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Innovative Therapeutic Care for Homeless, Mentally Ill Clients: Intrapsychic Humanism in a Residential Setting

by Katherine Tyson and Emily Carroll

Abstract

Residential care is increasingly recognized as an invaluable therapeutic resource for homeless, severely mentally ill, and substance-abusing clients. However, those managers and staff seeking to provide residential care can be perplexed by the communications of these clients and would benefit from a conceptual framework for planning psychosocial interventions to address these clients' diverse problems. This paper describes how a comprehensive psychology-intrapsychic humanism can be used as a flexible, consistent guide for serving this population in residential care. Based on a central principle that staff-client relationships can be a path to healing, intrapsychic humanism's other precepts include treatment planning that recognizes clients' conflicting motives and strengthens their constructive motives, understanding clients' self-destructive responses to positive experiences, and helping clients govern their self-destructive behavior while enhancing their self-respect.

A Caregiving Opportunity for Social Workers

IN THE MOST RECENT STEP in the trend towards de-institutionalization of severely mentally ill clients, the Supreme Court's landmark decision on June 22, 1999, ruled that "isolating people with disabilities in big state institutions when there is no medical reason for their confinement is a form of discrimination that violates Federal disabilities law" (*New York Times*, 1999). The occasion for the decision was a lawsuit brought by two Atlanta women against the state of Georgia, claiming that they were being held in an inpatient setting when they could benefit from residential care, and that their rights under the 1990 Americans with Disabilities Act (ADA) were being violated by the excessive confinement. In addition, as the *Times* reported, a determined, vocal grassroots movement on behalf of the rights of persons with disabilities has arisen nationwide to support the rights of clients with severe mental illness to live in the community in

the least restrictive environments possible (Chamberlin, 1990; Harp, 1990; Tower, 1994). These groups are also active in demanding funding from states to develop residential care. Although there are cutbacks in resources for other forms of mental health care, increased funding is available through The U.S. Department of Housing and Urban Development and other federal and state sources for residential programs for homeless mentally ill clients. For these and a number of other reasons, residential care is seen as critical to the future of mental health services. Social workers are especially suited to direct residential care programs, because the programs use psychosocial rather than medical means of healing (Sullivan, 1992).

This paper applies the unique, original psychology, intrapsychic humanism, to offer guidelines that social workers can use for residential program planning and management. The conceptual framework used as the base for the research presented here is the postpositivist heuristic paradigm, with an emphasis on the value of research for advancing human rights (Heineman (Pieper), 1981,

1989; Tyson, 1995; Witkin, 1993). The data presented here in the form of examples have been gathered from many years of consultation with administrators and staff of residential programs for severely mentally ill clients.

We use the term “severely mentally ill” to delineate those people who have been diagnosed with major mental disorders (e.g., schizophrenia, bipolar disorder, and severe borderline personality disorder) that obstruct their ability to function autonomously in this highly competitive society (Rothbard, 1996). The approach presented here is a step towards remediating the negative stereotypes, stigmatization, and social isolation that so often accompany these syndromes and aggravate the clients’ distress (Estroff, 1981; Mansouri & Dowell, 1989; Rapp, Kisthardt, Gowdy, & Hanson, 1994; Saleebey, 1992).

One client, Ali, exemplifies the population that is our focus (in concert with statute and the social work codes of ethics, the names and identifying information of all clients have been changed to protect their confidentiality). Ali came for residential care following an outreach effort that had extended for more than 6 months. Residing in a cardboard box under a highway bridge in a well-to-do suburban neighborhood, he maintained a sense of dignity through his conviction that he had a “job.” Clothed in rags, with his hair in dreadlocks infested with vermin, Ali at first was reluctant to shower or change clothes, and responded to staff’s questions about the most basic information (e.g., his name, social security number, former addresses, medications he had taken) by saying, “I don’t want to participate in that research.” Staff were initially in a quandary about how to help him. Most of all, they were concerned that he frequently voiced strong feelings of missing his cardboard box home, even though it was wintertime and he had been subsisting in subzero temperatures. As will be seen below, using the intrapsychic humanism approach staff were able to help Ali. He benefited from residential care to the point where, after several months, he could be discharged to a stable residence, participate in an outpatient psychiatric day program, and regularly attend the residential program’s alumni group.

Definitions and Benefits of Residential Care

Residential care is the essential part of the therapeutic plan for these clients, because it surrounds the client with the active caring that can bring out the client’s latent self-caretaking capacity (Lipton, Nutt & Sabatini, 1988). Residential care has traditionally been defined as the provision of supportive services outside the contexts

of inpatient hospital care or a private home (Ridgway & Zippel, 1990). Residential care can apply to a short-term, emergency context (e.g., 3 weeks to 3 months), or to a transitional program (e.g., 18 months), or to a permanent housing program. Generally, residential facilities are apartment complexes or homes leased or built for this purpose, so there is 24-hour, on-site involvement of the residents with support staff. Although homeless mentally ill people use a combination of drop-in day centers and shelters, recent studies emphasize that incorporating residential care into the service plan is far more effective in breaking cycles of homelessness that may otherwise last for a year or more (Assembly Task Force on Homelessness, 1989b; St. Clair, 1994).

