Social support networks and health-oriented behaviors among skid row residents with disabilities utilizing social rehabilitation services in Kotobuki, Japan

Ayako IDE (OKOCHI) and Yoshihiko YAMAZAKI

This study investigates the social support networks, health-related behaviors, and indigenous theories influencing these of mentally or physically disabled residents of Japan’s skid row for the purpose of gaining insights that may improve the quality of care provided for this population. Ethnographic data was collected on fifteen subjects who received welfare and who attended either a disabled workshop or a psychiatric daycare in the skid row known as Kotobuki. Participatory fieldwork and semi-structured interviews were used to collect this data, which was analyzed qualitatively. We found that most subjects no longer maintained close relationships with family outside of Kotobuki, and that social support networks within Kotobuki were characterized by lack of depth and usefulness. Reasons for the weakness of the social support networks observed in Kotobuki included awareness of the dangers of the neighborhood, a fundamental lack of trust and wariness towards the other highly mobile residents, a desire to avoid money-related troubles, and the extremely small sizes of the rooms. Those subjects who did maintain close relationships with family outside of Kotobuki and those who had significant experience of regular company work as opposed to day laboring, demonstrated little sense of belonging and even weaker relationships within Kotobuki than the other subjects. Subjects spent little time with anybody else outside of either a workshop or a daycare, and they tended to fill the remaining hours of the day with walks, watching TV, and lying down. However, health itself did not serve as subjects’ primary motivation for the walks or medical visits. Support provided by medical and social service workers was invaluable to the subjects, who despite their medical issues did not have a social structure to support each other. How best to foster relationships with emotional support is a subject requiring long-term consideration.

Key words: disability, health-oriented behavior, skid row, social support networks, welfare service use

I Introduction

Kotobuki, Yokohama, is among the three largest doya-gai or skid row communities (consisting of flophouses called doya) in Japan. The combined population of the three largest skid row communities is approximately seventy thousand, with approximately 6,700 residents in Kotobuki alone (Yokohama-shi naka hukushi hoken center service ka hogo tanto, 2002). The area grew active as a casual labor market called yoseba following the end of WWII, (Tanaka, 2002). There was a need to
accommodate a growing day laborer population. Hence over 100 flophouses stood in this small district of about 0.06 km².

Doya (a flophouse) in skid row has minimal living facilities. Each room is a narrow 4.5 m², with communal bathrooms and kitchens. Only approximately 20–30% of these flophouses have elevators, sit-down (Western style) toilets, and air conditioning units (Yokohama–shi Kotobuki seikatsuukan, 2002 ; Matsumoto, 2003). A flophouse is the lowest of the Japanese standard of living continuum.

In Japanese parlance, the “homeless” are generally referred to those who truly live on the street. However, studies in Europe and the US conventionally regard skid row people as the homeless. Skid row residents share the borderless status with those who truly live on the streets and itinerant day workers (Aoki, 1996 ; Rossi, 1989). Also, they live in a substandard housing with extreme poverty. Considering these criteria, they are grouped together as “homeless” in a wide sense, although residents of flophouses are not literary roofless (Brickner, 1985 ; Giamo, 1995 ; Iwata, 2000 ; Rosenthal, 1994 ; Springer, 2000). Therefore, the term “homeless” as used below also encompasses skid row residents.

Kotobuki has developed as a day laborers’ settlement (Stevens, 1995). However, the disabled population has steadily climbed since the oil shock of the 70’s, both because of an influx of disabled persons from other areas and because of progressively more disabilities occurring in the existing day laborer population with advancing age (Yajima 1997). As of 2002, the physically disabled accounted for approximately 5% of the total residents’ population of Kotobuki (Yokohama–shi naka hukushi hoken center service ka hogo tanto, 2002). Meanwhile, it has been estimated that the mentally disabled account for at least 10% of the total Kotobuki population (Sugawara et al., 1998).

Meanwhile, the disabled population of Kotobuki is aging (Yokohama–shi Kotobuki Seikatsuukan, 2002), and both homelessness and the highly strenuous nature of day laborer work are taking a severe toll on physical health (Yajima, 1997).

Skid row residents are stigmatized and face prejudicial treatment from greater society (Bahr, 1973 ; Caplow et al., 1968 ; Fowler, 1996 ; Otsuka, 1983 ; Vexilard, 1956). Disability and advancing age also involve stigma (Edgerton, 1967 ; Goffman, 1963 ; Osgood, 1992 ; Palmore, 1990 ; Susman 1994). In addition, the fact that the majority of disabled in Kotobuki receive welfare adds another stigma as a welfare recipient (Spicker, 1984). Thus, disabled skid row residents suffer from multiple levels of stigmatization.

This stigmatized status can cause negative effects on social life as well as health of the disabled in skid row. They could hardly establish social networks and obtain social support and even one study shows that both being homeless and mentally disabled affect the extent and character of one’s social life (Segal et al., 1997). It has been reported that homeless people have a high rate of health problems such as alcoholism, drug addiction and tuberculosis (Brickner et al., 1972 ; Ensign and Gittelsohn, 1998 ; Katsushima et al., 1993 ; Kosugi, 1975 ; Miyashita, 1995 ; Murata, 1991 ; Owaki, 1999), and unfortunately they might have little chance to cope properly with their ill health because acknowledged, the mal functioning of the social support networks impact negatively on the management of health problems (Asakura, 2001 ; Berkman et al., 2000 ; Uchino et al., 1996).

