What are the health consequences of shared housing arrangements?

Introduction and Selection of Research Studies
Conventional wisdom holds that when economic times are tough, many households start sharing homes with family, friends, sometimes even boarders. Yet with increasing numbers of people sharing homes – sometimes by necessity, sometimes by interest – housing providers are concerned about potential health impacts of such living arrangements. Consequently, we asked:

- Why do people live in shared housing arrangements?
- How pervasive are such arrangements in the United States?
- What do we know about the effects of shared housing arrangements on the economic, psychological, and physical health of residents?
- What environmental factors mediate health outcomes?

We conducted a search of research articles addressing prevalence and health impacts of shared housing arrangements in the United States, identifying 26 studies. These and specific references cited in this synthesis report can be located at:


Why Do People Live in Shared Housing Arrangements?
Shared housing arrangements are typically seen as a response to dire circumstances, generally a lack of money to maintain one’s own home and the conditions creating this situation. But reasons claimed by people sharing homes include:

- **Emergency situation and need**: taking in others for temporary periods to help them cope with a variety of calamities that have occurred
- **Subsidy (or residential improvement)**: in order to live in a better quality home and/or neighborhood than one could afford by oneself
- **Growth and change**: for social support, companionship, and/or instrumental support (such as assistance with child care)
- **Dependency**: providing caretaking arrangements for persons unable to physically provide for themselves, often due to age or infirmity

Economic factors do play a role in a household’s choice of such living arrangements, but so do lifestyle, age, immigrant status, and cultural-ethnic background. Indeed, one study carried out in Wisconsin found that shared housing practices were, for many families, a form of increasing economic and social self-sufficiency (18).

How Pervasive are Shared Housing Arrangements?
Counts of shared housing arrangements vary because of different definitions and classifications, methods of calculations and projections, sampling procedures and national databases used.

Koebel and Murray’s analysis (9) of the U.S. Census Bureau’s **1989 American Housing Survey (AHS)** showed that nearly one-quarter of family households included persons outside the householder’s nuclear family, suggesting that sharing a home is much more common than often assumed. At all income levels, White family households were less likely to share a home than African Americans, Hispanic and other racial-ethnic groups.
Since there is limited research on the health impacts of shared housing arrangements, many critics extrapolate from the research on residential crowding and health. This synthesis does not consider those research studies unless there was a clearly delineated sample that included shared housing arrangements. While many such households may reflect crowded home conditions, so too do many households not sharing housing.

The National Alliance to End Homelessness (4) analyzed data from the U.S. Census Bureau’s 2005 American Community Survey. From that survey data, they created three classifications of shared living, with: (a) family; (b) family, friends, other non-relatives; and (c) subfamilies. Using these classifications they estimated lower and upper bound figures of 2.4 to 35 million people living in shared housing situations, with approximately 2.4 to 10.5 million of those living below the poverty level.

**What do we know about the effects of shared housing arrangements on the physical health of residents?**

There is very little public health research that explicitly focuses on shared housing conditions. Most of the assumed health implications come from research on crowded housing conditions – which is a problematic source since crowding itself does not always reflect shared housing arrangements. Public health surveys do find that children living in households with large numbers of residents (e.g. with six or more people) were more likely to have asthma, although living in large homes (e.g. of eight or more rooms) was associated with protective effects on respiratory health. Yet, whether or not shared housing arrangements contributed to the larger numbers of residents in a household were not verified by the data collected (25). When families move in together to share expenses, the resulting density has the potential to increase respiratory infections and reduce air quality. But by reducing its rent burden, families who share homes also have an opportunity to spend their budget on healthy foods, adequate heating and ventilation and healthcare. To date, these potential health behaviors and conditions are only speculative.

A number of gerontological researchers attest to the health benefits of shared living among the elderly, whether the arrangement is intergenerational or between older people close in age. However, most of this research evidence constitutes self-reported health conditions and behaviors, such as sleeping and eating.

**In short,** we know very little of how shared housing arrangements can exacerbate or promote physical health conditions. We still need to learn if such arrangements: place increased demands on housing systems that can foster asthma or other illnesses; by reducing rent burdens, provide increased time and money that is directed towards enhancing healthy living behaviors; or foster greater social interaction, resulting in improved health and competence among individuals who would otherwise socially withdraw.

**What do we know about the effects on the psychological health of residents?**

Again, very little of the research has examined the psychological health effects of shared housing arrangements. Speculation comes from research on crowded housing conditions that demonstrates that emotional strain results from conflicts among household members, particularly when it is difficult to physically distance oneself (e.g. going outside, having a private bedroom) from undesired social interaction in the home. However, whether or not such household conflict is more prominent among individuals in shared housing arrangements or in independent housing arrangements has not been identified in these studies.
Note: The “involuntary” nature of shared housing arrangements is often difficult to assess. In many instances, shared housing arrangements may not be the most desired living situation but still preferred over other available housing arrangements, such as homeless shelters, deteriorated public housing, or homes in threatening neighborhoods.

What do we know about the effects of shared housing arrangements on the economic health of residents?

Economic health is often not mentioned as an outcome of shared housing arrangements. Yet, small-scale, qualitative studies (18, 20) suggest that many residents sharing homes can and do improve their economic living circumstances.

Some nationwide surveys and studies shed light on potential impacts on economic health. Using the Panel Study of Income Dynamics, a national dataset that has surveyed the same individuals and families since 1968, researchers Jodi Sandfort and Martha Hill (21) tracked nearly 300 young women who had their first child when they were between the ages of 16 and 22 and who were unmarried at the time of the birth.3.5mm\hspace{0cm}

For these women, shared housing arrangements and child support were important factors in later improving the economic prospects of young mothers by enhancing their chances of getting more education and of having fewer children.

A national survey conducted by the Shared Housing Resource Center (16) in 1988 found that shared housing arrangements were not only a cost-saving solution to home seekers, but also a significant income and financial benefit for the home providers as well. The cost of five shared housing facilities in Philadelphia ranged from $17,750 to $35,000 per household served, while under HUD Section 202 projects, the average cost per household was $53,591.

What environmental factors mediate the health outcomes?

Residents’ control and choice over their living environments are important mediators in health as documented in the extensive health literature of environmental stress. Controlling and managing social relationships in the home seems to be central to enhancing healthy environments. Yet how this plays out in shared housing arrangements – and what role cultural background plays in such social household interaction -- has not been examined.

Research would also be greatly aided by more attentive measurement of housing conditions and design. In perhaps the only study examining spatial properties of dwellings occupied by residents sharing homes, Carole Després (6) found the physical properties of the post-war (i.e. after 1950) apartment buildings and detached houses were more difficult to adapt to shared living arrangements because of their small sizes and spatial layout. The pre-war housing was much more suitable for homesharing; perhaps not surprising since many such homes were originally designed for extended households (of family, boarders and/or servants). The spatial properties that appear conducive to shared housing arrangements include interior spaciousness; private nature of circulation paths (hallways, stairs) within the home; multiple circulation paths in the home; multiple living spaces and the greater degree of enclosure of these living spaces through the use of walls and doors; and relative position of the bedrooms.

The home’s capacity for controlling social interaction and defining territory was a key factor in enhancing the living environment of these residents sharing homes.

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