Since the deinstitutionalization movement began in the 1960s (Mechanic & Rochefort, 1990), it has been increasingly recognized that in addition to being more cost-effective than inpatient care, residential care is also a more humane alternative for caring for people who are not able to live autonomously (Susser, Goldfinger, & White, 1990). Residential care protects and monitors clients who are not stable in an outpatient therapeutic relationship, and simultaneously engages these clients in therapeutic activities and self-help. It commonly maximizes the positive effects of a peer group by promoting a constructive and supportive community experience (Ridgway & Zippel, 1990). While some clients use residential care as a respite, and some as a stepping-stone in preparation for living autonomously in the community, other clients need residential care on a more permanent basis in order to maintain adequate self-care (Levine & Rog, 1990).

Unfortunately, common financial management practices in halfway houses have undermined clients’ development of the capacity to live autonomously, because typically halfway house clients are given only a small allowance (e.g., \$30 per month), and payment for their care goes directly from the government to the halfway house. By contrast, using the intrapsychic humanism approach presented here, all clients retain control over their finances and are billed for their care. In one program applying these principles, those without funds are given \$1 daily for spending money, which is added up as a loan to be repaid after discharge. It is remarkable that when that program systematically evaluated how many clients paid back that loan, the staff found that a very significant number (including Ali) paid \$5 per month on a steady basis, and often the clients returned in person to repay the loans. This example also illustrates how these clients have a powerful need for a sense of dignity and honor, despite the extreme poverty of their circumstances. Another example

of this need for dignity is the client who was playing the drum on the street to pick up extra cash. When a program staff member wanted to put \$5 into his bucket, he refused, saying, “What you’ve done for me in the program has saved my life—it means more than anything else.”

The Need for a New Theoretical Approach to Residential Care

In our survey of 10 local directors of residential care programs for the severely mentally ill population, we found that they used a “holistic,” “nontheoretical,” or “skills-based approach,” relying heavily on a combination of psychopharmacological approaches to treatment and variations of a token economy system (behavioral control via rewards and punishments, Rogers & Skinner, 1956). This combination of interventions was for some time the best amalgam available for these clients in residential settings.

Although many studies document that token economies help to change some of the behaviors of severely mentally ill clients in a residential setting (Glynn, 1990; LePage, 1999), a token-economy system also has disadvantages. The most notable is that it fosters dependency—it gives clients the message that rather than having a capability for autonomous self-regulation that can be developed, they need to have their behavior controlled through environmental manipulations (Kohn, 1995; Rogers & Skinner, 1956). All too often, whatever behavioral changes might occur in a token economy system disappear when the client is no longer in that environment. The token economy system does not adequately prepare clients for independent living, and in fact makes it more difficult for them to navigate our society, partly because the rewards and consequences in place in society are very different and much more inconsistent than those used in an inpatient setting. Clinical experience indicates that many homeless mentally ill clients strongly resist interventions based on rewards and punishments, either actively by defiance or by leaving the program, or passively by withdrawal and immediate or eventual noncompliance (Harp, 1990).

There is no doubt that psychotropic medications can have some value under some circumstances for some clients, but an exclusively biochemical theoretical emphasis has a decided disadvantage because it does not lead to any consistent principles for managing programs with these clients. In addition, practitioners commonly voice the belief (accompanying the biochemical theory) that severe mental illnesses are genetically caused and incurable, even though this belief currently lacks consistent scientific evidence (Cohen, 1989; Gottesman, 1996; Tsuang,

1996). Such a standpoint fosters an unjustifiably pessimistic attitude about what social workers and other mental health staff can do to help.

Finally, the great majority of the population of severely mentally ill, homeless clients have had numerous previous experiences with medications and token economy systems. The clients’ homeless, severely mentally ill status in itself demonstrates that these approaches have proven to be insufficient for helping the clients to develop a capacity for autonomous self-caretaking. For instance, eventually Ali’s residential counselors learned that he had been hospitalized numerous times in one of the better state facilities, which had treated him with a token economy model and also all the available psychotropic medications. He also had often been a research subject in that context, which, he confided to staff, had been an unwelcome experience—hence his assumption, voiced above, that his care would again be influenced by research processes.

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A related contemporary approach, the psychosocial rehabilitation model, focuses on peer democracy, integration of clients into the community, normalization of lifestyles, and helping clients act as normally as possible through employment and peer socialization (Jackson, Purnell, Anderson, & Sheafar, 1996). However, some clients are unable to participate in these programs because they may be frightened of the community experience. Moreover, since research about these models tends to focus on specific services that are found to be helpful, such as groups (Brown & Ziefert, 1990; Martin & Nayowitz, 1989) or drop-in centers (Segal & Baumohl, 1985), practitioners still lack overarching principles to be used in planning care. Thus, a theoretical approach is needed that can be more universally applied. That is, a more logically consistent, well-documented conceptualization of how to make staff–client and client–client relationships as therapeutic as possible is needed (Levine & Huebner, 1991), to which this paper responds.