It is beyond any doubt that disabled skid row residents face obstacles in their social relations as well as health. Nevertheless, almost no research has directly looked into their social relationships and health–oriented behaviors. Although interactions among skid row day laborers have been stud-
ied (Bahr, 1973; Fowler, 1996; Gill, 2001; Rooney, 1961; Stevens, 1995), those studies did not take account of the presence or absence of any disability. Moreover, except for the report of risk behaviors such as excessive drinking (Bahr and Langfur, 1967) and heavy smoking (Wright et al., 1987), almost no research is available on health-oriented behaviors of skid row residents with disability.

This study aims to shed light on the nature of social support networks as well as health-oriented behaviors among the disabled in Kotobuki. For this purpose, a qualitative methodology was selected as the most appropriate, considering the scarcity of previous studies that have examined these issues (Patton, 1990). Existing researches on disabled homeless in Europe and U.S. often focus on the mentally disabled (Rossi, 1989). However, considering the rarity of existing studies in Japan, we do not restrict the types of disabilities hereby studied. It takes as its subjects the mentally and physically disabled residents who use daytime facilities for the disabled. These facilities are both the workshop where most participants are physically disabled and the psychiatric daycare for mentally disabled.

Firstly, this research seeks to study the nature of the social support networks of disabled residents in Kotobuki both in general and in detail. It shows the structure and functions of their social support networks. It also clarifies the background factors affecting the state of their social support networks. Secondly, it evaluates their health behaviors and daily activities in order to understand their logics in coping with health problems. Thirdly, it seeks to outline a way that may improve the quality of care provided for this population.

II Methods

We basically use an ethnographic approach in which fieldwork is conducted to gain insight into the subject’s point of view on studied topics and as a result ethnography is written to portray their daily lives (Emerson, 2001). However, classical ethnography tends to focus only on the individuals in the field or confined to observations made in the field (Burawoy, 2000). In response to such criticism, anthropologists and sociologists have developed various methods that aim to extend those micro-minded methods to a more global level (Duneier, 1999; Burawoy, 1998). We will also utilize these techniques because in most homeless studies made since the 1980s researchers have focused more on macro factors that emphasize the interactions of individual and socio-economic factors (Rosenthal, 1994; Sonobe, 1996).

Fieldwork has been considered necessary not only to determine the focused topics of conducting studies (Whyte, 1984) but also to establish a rapport with the environment before starting to interview homeless people (Anderson, 1923; Bahr and Langfur, 1967; Fowler, 1996). Henceforth, the principal investigator in this study made visits to Kotobuki and volunteered at the facilities described above for about two years. The workshop studied was the first of three community-based workshops for disabled residents that have been established in Kotobuki. Most of its participants were physically disabled, although it serves some mentally handicapped and elderly users as well. This workshop had two full-time female staff members. The psychiatric daycare operated by a psychiatric clinic, offers programs for mentally disabled patients ranging from cooking together to sculpture to calligraphy. The psychiatric clinic, when part-time staff members were included, had three physicians, four nurses, an acupuncturist, two social workers and about seven other staff members. This clinic had more than two hundred patients a month. Both the disabled workshop and
the psychiatric daycare are open five days weekly. Average daily users were 17 (one woman) and 8 (two women) respectively.

In addition to participant observation at both facilities described above, she volunteered to conduct medical examinations for the homeless on the street, solicited opinions about health and social issues of residents in Kotobuki from medical and social workers, and visited homeless shelters. She encountered key informants like Doc who worked for Whyte to study an Italian slum (Whyte, 1993) or Hakim who was informing Duneier who studied people who made their livelihoods on the sidewalks (Duneier, 1999) who provided useful information of both town and people studied. Field notes were written immediately after the observation. No tape recorder was used during participant observation, because a tape recorder has been seen to be an overwhelming obstacle in skid row communications, as it tends to make participants less talkative (Fowler, 1996).

During her fieldwork, questions for intensive interviewing (Lofland and Lofland, 1995) were formulated, which resulted in interview guide with open-ended questions. Participants for these intensive interviews were recruited based on their willingness to cooperate and on recommendations from the facility staff. Interviews were performed at the workshop and daycare after other facility users had left. At the workshop only the interviewer and interviewee were present. However at the psychiatric daycare facility one male staff member was also present. Seventeen interviews were recorded with permission, excluding two interviews that a participant refused. All interviews were transcribed and afterwards interview transcripts, interview notes, and field notes were coded and categorized for analysis, using a standard methodology (Lofland and Lofland, 1995). Firstly, housekeeping coding was conducted to keep order in the basic information and later analytic coding was developed. At the initial stage of coding, as many separate codes as one can feel reasonable were generated. After these initial codes were accumulated, less productive codes were discarded and useful codes that should be focused on were selected. Facility staff, other researchers, and graduate students were consulted to help improve the validity of the analysis results.

