also indicates a more realistic explanation for the growth of homelessness during the 1980s.

Even for those persons who are ill and were deinstitutionalized during the decades before 1980, the precipitating cause of homelessness in 1987 is not illness but loss of housing. SRO housing, unattractive as it may have been, offered low-cost sanctuaries for the homeless, providing a degree of safety and mutual

support for those who lived within them. They were a demeaning version of the community health centers that society had promised; they were the de facto "halfway houses" of the 1970s. For these people too, then—at most half of the homeless single persons in America—the cause of homelessness is lack of housing.

A writer in the *New York Times* describes a homeless woman standing on a traffic island in Manhattan. "She was evicted from her small room in the hotel just across the street," and she is determined to get revenge. Until she does, "nothing will move her from that spot. . . . Her argumentativeness and her angry fixation on revenge, along with the apparent absence of hallucinations, mark her as a paranoid." Most physicians, I imagine, would be more reserved in passing judgment with so little evidence, but this author makes his diagnosis without hesitation. "The paranoids of the street," he says, "are among the most difficult to help."

Perhaps so. But does it depend on who is offering the help? Is anyone offering to help this woman get back her home? Is it crazy to seek vengeance for being thrown into the street? The absence of anger, some psychiatrists believe, might indicate much greater illness.

The same observer sees additional symptoms of pathology ("negative symptoms," he calls them) in the fact that many homeless persons demonstrate a "gross deterioration in their personal hygiene" and grooming, leading to "indifference" and "apathy." Having just identified one woman as unhealthy because she is so far from being "indifferent" as to seek revenge, he now sees apathy as evidence of illness; so consistency is not what we are looking for in this account. But how much less indifferent might the homeless be if those who decide their fate were less indifferent themselves? How might their grooming and hygiene be improved if they were permitted access to a public toilet?

In New York City, as in many cities, homeless people are denied the right to wash in public bathrooms, to store their few belongings in a public locker, or, in certain cases, to make use