The Intrapsychic Humanism Psychology

Intrapsychic humanism is a comprehensive, general psychology developed using postpositivist scientific principles (Pieper & Pieper, 1990). The intrapsychic humanism treatment model is based on the principle that the most lasting psychological healing occurs through caregiving relationships. Intrapsychic humanism yields a culturally-sensitive, non-misogynistic, completely individualized treatment approach that incorporates advocacy, concrete service provision, and a focus on client strengths in the healing process. Research applying intrapsychic humanism has demonstrated that even extremely traumatized, violent clients can retain a capacity for autonomous, constructive self-regulation (stable self-worth and the capacity to make choices that are caretaking of oneself and others), which can then be elicited and developed using this treatment model (Pieper & Pieper, 1995). In addition to formulating this demonstrably effective approach to understanding psychopathology and treatment (Ishibashi, 1991; Pieper & Pieper, 1992, 1999; Tyson, 1991, 1994), the Piepers also have applied the intrapsychic humanism theory of child development in a book about effective parenting (Pieper & Pieper, 1999).

Adapting intrapsychic humanism for residential care leads to the principle that in a residential setting the caregiving relationships between clients and staff are of primary importance. But rather than foster dependency, they instead develop the client's autonomy. Intrapsychic humanism's relationship focus does not exclude interventions such as employment training and the use of psychotropic medications. Instead, the approach can be used for enhancing and integrating many interventions in a holistic residential care plan. Our focus on residential care does not imply that it can be a substitute for individual or group psychotherapy, as ideally these clients would have a psychotherapy relationship available to them in addition to their residential care. However, all too often severely mentally ill clients do not receive psychotherapy, and the residential care principles described below can be applied even under those unfortunate conditions.

Fundamentals of the Residential Care Process

Understanding the Clients' Psychopathology

While some people develop severe mental illness and homelessness as a consequence of physiological conditions that significantly impair their functioning (such as a severe head injury resulting in a delusional disorder),

research and our clinical experience indicate that the great majority of homeless, severely mentally ill clients have suffered from psychosocial trauma in the course of their development (Bassuk, 1986). Although clients with disabling physiological conditions also can benefit greatly from residential care using intrapsychic humanism principles, the focus of this paper is on understanding and providing care for those clients with psychopathology that results from psychosocial trauma. The traumas include serious illness in the child or parent, a parent's death, or interference with the parents' caregiving caused by war, poverty, long work hours that keep parents away from their children, and/or community violence. Another interference may be that despite their best intentions the clients' parents have their own deep conflicts about caregiving if they were abused or neglected as children, and so they may unintentionally abuse or neglect their own children. Intrapsychic humanism understands the clients' symptomatic, pain-ridden behaviors as expressions of motives acquired when the clients strove, in the face of these traumas, to maintain a sense of agency but did so by misidentifying the resulting unhappiness as ideal, self-caused parental care (Pieper & Pieper, 1990).

To elaborate, when such traumas cause children to experience sustained unhappiness, because they love and trust their parents and lack any standard of comparison, they identify their unhappiness with caregiving. In caring for themselves and others, they then copy and seek to reproduce these unpleasant and even abusive experiences to which they have, unknowingly, attached the meaning of ideal care. In effect, then, children acquire motives for unhappiness that, if untreated, persist into adulthood and are aggravated by further psychosocial traumas such as discrimination, community violence, and deprivation of adequate education (Pieper & Pieper, 1990). These acquired needs for unhappiness explain clients' irrational self-destructive choices, as in the abused partner who states, "I know he loves me because he hits me," or the client who feels soothed when he spends his entire check on a new stereo, denying the reality that he has no place to live.

Acquired needs for self-caused unhappiness can be understood as organized in two basic ways. First, clients have motives for experiences that others can see are self-destructive but which to clients represent conscious pleasure, such as substance abuse, gambling, and promiscuity (called here, motives for self-destructive forms of pleasure). Second, clients have motives to bring about self-destructive experiences that they recognize as unpleasurable. Typically, they are either unaware of the motives that cause these experiences (e.g., inciting conflict with

others, nightmares, fearsome hallucinations) or, if they are aware that the experiences are self-caused, believe they cannot stop themselves (e.g., self-cutting, consistently failing at jobs). Yet even the most traumatized individuals possess a third motive: to have a stable inner self-worth and be able to make reflective, self-caretaking choices. Since most clients will actively seek help in developing this motive (Pieper & Pieper, 1995) therapeutic interventions can work. Indeed, according to intrapsychic humanism, therapeutic relationship experience is the most powerful way to elicit and strengthen this innate motive for constructive self-caretaking pleasure, as will be seen further below.

Because these clients have been so traumatized, their self-destructive motives can seem overriding and it can be challenging for therapeutic staff to distinguish the three motives we have described. Most often the constructive motives are embedded in considerable self-destructiveness, and motives for self-destructive forms of pleasure and unpleasure may be entangled with each other. An example is when a client is involved with an abusive partner: The client's motives for constructive pleasure are expressed in the effort to be involved with a partner; however, the self-destructive motives create a pattern of connection to abusive partners. One reason it is important to perceive clients' different motives is that without help clients generally cannot distinguish their constructive and self-destructive motives, so they do not know their own ability and potential, nor can they control the motives that sabotage their unhappiness.