As a fieldworker, ethical issues have been taken into consideration (Whyte, 1993). Research purpose and methodology were determined based on discussions with facility staff. The researcher conducted participant observation only after explaining the purpose of her data collection for an academic study. Participants’ consent was obtained after explaining interview purpose, participant rights, and privacy protection. Finally, care was taken in storing all field notes and memos that included participants’ names.

III Results

1. Subject attributes and backgrounds

Fifteen participants were recruited for interviews from the facilities described above. All participants were welfare recipients, and all, but one who lived in municipal housing nearby, lived in flop-houses in Kotobuki. All participants were Japanese citizens. Table 1 shows characteristics of those participants. The female participants who were the minority in this male dominant Kotobuki were coming from both facilities. Participants from the workshop were slightly older than the psychiatric daycare participants, with an average of sixty that is approximately two years older.

Seven participants had exclusively physical disabilities such as visual impairment, partial paralysis or amputation below the knee. The level of physical disabilities was relatively mild and two of these were congenital. Mental disabilities suffered
by the participants were: bipolar disorder, schizophrenia, depression, aftereffects of amphetamine use and alcoholism. Five out of seven psychiatric daycare participants were addicted to either drugs or alcohol. Two participants had both of physical and mental disabilities. At least eight participants suffered from sicknesses such as diabetes, tuberculosis, stomach ulcer, high blood pressure, myocardial infarction and spinal osteoarthritis.

Five of the fifteen participants had a high school education or greater, with psychiatric daycare participants having in general a higher level of education. Eight participants had experienced life as a day laborer, mostly as a construction worker called *dokata*. Both of peddler and deliveryman were another kinds of day work. Even among those who did not have day work experience, less stable types of occupations such as hostess, barten-
der, pinball parlor attendant and roadside stand vendor, were mentioned. Three participants from psychiatric daycare had relatively long experience of company employment. Also, nearly all participants from the disabled workshop had experienced unstable employment at the very beginning of their work lives. The workshop participants had fewer years of residence in Kotobuki. However, Six participants had experienced life on the streets, although this number was underestimated.

All participants were estranged from their family before coming to Kotobuki. Four out of fifteen participants had a father who either died or left home before they were 15 years old. Nine had been married (including common law marriages), and only one subject still lived with a spouse. The reasons for their estrangement from either their family of orientation or their family of procreation included

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<table>
<thead>
<tr>
<th>Variable</th>
<th>Total sample (N=15)</th>
<th>Workshop participants (N=8)</th>
<th>Psychiatric daycare participants (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male 13</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Age (years) Mean (range)</td>
<td>59.0 (48–72)</td>
<td>60.0 (48–72)</td>
<td>57.9 (49–70)</td>
</tr>
<tr>
<td>Types of disability</td>
<td>Physical disability only 7</td>
<td>7</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Mental disability only 6</td>
<td>—</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Physical and mental disability 2</td>
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<td>1</td>
</tr>
<tr>
<td>Suffering from a sickness other than the disability</td>
<td>Yes 8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Having high school education or greater</td>
<td>Yes 5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Experience of working as a day laborer</td>
<td>Yes 8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Residence in Kotobuki (years) Mean (range)</td>
<td>11.5 (25–1.5)</td>
<td>10.3 (2–25)</td>
<td>12.8 (1.5–37)</td>
</tr>
<tr>
<td>Experience of marriages (including common law marriages)</td>
<td>Yes 9</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Still married</td>
<td>1</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Relationships with family before residence in Kotobuki</td>
<td>15</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

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money problems, delinquency and mental disability.

Participants’ answers are given in quotation marks or fully written. Supplementary explanations are given in parenthesis, while non-verbal explanations are included in bracket.

2. Social networks

1) Current state of informal network creation

Relations with people other than the welfare or medical staff are referred to as “informal” networks. Table 2 shows the current state of informal network creation within and outside of Kotobuki. Nearly all participants claimed having some kind of relationships with Kotobuki people other than those at the workshop or daycare. Over half of the participants had friends within Kotobuki. However, only two of the fifteen participants claimed that their friends within skid row who were trustworthy and ready to give and/or receive aid. In addition, we have to mention that those friends included their divorced or separated spouses in Kotobuki and they actually served as a trustworthy or supportive friend. Therefore, with exception of these three participants, relationships within Kotobuki in most cases stopped at the level of daily greetings or acquaintance.

As for informal networks outside of Kotobuki, four out of fifteen participants had friends. Seven participants maintained regular contact with family members. Participants from psychiatric daycare tended to have more relationships with friends or family outside of Kotobuki than the workshop participants. With one exception, those who did maintain family contact did so with their family of orientation.

2) Factors affecting informal networks within Kotobuki

Social relationships within Kotobuki were characterized by their lack of depth. Even those participants who did have friendships described those as irregular relationships lacking trust, without even shared leisure activities. The shallowness of the social networks within Kotobuki is most directly attested to by the phenomenon of solitary death:

A female daycare participant: People die here all the time without anyone noticing. Just when you think you haven’t seen anybody for a while… they will have been dead a week.

