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Direct Social Work Practice with Homeless Clients with Disabilities: Addressing Oppression Using Client-Centered, Constructivist, and Structural Approaches

Wilson

Introduction

This paper illustrates how a social worker who works with homeless clients who have disabilities informs social work practice, indicating a constructivist model in addition to person-centred and structural approaches are required to engage in anti-oppressive social work practice. In the process, the author suggests it is important to understand that using an eclectic model positions a social worker to be flexible and continuingly adaptable to client circumstances. The discussion also explains how an eclectic model of practice aids the social worker in understanding and articulating the uniqueness of a client's story and what direct social work approaches are most helpful given the circumstances.

Homelessness and Disability

The homeless population is a vulnerable, oppressed demographic (Muhammed, 2013; Warner, 2008) and a diverse group of people differing in gender, age, ethnicity, income, physical and mental health, national status, substance abuse, and employment (Zald, 2004). Barker (2003) defines homelessness as "the condition of lacking a permanent residence and the means to obtain one."(p. 199). Homeless individuals are described as transient, impoverished, and lacking in sufficient social skills or emotional stability to improve their circumstances without help. Gaetz, Donaldson, Richter, and Gulliver (2013) reported 200,000 Canadians experience homelessness yearly and 30,000 Canadians experience homelessness nightly. Gaetz et al. write that almost half (47.5%) of the homeless Canadian population are men between the ages of 25 and 55 who have greater incidences of mental illness, addictions, and disabilities, including invisible disabilities, such as brain injury, suggesting efforts targeting this population are warranted.

The World Health Organization (WHO) points out that disability is a complex phenomenon that can happen at any time, for varying times, occurring between the features of a person's body or mind and the features of their society (World Health Organization, 2017). WHO describes disability as "covering impairments, activity limitations, and participation restrictions." WHO views impairment as "a problem in body function or structure." An activity limitation is viewed as "a difficulty encountered by an individual in executing a task or action," and a participation restriction is seen as "a problem experienced by an individual in involvement in life situations." (para. 1).This broad definition of disability can be applied to many of the homeless residents who need an array of services due to physical limitations, mental health needs, intellectual and developmental disabilities, addictions, etc.

Homeless shelters "provide ideal locations and critical opportunities to utilize interventions designed to increase an individual's motivation to change" (National Institute on Alcohol Abuse and Alcoholism, 2017, para. 26). The degree of disability among the homeless necessitates that social workers be trained to use effective strategies to address the numerous barriers to assist homeless clients in meeting their needs. Recently, to improve outcomes and recidivism rates, there has been a shift to more emphasis on solutions to address homelessness (The Alberta Secretariat for Action on Homelessness); for example, The Housing First Program (Gaetz, Donaldson, Richter, & Gulliver, 2013). Social workers who work in crisis centres and programs that are mandated to assist homeless individuals with disabilities also require direct practice approaches in helping homeless clients who are often "less likely to seek help, and more difficult to engage in services" (Mullen & Legenski, p. 2). Homeless clients require an eclectic approach that employs client-centred, constructivist, and

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structural social work approaches that not only highlight client strengths and resources, but raise awareness that the limitations presented may not be created by the client, but rather, by the system in which the client exists.

Client-Centered Theories

During the 1950s, Carl Rogers (1957, 1959) promoted client-centred therapy that placed emphasis on the empathic, therapeutic relationship involving unconditional positive regard for the client (Prochaska & Norcross, 2013). The client-centred therapist focuses on listening and reflecting clients' feelings and thoughts without emphasizing other skills and techniques (Ivey, D'Andrea, & Ivey, 2012). As research indicates that some of the homeless population do not trust society or some helping professions (Seeger, 1990; Hwang, 2007; Cormack, 2009), a client-centred approach that provides unconditional positive regard, warmth, genuineness, and empathy will unquestionably have uses in a number of scenarios when listening to the stories of oppressed individuals. However, criticisms surfaced that the success of counseling based largely on a person-centred approach was a bit persuasive, causing person-centred therapists to concede that empathy, positive regard, and genuineness, although facilitative, are not as potent as once thought (Prochaska & Norcross, 2013; Rothery & Tutty, 2008).