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In addition to early trauma, severely mentally ill, homeless clients have commonly experienced recent, often chronic, aggravating conditions. They become homeless because environmental supports, such as funding and family care, are inadequate and even completely unavailable (Belcher & DiBlasio, 1990; Goldman & Gattozzi, 1988). They may be immigrants suffering from culture shock, unable to advocate for their own needs, or ineligible for funding and medical care. They may suffer

from a range of traumatic health problems including head injuries, chronic illnesses such as diabetes and thyroid disorders, or terminal illnesses such as cancer, Alzheimer's disease, and AIDS (Spitz, 1996). These more recent traumatic losses obstruct clients' ability to function effectively, further erode their autonomous self-worth, and undermine their hope that others will provide helpful care. Additionally, the pain of these losses all too often increases the self-loathing and alienation generated by the client's self-destructive motives. Accordingly, a major priority in residential care is to enlist the clients' constructive motives by earning their trust and giving them the experience of controlling their destinies and, thus, creating meaningful, fulfilling lives (Belcher & Ephross, 1989; Susser et al., 1990).

A Therapeutic Process Based on Strengthening the Clients' Constructive Motives

Eliminating these clients' homelessness requires an outreach and case management process that continues into residential treatment (Drake, Teague, & Warren, 1990; Levine & Huebner, 1991; Susser, Goldfinger, & White, 1990). Residential care staff can enable the clients to maintain connections with service providers and by providing for their basic needs, reduce their anxiety about survival and enhance their reality-testing. The intensive, constant care provided in a residential setting based on intrapsychic humanism principles helps clients to experience their own constructive motives reflectively, often for the first time. One of the most essential principles of milieu therapy is that the client identifies with the way the staff relates with the client, and this identification elicits and strengthens the client's motives for constructive self-caretaking pleasure in many ways (forming friendships, developing vocational motives, improving physical self-care, etc.). Residential care has a therapeutic effect as clients gradually forego their needs for unhappiness because they recognize that pursuing their constructive motives affords greater pleasure, as will be shown in numerous instances below.

A residential care program for this population has three goals as a base for the casework plan: helping clients to obtain (a) housing, (b) funding, and (c) psychological stabilization. Providing concrete services—housing, meals, funding, and medical and dental care—is the fundamental precursor that makes it possible for the client to experience a psychological change process through supportive relationships with staff. The psychological stabilization results in reduction of those expressions of self-destructive motives (i.e. symptoms) that are

most corrosive of the client's day-to-day self-care, such as paranoia (which causes clients to feel they can only feel good if they withdraw or express their alienation by inciting interpersonal conflict) or grandiose delusions (which cause clients to make choices that endanger themselves or others). The staff's involvement with patients through concrete services (e.g., helping clients with laundry, grocery shopping, and other basic necessities, and being present for and serving meals) provides a nurturing context within which the client's motives for constructive forms of pleasure can be consistently strengthened and clients are supported in foregoing their self-destructive motives. Clients need to feel there is a relaxed environment where people are available but where clients are not being evaluated or watched in a critical way; so optimally, the milieu is built on a very tolerant, flexible approach that responds to a high degree of deviant symptomatology without censure (Susser et al., 1990).

These clients' self-destructive motives were formed in contexts where relationship experience was associated with conflict, rejection, alienation, loss, and/or competition. Since the experience of being a respected member of a community is foreign to most of them, the community setting of a residential treatment program affords an intrinsic group structure that can be a natural healing agent. Because intrapsychic humanism recognizes that humans develop optimally through experiences of relationship pleasure, an important way to help clients strengthen their constructive motives is to encourage their participation in unit activities, which means involvement with other clients and staff in supportive and educational groups (e.g., men's and women's groups, groups for art therapy, current events, discussing medications, and job hunting). The groups offer opportunities to learn skills, and, as therapeutic change agents, can be effective in eliciting and strengthening clients' motives for constructive forms of pleasure.

This approach to milieu therapy emphasizes respect of the client's pace regarding involvement in and availability to caregiving relationships, with the precondition that all clients are expected to attend all treatment appointments. New clients need to be able to settle in at their own speeds and yet become part of the milieu in their own ways. For example, within the first few days clients can receive orientation from residents who have been there longer, join community meetings immediately, and sign up for chores. This enables new residents to feel included. The counseling or case management discussions between clients and staff can occur in the place the client chooses—e.g., at the client's door, in a private room, in the milieu, during games.

In formulating specific goals of care, the focus is on responding to what the client regards as important in a way that will give the client an experience of her/his own healthy self-caretaking agency. Many seemingly small actions on the part of staff can have powerful healing effects. For example, Fernando had bought a pair of sneakers that turned out to be defective. A lifetime of demeaning discrimination had taught him to accept unfair deals, but he showed the sneakers to staff, who then offered to go with him and return the shoes in exchange for an intact pair. He was at first stunned and then, when they made the exchange, profoundly moved. He felt truly respected and could experience someone as aiding him in advocating for himself in the wider community. This interaction was one of many that resulted in Fernando making a successful transition to a long-term transitional living program and also engaging many of his homeless friends into residential care.

By contrast with other approaches that rely on insight or behavioral control and that frequently employ confrontation (Harris, 1988), the intrapsychic humanism model focuses on giving clients space and plenty of chances, and confrontation is rarely used as a therapeutic intervention. For example, Michael had been in a residential program for 3 months and was just making a commitment to an employment training program. Then, in an upsurge of self-destructive motives, he was late for curfew and gave the excuse that he had to take his relative to the hospital. When staff administered the urine drug test always given to tardy clients, they found no evidence of intoxication. Aiming to control Michael's self-destructive behavior, staff considered a lecture, confrontation, imposing negative consequences, or a warning. However, they reasoned that it was more supportive of Michael's constructive motives to preserve his experience of being trusted, which the foregoing options would only erode. The staff's acceptance of his excuse and welcoming confidence allowed him to relax and become more involved with the program. Subsequently, Michael returned more punctually and also continued to pursue the employment program.