Factors behind the shallow nature of Kotobuki’s social networks are: awareness of danger; distrust of other residents; wariness surrounding sharing personal information; caution of falling

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Table 2  Current state of informal network creation within and outside of Kotobuki

<table>
<thead>
<tr>
<th></th>
<th>Total sample (N=15)</th>
<th>Workshop participants (N=8)</th>
<th>Psychiatric daycare participants (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Kotobuki</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No contacts</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Greeting-level contacts</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Any friends*</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Any friends trustworthy</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Any friends with aid</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Outside of Kotobuki</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any friends</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Family with regular contacts</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*Include two of ex-spouses (divorced or separated).
into financial troubles; small rooms; and solitary tendencies.

Participants mentioned fearing danger such as robbery, beating and assault. Some of them described Kotobuki as a place full of “nagaremono” (vagrants), with a constant danger of theft and “maguro” (muggings), making it a place where “you can’t feel safe living.” Avoiding this kind of danger by voluntarily limiting their social networking was one pattern observed:

A male daycare participant: I don’t walk around in Kotobuki very much. It’s too dangerous. You could get beaten up horribly, then all your money taken. …It would be your own fault if you went there and something happened to you.

Some Kotobuki residents “have no concept of responsibility”, and so “tonko” (run away) with money from loan sharks or welfare payments. This results in distrust among other residents, who then lack desire to actively establish relationships:

A male workshop participant: I don’t think people in Kotobuki are…very good people…some people will borrow money and then run away. …You just can’t trust anybody.

Wariness surrounding sharing personal information is another reason. Participants describe avoiding serious relationships with other residents out of “wariness” about having others learn of their “dark pasts”:

A male daycare participant: We don’t talk much about ourselves. Just greetings, mostly. The other guy must have a past or other personal information he doesn’t want to share. People just don’t delve into each other’s lives here.

Participants describe avoiding any serious relationships because of the possibility that, if friendship is formed, financial troubles could consequently occur from lending money:

A male daycare participant: In Kotobuki, if you become friends with somebody there is always lending or borrowing of money. It’s really horrible, all the borrowing that goes on. You can’t avoid it. And, once it starts, it always leads to trouble. It’s better not to make friends.

The extremely narrow rooms also prevent visiting another’s room for pleasure or leisure activities. A male workshop participant: It’s hard to form relationships when everybody lives in such small rooms. The rooms are small to begin with, and then you have your stuff there too. What are you going to do when someone comes?

Lastly, solitary tendencies are observed. Participants tended to accept the shallowness of the social network because they are accustomed and resigned to isolation from long years of uncertain employment and estrangement from their families. They have also voluntarily lowered their expectations for interpersonal relations:

A male workshop participant: I’ve been alone for so long now…It’s been years…I just take it for granted now that I’m alone.

3) Sense of belonging

The sense of belonging to Kotobuki is another factor affecting their social networking. Two forms of this sense of belonging were observed: a fatalistic acceptance of life on skid row and a continued strong resistance to it. As described below, these are related to the types of relationships outside of Kotobuki.

Resignation led to fatalistic acceptance of life in Kotobuki. Participants who suffered from disabilities while wandering as itinerant workers since their teens describes a kind of psychological affinity with other residents who had similar life histories:

A male workshop participant: Everyone is like that in Kotobuki…after leaving the work bunkhouse…they get sick and then wind up here. That’s just how it is.

Those who have lived for so long at the bottom
of social ladder possess a pragmatic awareness that they “can’t do any better for themselves” now that they are disabled and elderly. They convince themselves that their disability or advanced age make them reliant on welfare.

A male workshop participant: I realize that this is all there is for me, and there’s no way around it…With my health as it is, I am resigned to it. If I was healthy, it would be a different story, but as it is I just accept things as they are.

Those with no friends or family to help them leave skid row must face the reality that they “can’t live anywhere else.” This leads to an acceptance that, for them, “It ends here (in Kotobuki).” They must learn to be “satisfied with life in Kotobuki.” Those participants who had arrived at this fatalistic sense of belonging in Kotobuki exhibited a tendency to form more intimate relationships than greeting-level ones.

In contrast, some participants talked about their dislike of Kotobuki and their desire for leaving. Four participants in the psychiatric daycare voluntarily described a desire to leave Kotobuki. These participants had long experience as company employees and continued maintaining close relationships with their families, which gave them more psychological distance from Kotobuki itself and the other residents. Thus, they had not internalized their status as Kotobuki residents:

A male daycare participant: I feel like I shouldn’t be in Kotobuki. I just don’t feel like this is a place where one should live. I guess [stops to think]...hmmm...[silence]…I hate the idea of ending everything here...

Thus the perception of living in Kotobuki as “not my true self”, and the goal of finding work to get off welfare and even leave Kotobuki:

A male daycare participant: I don’t want to spend the rest of my days in Kotobuki. …I’ll talk once more with someone down at the ward offices, have them rent me an apartment, and then live like a normal person...