Ivey, D'Andrea, & Ivey (2012) point out that Rogers' emphasis "on the client's ideal self and real self tends to obscure the impact of broader and environmental issues" (p. 386). For example, some homeless clients who are mentally ill may not know what they need in the form of interventions. If so, the therapist may be forced to take some directive, protective control of the session to move the client toward intervention, an idea that is not typically associated with the theory of person-centred therapy (Prochaska &Norcross, 2013). Thus, implementation of the Rogerian approach in some circumstances may require an integrated approach, applying strategies from other counseling approaches such as motivational interviewing.

Motivational interviewing (MI) reflects the principles of client-centred therapy (Rogers, 1957; Prochaska & Norcross, 2013) and was introduced by William Miller (1983) and described by Miller and Rollnick (2009) as "an evolution of client-centered counseling" (p. 135). MI moved beyond the client-centred model by including the therapist's ideas for therapeutic direction and interventions to achieve behavioural change (Moyers & Roenick, 2002). Thus, in MI the therapist takes some control of the session so as to move clients in a gentle progression towards agreed upon goals (Prochaska & Norcross, 2013). MI was originally used to treat addictive disorders (Arkowitz, Westra, Miller, & Rollnick, 2008; Prochaska & Norcross, (2013), making it a sensible choice for someone who works with the homeless population. Stewart (2012) concluded that a large amount of evidence exists pertaining to the efficacy of MI, noting that MI produces positive outcomes in traditional clinical practice and across different settings and populations. Moreover, Prochaska & Norcross (2013) noted that in Project Match one of the most significant psychotherapy outcome studies, MI was as effective as lengthier forms of psychotherapy in certain situations and more effective than cognitive-behavioral training with patients less motivated to change.

Although MI is proven to be a useful approach with homeless clients as it is goal orientated, makes use of hope in a therapeutic relationship, stresses collaboration with the social worker, and places no limits on the client's ability to change (Manthey, Knowles, Asher & Wahab, 2011), some literature on MI indicates areas of concern. For example, MI "works by looking for cognitive -behavioural discrepancy from a predetermined mindset and the client is principally assessed through the cognitive channel" (Graham, 2004, p. 496). As it is suggested MI works best with talkative and cognizant clients, it likely, theoretically, excludes some people who are cognitively impaired. Concurrent disorders consisting of mental health and addiction issues are prevalent amongst the homeless population (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005) as well as specific cognitive

impairment (Spence, Stevens, & Parks, 2004; Buhrich, Hodder, & Teesson, 2000). The fact that MI may be problematic in treating concurrent mental health and addiction disorders, or other issues in which individuals present with cognitive impairment, illustrates the need for social workers to have an eclectic model of practice.

Constructivist Theories

Saleebey (1992) is credited with establishing the strengths perspective as one of social work's useful constructivist approaches in working with clients. A strengths perspective suggests that everything we do as social workers will be predicated, in some way, "on helping to discover and embellish, explore and exploit, clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings" (Saleebey, 1992, p. 3). Thus, Saleebey (1992) indicates that social workers should assess clients in light of their abilities, competencies, values, and hopes. He promotes the idea that clients persist in spite of their difficulties, emphasizing human resilience and the skill and ability accumulated over time to overcome adversity (Walsh, 2010). Empowering a client by having him or her overcome an issue by using their own abilities and resources (strengths) is an outcome that social work practitioners hope to achieve. The strengths perspective offers social workers an alternative to the deficits perspective that allows the social worker as well as the client to see their resilient characteristics accumulated from previous experiences (Saleebey, 1992). For example, a strengths-based approach can be used in crisis intervention with homeless clients to address the needs of individuals who have experienced very stressful scenarios that may lead to post-traumatic stress disorder (Lantz & Walsh, 2007).