Assessment and the Admissions Process

While most clients seeking care can be helped by a therapeutic process based on intrapsychic humanism principles, the context that is needed for clients to benefit varies considerably depending on the balance between the client's constructive and self-destructive motives. In a residential care context, the aim is that clients experience

both their constructive and self-destructive motives as reliably recognized by caregiving staff, which occurs when there is a good fit between the client and the program. Some client's self-destructive motives are so powerful that they need intensive inpatient care before they can make use of residential care, and so it is important to avail ourselves of all levels of care in order to aid these clients (Lamb, 1984). Moreover, residential programs can be available that provide varying degrees of structure and organization in response to clients' individual needs (Bachrach, 1989). Accordingly, a crucial aspect of assessment and admissions decisions is determining whether the balance between the client's constructive and self-destructive motives is such that the client can make use of a residential program.

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An example of a client who was not yet ready for residential care is Charles, who had suffered traumatic family losses during his childhood and who, morbidly obese, suffered from life-threatening heart disease, a longstanding serious thought disorder, and severe depression. Through numerous inpatient admissions and discharges over the past 20 years, Charles had consistently made violent suicide attempts within 3 weeks of being discharged from the hospital to residential care. But as long as he was in intensive inpatient care, which protected him from acting out his self-destructive motives and provided him with a very high degree of interactive support for his constructive motives, Charles did not make suicidal gestures. He interacted well with other clients and staff and was a productive member of the inpatient employment training program. Perhaps after several years of uninterrupted inpatient care, Charles' constructive motives would have sufficient hegemony over his self-destructive motives for him to stably enter residential care. For such clients, the active caring of inpatient treatment is needed on a very

long-term basis. Unfortunately, such long-term intensive inpatient care is more and more difficult to obtain. All the same, it is far better to plan care recognizing the client's needs and to advocate for more resources, rather than to force clients to fit into environments unsuited for them, thereby precipitating destructive reactions (Axleroad & Toff, 1987; Morrissey & Levine, 1987). Also, this recognition helps staff to avoid the consequences of an unrealistic therapeutic ambition that misunderstands clients and sets unmeetable demands on clients and staff.

The Pivotal Role of the Mental Health Worker

Services for homeless and severely mentally ill clients tend to be organized around either a *team* model (in which care for a client is distributed among members), or a *primary relationship* model (in which one staff member, the *primary*, has major responsibility for the care plan and for providing supportive counseling and location of resources (Assembly Task Force on Homelessness, 1989a; Daly, 1996; Harris, 1988). From the standpoint of intrapsychic humanism, the primary relationship approach is optimal. It offers more opportunities for a deeper caregiving intimacy between the client and her/his primary, whereas the team model inevitably results in more superficial relationships between the client and staff members. With a deeper knowledge of the client, the primary staff member can better individualize the treatment plan, including how the staff member relates to primary clients. It follows then that clients can be empowered through the relationship process itself. In other words, instead of the token economy focus on behavior and the (unrealizable) aim of consistency across clients, individualized tailoring of staff-client contact makes it possible for clients to experience their communications about their wishes for involvement with staff as an effective means of making their caregiving relationships with staff a pleasurable, supportive experience.

For instance, when Ali first came to a residential care program, he responded to a second 20-minute interview with his primary by withdrawing into his room during the time the interview was scheduled. Staff worker and supervisor concluded that the withdrawal was not a reaction to a caregiving lapse (Pieper & Pieper, 1990, p. 210-211) by the worker, but that instead the sustained contact was frightening to the part of Ali that felt shielded by the emotional distance built in to his previous way of living. The worker and Ali planned a brief check-in twice a day as opposed to one 20-minute interview every day. Ali valued the brief check-ins, and his capacity to receive care steadily grew to the point where he could even

regularly attend the alumni group after discharge. A key to the effectiveness of this approach is that the therapeutic plan and goals are based on providing care in a way that the client can experience as empowering. Accordingly, as the example of Ali illustrates, the goal is never that Ali would be able to attend 20-minute interviews or comply with some universally applied behavioral goals (as in the token economy model), but rather that staff be able to discern and respond to each client's motives for constructive forms of pleasure in ways that consistently strengthen those motives.

What clients can experience as caregiving varies considerably. For instance, Tony, a musician who was very proud, suffered from an acutely decompensated psychosis that interfered with his problem solving. Even more, he soothed profound feelings of shame with a reactive pride that made it impossible for him to ask for help with even the simplest things, such as operating the stereo. This motive for a self-destructive kind of pleasure was very crippling for him. Once staff understood this dynamic, they diplomatically offered assistance in a light, casual way. Tony became able to accept help in a variety of ways and entered a job rehabilitation program, to which his shame had previously erected an impenetrable obstacle.