Subjects with these kinds of wishes to return to life outside Kotobuki either had no friends in Kotobuki or, even if they did, still sought emotional fulfillment from family members outside.

### 3. Social support

1) Support from informal network

Support other than that received from welfare and medical services staff is referred to as “informal” support which has been prevalent in our study group. Basically, participants have been hesitant to give or receive support among residents, as they have been seen to subscribe to “individualism” where both dependence and being dependent are avoided.

A male daycare participant: I don’t want to have to bother with them (other psychiatric daycare users) at all. Yep, not my business… I just want to do the minimum I need to do to get by, by myself…I have no desire to get involved with other people’s lives...

Although the basic stance is one of “not having to deal with others”, some participants reported giving support in the form of goods or information about welfare to other peers who were unemployed and either in danger or already living on the streets. When others’ very survival was at stake, these subjects were willing to help out those worse off than they were:

A male daycare participant: I did aokan (living on the street) for about a month and a half. I knew a few people in Kotobuki, and some of them rendered favor of giving me some bread…those on the streets want cigarettes more than anything. Sometimes, I give them some.

In addition to residents’ support to those who live on the street, participants mentioned that emergency aid in the flophouses is also available.
Because flophouse residents live alone without anybody making regular visits, it is up to the flophouse manager ("choba-san") or neighbors to make emergency contact with welfare or medical services:

A male workshop participant: I was throwing up (blood) in my room... I live on the sixth floor, and the phone is on the first. I couldn’t walk down in my state. So I called someone who lived next door... I had him go down and ask choba-san to call me an ambulance.

Besides informal support among residents, some subjects received support from their families that they could not either obtain or were denied from formal support networks; especially monetary donation to meet their obligations to pay off bar tabs or gambling debts:

A male daycare participant: I call my sister once or twice a month... She gives me some money... 20–30,000 yen. I can’t let the welfare people find out though.

However, only three out of fifteen subjects described this kind of substantial support from their families.

2) Support from formal networks

The relations with welfare and facility staff members are referred to as “formal” social networks. They offer participants both emotional and informational support. For example, emotional support from facility staff members is observed in various situations such as cooking together at a psychiatric daycare or packing various merchandise at a workshop. Staff members resorted to praising participants for cutting vegetables beautifully or lining up toy parts neatly.

The principal investigator observed that facility staff members helped participants with moving from one flophouse to better one, with arranging nursing staff members for disabled residents who live alone in a flophouse, and with filling application forms for welfare. Welfare caseworker also arranged for the following participant a more comfortable flophouse:

A male workshop participant: The other place (previous flophouse) was so dark you had to turn the light on to see even during the day [laughter]. So, my caseworker (from the ward office) told me I’d get sick if I stayed there, and I should move (to the current flophouse). So, here I am.

Managing participants’ welfare money was another form of formal support. The majority of participants took charge of their monthly welfare payment (less than 150 thousand yen) and paid for their flophouse rent (about two thousand yen per day) through banks by themselves. However, some participants had facility staff or a welfare caseworker manage their money: pay their rent; decide the sum of amusement expenses they should receive and find a way to get out of their bar tabs. Otherwise, they would be afraid of being in danger of running out of money even within a day and being tempted to run away or tonko somewhere else. In other words, he/she would not “do anything good” (a male workshop participant), if welfare or facility staff did not take care of their social welfare payment.

Thus, formal support from staff members has been felt to be indispensable to participants. Participants often mentioned feeling gratitude toward welfare or facility staff, saying “thanks to” and “I’m indebted to” them:

A female daycare participant: I couldn’t have gotten to where I am today without Doctor Z (from the psychiatric clinic).

Some participants referred to their relation with staff members as “being dependent” on them. A staff member of the daycare admitted that some staff members were subjected to participants’ dependency. However, not only dependence but
also practical wisdom was observed which have been gained from the formal support given. Subjects were aware of the advantages of using the facilities in terms of maintaining their welfare status, and utilizing formal support:

*A male daycare participant*: The caseworker doesn’t say anything if you keep on going to these places, to the workshop or the daycare. The daycare staff will fill out the application forms for the welfare and send them to your caseworker every three months. That way the caseworker doesn’t say anything...It’s the most convenient thing there is.

### 4. Health-oriented behaviors

#### 1) Dietary habits

Over-consumption of carbohydrates characterizes the dietary habits of the subjects. Reasons behind that situation are lack of money, the inconvenience of the flophouse’s kitchens, and the fact that so many of the residents are single men. Participants usually bought rice for a month immediately after they obtained welfare payment. By doing this, they could secure enough food until next month’s payment even when they spent all allowances on *pachin-ko* (pinball) or drinking. When they could afford they treated themselves to *sozai* or cooked dishes to accompany their rice.