Identifying client strengths is often not enough to surpass the social barriers confronting homeless clients significantly disadvantaged through poverty and disabilities. Guo and Tsui (2010) question whether "resilience enhancement programs really empower disadvantaged people" (p. 236). They clarified that strength-based models "neglect resistance and rebellion, which have often been key resources for disadvantaged individuals and communities" (Guo & Tsui, 2010, p. 236). Thus, models that include other social approaches that address oppression may be more appropriate than relying solely on a strengths-based approach when working with those who are disadvantaged and vulnerable. The strengths perspective can be used in identifying positive client assets while remaining vigilant for the need for other approaches to counseling that the strengths perspective may not be sufficient to resolve, such as social obstacles and injustices that stem from oppression.

As a constructivist theory, solution-focused social work, a brief therapy model that emerged in the 1980s, focuses on how progress is made, using the client's strengths (De Shazer, 1985; De Shazer & Berg, 2002; Trepper, Dolan, McCollum, & Nelson, 2006). Walsh advises that solution-focused therapy is inherently strengths-based and became established as an approach to clinical practice based on roots in several other theories such as crisis theory (Walsh, 2010). Solution-focused therapy's similarity to the strengths-based perspective is echoed by Lee (2011) who stated that strengths are a main focus in solution-focused therapy. Lee also stated that in solution-focused therapy clients have the answer, and that clients define their goals and solutions. Thus, solution-focused therapy is essentially client driven, a concept that is also shared with person-centred therapy in which clients direct the flow of sessions (Prochaska & Norcross, 2013). Solution-focused therapy is an intervention that responds with "focused, effective interventions for people in need of immediate relief" (Walsh, 2010, p. 231), such as the homeless population, without having to solve, immediately, all the clients' problems (Walsh, 2010). As Walsh (2010) points out, an outstanding benefit of solution-focused therapy is its potential to address social justice issues as it "highlights client strengths and the client's potential to access resources and enact change" (p. 240). Thus, Walsh suggests that the

solution-focused approach to therapy has relevance for applicability in the areas of poverty, unemployment, discrimination, and other forms of social justice as experienced by those who are homeless.

Critically, Lipchik (2002) writes that solution-focused therapy denies clients the opportunities to explore, at greater depth, problems faced by the client. Placing an emphasis on thinking positively might lead the client to minimize their problems. In reality, achieving goals may be difficult in the case of homeless clients facing oppressed circumstances. Although solution-focused therapy has been found to be useful, it needs further research to determine its effectiveness (Corcoran, 2008; Prochaska & Norcross, 2013). However, it has been found to be more effective than no therapy and less costly due to a focus on brief therapy (Prochaska & Norcross, 2013). When to use or not to use solution-focused therapy may be best decided by understanding its limitations. For example, the delivery of solution-focused therapy and its time limitations do not often allow for the deep exploration of thoughts and feelings. Thus, if a client presents with complex problems, such a homeless person with disabilities, solely using solution-focused therapy may limit therapeutic effectiveness.

White and Epston (1990), who developed narrative therapy in the 1980s, believed our world is socially constructed, based on multiple narratives in which the change in the narrator occurs over the multiple times the story is told. Walsh (2010) describes narrative therapists as believing individuals construct stories or narratives from life events to gain an understanding of themselves and the events happening around them and to make meaning of their life experiences. Therapeutically, narrative therapy allows the client to seek underlying assumptions about beliefs and discover ways to re-author or reconstruct their story so that it is more in line with their hopes and dreams (Walsh, 2010). A narrative approach helps clients with "self-denigrating beliefs" (Walsh, 2010, p. 279) to reconstruct a more positive position. The therapeutic relationship aims to be an unstructured, collaborative relationship that helps to empower the client by addressing their beliefs.