A contrasting example is 30-year-old Melinda who, staff said, practically wore them out with her constant pleas for their attention. Entering the program from a family in which she had been literally bound and sexually abused for 15 years, she was overcome with feelings of helpless incompetence. She needed almost constant contact to begin to experience her constructive, self-caretaking motives, and that is how a healthy sense of agency grew. Staff had been faced with the choice of either (a) responding to her many demands in the belief that their caregiving availability would stimulate her autonomous self-caretaking motives, embedded in her frantic requests for help, or (b) setting limits in the belief that doing so would make her realize that help would always be limited. They followed the intrapsychic humanism model and tried to respond as much as possible to even her seemingly maladaptive requests. Their responsiveness helped Melinda become more solidly connected with staff, and then she realized that she could wait quietly and staff would still help her. Within 2 weeks she was able to be more resilient and autonomous.

It is important to understand that these clients often find it extremely difficult to express the impact of the caregiving relationships offered while the care is ongoing. They can make considerable changes, yet seem not to connect the changes explicitly to the staff-client relationships.

However, we have found that in fact clients believe there is a powerful connection between what transpires in these relationships and client behavior—in one written survey of 190 clients receiving emergency residential care, we found that more than 80% of the clients rated their relationships with staff as the single most important form of help the program made available to them (Tyson & Carroll, 1992).

Giving Clients as Much Agency as Possible

This client population tends to have been so deprived and abused from childhood on that they most commonly experience themselves as reacting to negative external influences rather than as having a sense of control over their own choices and, ultimately, their own lives. In the reflective atmosphere of a compassionate residential care program, clients whose basic needs for food, clothing, and shelter are met and who feel safe in the supportive relationships often make use of the opportunity to take a step back, evaluate their lives, and, often for the first time, begin to think about what they really want for themselves. Staff can encourage this process in clients, which, in many ways, is critical to the process of recovery.

For many clients, having a staff member ask what they want and help them to realize their constructive aims is a unique experience. Staff can help clients think through the concrete aspects of their aftercare plan—where they will live, their sources of funding, where they will receive ongoing supportive care, employment possibilities, etc. Many studies emphasize that effective practice with this population is based on respecting clients' self-determination (Coursey, Farrell, & Zahniser, 1991; Leete, 1988; Sheridan, Gowen, & Halpin, 1993); when clients' constructive motives are respected, they experience a healthy sense of agency.

At times when clients' goals are not realistic (e.g., the man who, surviving on a small federal grant and unable to care for himself autonomously, nonetheless wanted to live in an expensive high-rise), staff can gently steer clients in a direction that will be attainable and which the clients can feel is a step towards a valued goal that is also good for them. For instance, rather than requiring clients to adopt the common, but unjustifiably negative viewpoint that they have an incurable mental illness that will require a lifetime of medications and dependency, it is preferable to aid clients in moving step-by-step towards accomplishing their goals. This experience of hope and agency is, in itself, profoundly therapeutic for these clients and is often a new experience.

As noted above, the staff member does not take all the client's wishes as equally desirable, because the cli-

ents' needs for unhappiness can be, unbeknownst to them, skewing her or his goals. Assessment, then, continues to be of utmost importance, and in terms of psychological change, the staff member evaluates (1) where, in the client's goals, the client's healthy self-caretaking motives are expressed and how those motives can be strengthened via a care plan, and (2) where in the client's goals the most toxic aspects of the client's self-destructive motives are expressed, so that the staff can help the client with self-protection.

The focus is on evaluating their loss
on an individual basis to see how client
motives—constructive and self-destructive—
are directing response to the loss.

For example, Olivia's boyfriend broke her jaw and three ribs, and her body was full of scars from previous episodes of violence. She had become addicted to alcohol as a way of numbing herself to her boyfriend's violence, and stated her primary goal was to return to her boyfriend, who, she said, was the most wonderful man she had ever met. The staff reasoned that her healthy motive to have a satisfying romantic intimacy was constantly being overtaken by her need to re-create in her current life the extremely abusive parenting relationships she had been subjected to in her childhood. The therapeutic plan was to demonstrate that a rage-free caring relationship was more pleasurable than an abusive relationship, and to help her feel she was making self-caretaking choices. Since her boyfriend was in jail only temporarily for the violence against her, staff asked her to refrain from telling him where she was staying, which she agreed to do as long as she could maintain her telephone contacts with him. Olivia was able intermittently to recognize that her boyfriend was in need of help to control his violence, so staff supported her motive to cooperate with legal authorities. They did not confront her motive for involvement with him. After several months of supportive care, Olivia had made significant incremental steps towards freeing herself from the abuse: she successfully protected herself from her boyfriend, testified in court about what he had done to her so that he stayed in jail, and resumed mothering responsibilities for her twin children. Also, she was able to hold onto the hope that he would be helped as she had been.

Staff often are challenged when client needs for unhappiness take socially inappropriate or unsafe forms. It might seem necessary to curb the client's expression of these motives in order to bring about socially appropriate behavior. An example is Charisse, who had the common symptom of hoarding (a motive for a self-destructive form of pleasure). Charisse hoarded plastic flowers, so many that her tiny room was filled with a myriad of brightly colored roses, orchids, daffodils, snapdragons, daisies, and asters. Staff, in a quandary, interpreted safety rules rigidly rather than trying to come up with creative solutions. She was required to dispose of the flowers within 24 hours. Charisse accepted the news stoically, but then, agonized and confused, first dumped coffee all over the dining area and then stuffed her flowers into garbage bags and went back to live on the streets. An outreach team found her, floridly delusional, hallucinating, and still clutching her bags full of flowers. When the staff reflected on this incident from an intrapsychic humanism viewpoint, they realized that the negative consequences of restricting the client's agency outweighed other considerations. They decided in the future to try to find more creative solutions that would enhance the client's capacity for constructive self-regulation. One staff member reflected that they could have discussed the problem with Charisse and set up a system where she could keep most of her flowers in another room and choose which flowers to rotate into her room on an ongoing basis.