*Ramen* or precooked Chinese noodles have been known to be inexpensive and convenient meals. A pack of *ramen* is less than a dollar and you can cook it just by pouring boiled water or boiling it in a pan. Some complained that the communal kitchens in the flophouse have been overcrowded at mealtimes. However, in case of *ramen*, participants were not bothered with this congestion because they were able to cook it in their rooms. A participant with diabetes unfortunately mentioned that he/she was not able to resist this convenience and fed on to this finished his supper with high-carbohydrate and salty precooked Chinese noodles every day as they did not have many opportunities to share healthy meals served at the facilities. However communal lunch at the workshop and daycare has remained offered to them and has continued to provide a balanced and nutritional option for participants in addition to giving them to chance to socialize and converse with others. Some participants made a habit of going to these facilities especially because they enjoyed cooking and eating the food.

Besides providing lunch, the disabled facilities represent a place where “just being there is fun”, and is a daily destination that encourages health and thus results in a greater feeling of well-being and becomes an activity around which structure the participants’ day:

*A female workshop participant*: I am full of vigor.

...When I come here (the workshop) in the morning, I forget about the pain and everything else.

This pleasant time at these facilities greatly contrasted with the participants’ lives in their flophouse where boredom, laziness and inertia are master. Participants mentioned that they have been “just watching TV” or “just lying around in their flophouse. As an example of this excessive inertia, a medical staff of the psychiatric clinic mentioned that some physically fit residents had bedsores because they watched television all day in the same position.

#### 2) Non-health-oriented walks and exercise

Six subjects made a habit of taking walks outside of Kotobuki after workshop and daycare hours, with one subject using sports center until it was shut down. However health is not the main goal of these walks and exercise. Instead, subjects need a way to kill time because there is “nothing to do but stare into space” in their flophouse rooms. Also, by “immersing themselves in normal society” (from the interview with a clinic doctor), they alle-
violate the negative self-image arising from the stigma of living on skid row.

A male daycare participant: I feel frustrated and disappointed in living in this place. So, even if I get out of daycare early, I don’t want to go back (to the flophouse). So, on the way back, I’ll get on a bus and go into Yokohama, where I’ll just walk around town.

3) Reasons for physician visits

Subjects described themselves and their daily lives as “full of inertia”, “99% feel negligent and reckless”, and “half dead”. However, even subjects as despondent as these made regular visits to medical facilities, although not from purely health-related motivations. First, medical examinations have been required for maintaining welfare benefits for those who qualify for welfare based on illness or disability:

A male daycare participant: It’s our job to come to the hospital. As long as we come to the hospital when we’re supposed to, (the ward welfare case office) doesn’t say anything.

Besides fulfilling welfare requirement, seeking to communicate and chit chat with others was another reason for visiting the physician. As described earlier, the majority of participants had little chance to talk to others, and even when they did, they exhibited “wariness” around other residents. Medical staff, however, has given them another opportunity to communicate. Also, when their physical or mental condition is poor, participants can receive support from facility staff and other formal support providers, making themselves feel cared for.

A female daycare participant: There’s no one I can open my heart to. But, when something happens, I can go to my caseworker or the staff here (at the psychiatric clinic). There’s no one else, except Doctor Z. He will listen to anything I have to say.

These are the circumstances that attracted participants to seek regular medical care, even if they are not interested in direct health benefits per se. It is needless to say that participants had free access to medical care because of welfare.

5. Summary of the participants’ social support networks and their health-oriented behaviors

1) Social support networks

We found that informal social support networks within Kotobuki characterized by lack of depth. Most participants had greeting-level contacts with other residents. Also, solitary tendencies were observed. Participants described avoiding providing and receiving any supports from other residents. In addition, most participants no longer maintained close relationships with their family. Therefore, supports from their family were not available.

However, participants received formal supports from welfare and facility staff members. The relations with these staff members made good the shallowness of informal social support networks. Moreover, a principal investigator observed that participants made their daily visits to the facilities for the greater feeling of well-being.

2) Health-oriented behaviors

We found that the participants’ lives in their flop-houses were full of inertia. Some of them made a habit of taking walks and doing exercises mainly to kill time. Maintaining or enhancing health was not the main goal of these health-related behaviors.

Furthermore, participants made regular visits to physicians, although not from solely health-oriented motivations. Medical check-ups were recognized as the requirement for maintaining welfare benefits for them who qualified for welfare based on illness or disability.
IV Discussion

In this qualitative study, we found that informal networks within Kotobuki lacked in most cases deep contacts, although participants with disabilities did maintain some social networks with other residents. Characterized by irregular contact, interpersonal relations did not mature enough to allow trust and the ability to consult about problems to emerge. It is reported that homeless persons who receive low social security payments in the US and Europe developed systems of mutual assistance (Peterson and Maxwell, 1958). These support networks function to assist in survival on a daily level, and include sharing of food, alcohol, and tobacco (Cohen and Sokolovsky, 1989; Rooney, 1961). However, the subjects in this study demonstrated no need for substantial support, so support for actual survival was limited to only emergency cases. Because of financial security thanks to welfare, they might actually have less daily interaction and mutual assistance systems. More than 100 people are said to die solitary deaths in Kotobuki every year, either from illness or suicide. This socially solitary structure is similar to conditions in which a high rate of solitary deaths was reported among single residents of the temporary housing after the Kobe earthquake (Nukata, 1999).