Another example is that given their habituation to a harshly depriving, survival-based lifestyle on the streets, these clients often hoard food, which can be hazardous to the community because it can attract vermin. Staff can find creative solutions so that clients can keep their food safely. For example, one program recently gave clients plastic storage containers as Christmas gifts. With time, as these clients discover that food is readily available, they give up the need to hoard food.

Helping Clients With Their Psychological Crises

Clients generally seek emergency residential care because they have experienced a psychological destabilization in reaction to a threatened or actual loss. The ache of the loss typically inflames the client's self-destructive motives, unhinging their coping skills so that they become unable to care for themselves and even become suicidal or homicidal. Most often, clients experience the loss through the lens of their core sense of worthlessness, so it signifies their incompetence, undesirability, or inability to create a meaningful life.

Rather than aiming to control the upsurges in the clients' maladaptive behavior by prioritizing medication compliance or by using behavioral change methods, when staff use the intrapsychic humanism theory for crisis intervention, they focus on empowering the clients by helping them to seek comfort for their losses through supportive relationships, and to find ways to cope adaptively with the consequences of their losses (Tyson, 1999). The focus is on evaluating their loss on an individual basis to see how client motives—constructive and self-destructive—are directing response to the loss. Then, staff support the client's constructive motives. This is not easy to do because for these clients, the constructive motives commonly are embedded fairly deeply in seemingly dysfunctional behavior patterns.

An example is Celina, who had been an alcoholic for many years and learned she had a genetic heart valve impairment that required a potentially life-threatening surgery. She had delayed the surgery for some time, and then, upon scheduling it, began, in a nonchalant, entitled way, to ask staff for special favors (e.g. extra loans, making coffee before the appointed time, etc.). Perceiving Celina's constructive motives was especially challenging for staff because she was soothing her terror about the surgery with a motive for a form of self-destructive pleasure expressed in a diffidence that demonstrated no recognition on her part that her requests were either important to her or deviations from program rules. Yet, rather than focusing on a concern that gratifying her requests would set a bad precedent for her and other clients (a behavioral control model), staff decided that embedded in her requests was a constructive motive to use their care to soothe her anxiety about the impending surgery, rather than to turn to alcohol as had been her wont. With staff's support of her heightened wishes for care, Celina faced the surgery without relapsing.

Understanding Clients' Aversive Reactions

Given that residential care is always voluntary (in the sense that clients needing involuntary commitment are not eligible but are inpatients), clients seek residential care because, to greater and lesser degrees, they want help of some kind. In general, clients arrive, meet the staff, and make a commitment to participating in residential care. Then, their learned needs for unhappiness cause ongoing paradoxical reactions to the process of receiving care. These paradoxical, negative reactions to the client's gratification of constructive motives are termed in intrapsychic humanism *aversive reactions to pleasure* (Pieper & Pieper 1990, 1999).

Although observers can perceive the client clinging to such manifestly self-sabotaging patterns, from the client's perspective, these patterns are needed sources of gratification. For people who had become so accustomed to unhappiness, what feels most familiar and comfortable is pain and abuse (e.g., living in a cardboard box, being involved in unhealthy relationships, being addicted to drugs or alcohol). Their aversive reactions to getting residential care are caused by the part of them that has misidentified abuse as care, and so causes them to treat themselves abusively. These motives can lead the client to undermine the therapeutic process, before the client has any awareness of this dynamic. An important variation of these aversive reactions is the conviction, "I know they will kick me out soon," an experience that often leads the client to try to make the axe fall and get the rejection over with. Another common aversive reaction is when clients acquire some money upon linking with social services, and then go on a drinking spree or give the money to an abusive relative.

Often, these clients' aversive reactions to getting help initially take the form of substance abuse (about 80% of severely mentally ill patients have substance abuse problems [Drake, Teague, & Warren, 1990; Walsh, 1986]). One policy that helps clients regulate their motives for substance abuse is to require that they be on the premises of the unit, with the exception of therapy appointments and brief breaks (e.g., for smoking), for 7 days after admission. The great majority of clients can ride through these initial aversive reactions with this kind of rule. Such a program policy actively shores up the clients' self-care-taking motives and helps the clients control their reactive needs for unhappiness. It also fosters the engagement process, so that once the 7-day restriction has expired, the clients' newly formed relationships with staff can aid in controlling their self-sabotaging motives. Some clients' aversive reactions are so extreme that it becomes evident that for safety reasons they have to be cared for in inpatient programs. For instance, they smoke in bed, break curfew, or instigate a physical fight with another client.