A sense of discrimination among residents might hinder the formation of informal social networks. Participants from the psychiatric daycare who had expressed a dislike of Kotobuki had experiences of extended living and working outside of Kotobuki, while some of them had experiences of leaving skid row to live and work outside its confines. These participants, therefore, shouldered a certain pride that they were destined to leave Kotobuki again, placing them at a psychological distance from the other residents, who felt Kotobuki as home with resignation. In addition, these participants who had less sense of belonging to Kotobuki thought their mental disabilities could be cured and so that they could leave there. That is why some participants with mental disabilities might more often mention their wariness toward other residents than participants with physical disabilities. The discriminatory thinking of a part of mentally disabled participants is considered one of the factors behind the failure of creation of supportive informal networks in Kotobuki.

We found that disabled participants’ wariness to normal residents was another form of discriminatory thinking that led to shallow interaction. Participants who were disabled with advancing age were wary of normal or physically fit residents because some of them might become a mugger who beat up the disabled participant. Besides wariness, disabled participants showed a kind of prejudice toward highly mobile normal residents. Some normal residents tended to be highly mobile as a result of their debt or crime, while disabled participants settled down in Kotobuki to receive welfare. High mobility was not respected in Kotobuki. This situation contrasted with a hierarchy found in skid row of Chicago, with highly mobile seasonal workers at the top (Anderson, 1923). Wariness or caution against highly mobile normal residents affected relationships among the other residents as well, until social networks within Kotobuki became shallow.

However, relationships between facility staff and users compensated for support insufficiencies in the informal social networks, and also appeared to encourage appropriate responses to health problems among the participants. Participation in the workshop and psychiatric daycare provided a basis for psychological stability through emotional contact. Goldschmidt (1967) reported that being praised has a positive effect on mental health of mentally retarded people. It is considered that in
this study participants’ receiving praise from staff members and other users of the facilities served to improve negative self-images and enhance psychological well-being. Previous study on homeless youths says that they utilize their family and friends to tackle with their health problems (Ensign and Gittelsohn, 1998). In this study we found that instead of family and friends, facility staff turned to be a resource for dealing with health issues. In addition, staff members acted as “mediators” (Sussman, 1976) between participants and government workers or health care service providers who advocate for their needs.

It has been reported that many single mentally disabled persons living in neighboring city of Yokohama had neither place to go nor role to fulfill during the day (Oshima, 1998). We found that the facilities, which our participants utilized, served as a daily destination which previous research described above claimed the necessity of its presence. Because of its presence, none of the subjects showed ill health effects seen in Kotobuki residents such as bedsores from staying in their room with a same position all day (Yajima, 2001). Previous research confirmed the necessity of meaning and eventfulness in the lives of homeless mentally ill persons in the skid row district (Cohen, 2001). Participation in the facilities helped the subjects to establish routines in which they found meaningful human contact.

Participation in the facilities for the disabled is considered to provide a positive effect on participants’ psychological well-being. Participants felt confined in their cramped flophouse rooms with no privacy, as it has been reported that shared living has a negative effect on subjective QOL among the mentally disabled (Hansson et al., 2002). Then, the workshop for the disabled and the psychiatric day-care represent a daily escape from the flophouses, a place where participants could relax and feel safe within Kotobuki. Thus, participation in those facilities compensated for weakness of participants’ informal networks and as a result it helped to enhance their psychological well-being.

We also discovered that participants’ health-orientated behaviors were motivated by considerations other than health itself. The characteristics of their lifestyle were heavy consumption of carbohydrates and non-health-oriented walks. Their dietary habits were dependent on socioeconomic constraints such as money shortage and inconvenience of a communal kitchen. Balanced diet was not an option of even those who suffered from diabetes and high blood pressure. Previous research showed even in cases where food is relatively ample, lack of essential nutrients is found among the homeless (Wright et al., 1987). No-health-oriented walks were ways to fill up the rest of the day after participants left the day facilities. The main objective of this kind of walks was to kill time and therefore exercise or health per se was not much concerned about.

We found that participants’ physician visits were also motivated by their own logics other than seeking health itself. The fact that all participants were welfare recipients made maintaining eligibility for welfare payments of the highest priority. That is why they had to play a patient role and voluntarily received regular treatment. This model patient attitude is not consistent with a report about Kotobuki patients whose self-destructive attitudes caused them to abandon treatment (Katsushima et al., 1993). One potential reason for this inconsistency is that the participants of this study had a particular physician who has been the person’s regular source of care, which has been identified as an important variable of physician visit (Cockerham, 2001). Moreover, receiving none of the stigmatization from medical care staff that has been reported to deter the homeless from receiving care (Shiner,
was another potential reason for the participant continuation of medical care use.

This study shows the weakness of the informal support networks both within and outside of Kotobuki and especially emotional contacts were scarce. How best to foster relationships with an emotional element is a subject requiring long-term consideration. For this objective, this study also suggests the importance of volunteer activities that has been reported to provide the elderly facility users the chance of interactions with the persons outside of the facilities (Kai, 2002). We found no financial obstacle for the participants to seek medical care because welfare secured them free access of medical care. However, we suggest that considering how to improve the quality of medical care toward them is of necessity. This has been the problem remained to be solved even after the spread of welfare enabled medical use among the poorest (Cockerham, 2001).