Understanding clients' aversive reactions helps staff focus on clients' constructive motives, which is essential to forming a stable, healing alliance, even when the clients are behaving in bizarre, negative, or rejecting ways. For instance, Shondra was a 40-year-old woman who had graduated from college and worked as an art teacher for some time. During an acute episode of a longstanding psychotic illness, she adopted the name of Mary, obtained a new social security number, and, dressed in a full-length blue coat, with very long curly hair, presented

herself as a prophetess and sought to enlist converts by preaching in and around McDonald's. Police brought her to the hospital after numerous arrests for disorderly conduct. She entered care in a state of acute hunger, unwashed, with many layers of rags but in fact barely clothed. Despite the evident psychosis caused by her self-destructive motives, she demonstrated a constructive self-caretaking motive when she said that her goals for being in the program were to have help with "schizophrenia" and to "have better relationships." After a month in care, and on a small dose of medication, she formed a good alliance with the program staff and especially her primary worker. She ate profusely, so that she was no longer malnourished, had help in dressing appropriately, and attended all the group meetings where she was quiet but available to help. Then, she abruptly began to go back to McDonald's, preaching in such a manner that she might provoke the police to arrest her for disorderly conduct. The staff understood her reactivated "preaching" (a motive for a self-destructive form of pleasure) as an aversive reaction and asked her why she felt it necessary to resume preaching again. The staff's aim was to communicate to Shondra that they would stick with her through the process of getting control over this aversive reaction to settling down, so they could help her on to the next step of developing some productive goals for her life. She confided she was worried there would be an apocalypse at the new millenium, and she was trying to help people prepare for it. Over the course of these discussions, staff suggested alternative ways she could fulfill her religious zeal. Although she did not follow up on any suggestions, the supportive process of talking through her fears gradually strengthened her constructive motives so she could forego endangering herself in her preaching.

One of Daniella's aversive reactions took the not uncommon form of a drug relapse that necessitated her discharge from the program (e.g., Walsh, 1986). She was 60-years-old, feeble and disorganized, and had been helped off the streets and into the residential program by a diligent outreach team. She accepted residential care for a week, but then went away for a weekend and returned late, claiming that her food had been poisoned at a restaurant. She tested positive for valium and was discharged to a state hospital. From the hospital, she called the program director every week for 3 months (the period of time it took for her to be restabilized on new medications). In her pleas to the program director, she repeatedly asked for readmission, while still claiming she had been poisoned at the restaurant. Rather than focusing on Daniella's manifest difficulty telling the truth, which was

part of her aversive reaction, the program director focused on her motivation to return to the program, and accepted her back. She stayed for several months, obtained funding, was involved in the groups, had no further relapses, was discharged to autonomous housing, and remained a loyal member of the alumni group.

Why Discharge as We Know It Should Be Ended

Although discharge has tended to be regarded as an inevitable event in short-term residential care, several data indicate that a more helpful focus is on enabling these clients to make use of residential care for as long as they need it (Christ & Hayden, 1989; Lamb, 1984). Most notable of all is that many homeless mentally ill clients are intensely motivated for a secure, stable, long-term residential care option when it is offered based on the principles described above. In one program based on intrapsychic humanism principles that recently opened permanent housing, every one of the clients in the temporary (3–12 weeks) and transitional (18-month) programs wanted permanent housing, even those with a remaining, guaranteed stay of a year or more. The clients are expressing their motives for constructive self-caretaking when they communicate their wish for long-term residential care. The requirement of discharge removes the hope that these constructive motives will be satisfied. Then, the clients have no choice but to fall back on learned self-destructive motives that lead them to (a) get the loss over with and leave emotionally or physically, or (b) protest in the form of symptom aggravation, for some clients even to the point of suicide.

The consequences of discharge-induced regressions can be extremely serious for the client and society. One client with a history of having committed a violent crime almost 2 decades ago, but having exhibited no violence at all as an inpatient, told his inpatient mental health workers repeatedly that, for the protection of himself and others, he should not be discharged. But state guidelines required his discharge, less than 2 months later he committed a horribly violent crime against an outpatient mental health worker. Other similar episodes underscore that a system in which these clients are pushed through one revolving door after another is not only inadequate to meet their needs, but may even worsen their conditions (Allen & Goldfinger, 1986; Axleroad & Toff, 1987; Belcher, 1991).

Because of insufficient permanent housing resources that could yield comparative data about these clients' progress under conditions free of the threat of discharge, the iatrogenic impact of discharge has not been fully recognized. Unfortunately, even though dis-

charge regressions are recognized as universal, they tend to be misattributed to the clients' pathological dependency or to inadequacies in how staff handle the discharge process, when in fact policy changes could eliminate them. In the United States, the public mental health care system has been set up with the aim of the state relinquishing responsibility for people in the name of "independence," a trend that is aggravated by managed care requirements (Spitz, 1996). But it has become increasingly clear that society would be best served by allocating resources for residential care and preserving a supervisory caregiving regulation that helps people with severe mental illness develop their strengths and maintain control of their self-destructive motives.

Conclusion

All too often, homeless, severely mentally ill and substance abusing clients have been unjustifiably characterized as incorrigibly chronic and unresponsive to social work interventions. With the principles of intrapsychic humanism, social workers have a new perspective to use in transforming a housing resource into a lasting therapeutic experience for this disenfranchised population. The clinical examples presented here indicate that despite the considerable trauma these clients have experienced, they retain constructive motives for care that can be enlisted and strengthened in a residential context. Homeless mentally ill people, who are so often excluded from society's benefits, can be embraced by the care and advocacy of social workers who have the scientific means to help them make progress towards recovery and living better lives.

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