This study suggests that new conceptual frameworks and measurement scales are required for studying the social support networks of the disabled skid row residents, because a degree of intimacy was not consistent with the one of general population. For instance, we found it difficult to categorize the participants’ relationships into those with confidants with whom they share a deep trust, and companions with whom they share leisure activities (Connidis and Davies, 1990). We also suggest the need to delve more deeply into the attitudes of disabled skid row residents regarding their own particular health issues. Seeking health per se was not the main objective of the participants’ health–oriented behaviors. Homeless studies have suggested the importance of focusing on their own logics in coping with health problems (Ensign and Gittelsohn, 1998; Shiner, 1995). Shedding light on the particular concepts of the health–oriented behaviors among the disabled skid row population is considered to be necessary in order to provide the most appropriate medical care.

The limitations of this study should be noted. Participants were recruited through the source of the facility users. The sample of this study lacks the literally homeless persons with disability who do not receive welfare. That is why participants of this study may not be the representatives of the larger population of disabled skid row residents. Allan (1989) discusses the influence of social and economic factors on friendship, and it is indeed possible that the fact that subjects were welfare recipients did affect their social support networks. There are also possibilities that results might have differed with disabled subjects with different kinds of disabilities or facilities used. Facility staffs were of the opinion that subjects spoke truthfully in the interviews, but investigator bias may still negatively impact the study results. The sample of this study is not affluent. As with all qualitative studies, statistically valid generalization cannot be undertaken. In the future study is required not only of other facilities within Kotobuki, but also disabled skid row populations who do not receive welfare in order to elucidate their social support networks and health–oriented behaviors.

V Conclusion

This research studied the social support networks and health–oriented behaviors of skid–row residents who utilized facilities for the disabled. We found hardly any informal networks existing offering support other than survival–oriented, substantive support on an emergency basis. We observed exercise and medical attention not primarily motivated by health alone, and the psychological stability fostered in participants by the facilities for the disabled they attended, which also lead to appropriate coping with health issues. Finally,
the solitary and aimless behavior exhibited by subjects after these facilities closed for the day suggests the need for a social locale at which they can spend time.

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References

Anderson N (1923) : The Hobo : The sociology of the homeless man, University of Chicago Press (Chicago)
Aoki H (1996) : Toshikaso no kozo to dotai—Yokohama/Kotobukichiku wo jirei to shite— (Structure and Dynamics of Lower Urban Strata—Using Kotobuki, Yokohama as an Example), Nihon Toshi Shakaigaku Nenkaiho, 14, 93–108 (in Japanese)
Bahr H (1973) : Skid row : An introduction to disaffiliation, Oxford University Press (New York)
Connidis I and Davies L (1990) : Confidants and companions in later life : The place of family and friends, J Gerontolo, 45, S141–S149
Edgerton R (1967) : The Cloak of Competence : Stigma in the lives of the mentally retarded, University of California Press, (Berkeley, California)
Gill T (2001) : Men of Uncertainty : The social organization of day laborers in contemporary Japan, State University of New York Press (New York)
Hansson L, Middelhoe T, Sogaard KW et al. (2002) : Living situation, subjective quality of life and social
network among individuals with schizophrenia living in community settings, Acta Psychiatr Scand, 105, 343–350


Kosugi Y (1975) : Alcohol chudoku to chichiki shakai–Osaka Airin chiku no chosa kara– (Alcoholism and local communities–a study of Osaka’s Airin district), Rinsho Seishingaku, 4, 297–308 (in Japanese)


Murata Y (1991) : Toshi no jyushu huteisyai to alcohol mondai–Kotobuki doyagai de seikatsu suru hiyaiyodorosha to alcohol mondai– (The homeless and alcoholism–alcoholism of day laborers living in Kotobuki skid row district), Alcohol Iryo Kenkyu, 8, 27–29 (in Japanese)


Osgood N (1992) : Suicide in Later Life : Recognizing the warning signs, Lexington Books (New York)


Otsuka Y (1983) : Hiyairodosha no machi kara (From the City of the Day Laborers), Rakan–tachi, 123–143 (in Japanese)


Rooney J (1961) : Group processes among skid row winos, Q J Stud Alcohol, 22, 444–460


Sonobe M (1996) : Homeless chosa wo meiguru hoho to data (Methods and data in surveys on the homeless), Nihon Toshi Shaikai Gakkai Kenpo, 14, 53–63 (in Japanese)


Sussman M (1976) : The family life of old people, Bin-


Vexilard A (1956): The hobo: Myths and realities, Diogenes, 16, 59–67


Yajima M (1997): Kotobuki chiku no rekishi to genkyo (History and current state of Kotobuki), Kotobuki hukushi sagyosho kinen shi, 12–24 (in Japanese)


Yokohama–shi Kotobuki Seikatsukan (in Japanese)


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