Ungar (2011) describes narrative therapy as "an approach that integrates postmodern epistemology and social constructionism" (p. 34). A postmodern epistemology suggests that we are constantly evolving a sense of self through experiences that are seen as positive or negative. From a postmodern perspective the counselor does not see reality as fixed. Further, Ungar (2011) suggests social constructivism plays a role in postmodern counseling by emphasizing the differences in people and "the decolonization of a Eurocentric bias" (p. 34) as the truth. Ungar (2011) sees all of us as constructing meaning and that meaning changes over cultures, although there is agreement on some things with respect to the way we behave socially. Thus, in narrative counseling, the social worker is not seen as the expert, letting clients find solutions that make sense to them (Ungar, 2011).

Narrative therapy shares common ground with any therapeutic model that looks at problems as being created by past experiences. The difference lies in the fact that narrative therapy will focus on re-storying a narrative while specific other therapies will try to treat a specific problem (Walsh, 2010; Prochaska & Norcross, 2013). The homeless population is an extensively diverse group of people differing in, but not limited to, gender, age, ethnicity, income, physical and mental health, national status, substance abuse, and employment (Varney & Van Vliet, 2008; Chamberlain & MacKenzie 2006; Zald, 2004). Many people without a home will have endured a different set of experiences, bringing dissimilar issues to the counseling table. Social work skills, as well as narrative therapy, can be beneficial in helping the client articulate their story as well as build a new story in creating a better future.

Walsh (2010) describes narrative therapy as having great ability to address social issues. The social worker considers how the client may be affected by oppression while the client tells their story, appropriately making the client aware of social resources. Key to helping the client identify and address social issues is the social worker's knowledge of oppression and cultural and ethnic

diversity (Walsh, 2010). Social workers who work with homeless clients are confronted by the socially disadvantaged and oppressed on a daily basis. As a part of an eclectic practice model, narrative therapy offers the social worker with advanced knowledge of oppression and diversity the possibility of noting issues related to vulnerability and oppression while engaging the client in telling their story.

Although thought to be empowering to clients, those who have immediate needs for shelter, food, health care, income, and employment, such as homeless, disabled individuals, may require more than narrative therapy to address multiple needs quickly (Williams & Kurtz, 2003). Also, it is challenging to avoid labelling, an aim of narrative therapy, in an environment where there is a need to identify a problem, for example, when suggesting referrals and medication for delusional, paranoid, or addictive behavior. Thus, in using the narrative approach to acquire the client's story, both the social worker and the client are more likely to benefit from an eclectic approach that also includes structural social work.

Structural Social Work

Barker (2003) defines a structural social work model as one "in which the social environment is the primary target of change, and the intervention is to improve the quality of the relationship between people and their social environment by changing, creating, or using existing social structures" (p. 420). Proponents of structural social work view social problems as the result of the liberal/neo-conservative capitalistic system characteristic of the western world (Mullaly, 2007). Structural social workers "believe that it is mainly the social structures that oppress by privileging dominant groups over subordinate groups" (Mullaly, 2010, p. 19) while anti-oppressive theorists "believe that all subordinate groups are oppressed on personal, cultural, and institutional levels by visible and invisible structures and by conscious and unconscious means" (p.19). Mullaly (2010) concludes that his consideration of oppression is explained by a cluster of critical social theories that are all explained as critical of "existing systems of social arrangements as unjust" (p. 19). Thus, structural social workers strive to relieve the negative effects that structural issues can put on individuals and to change social structures in a way that reduces or eliminates the negative effects of social structures thought to be oppressive (Mullaly, 2010). The homeless population is regarded in the literature as an oppressed population demographic (Fraenkel, Hameline, & Shannon, 2009; Muhammed, 2013; Warner, 2008). Thus, accordingly, some people are likely homeless more so because of oppressive social structures and less so because of their own choices. For example, a seriously ill sole family income earner's benefits may be time limited, ceasing prior to the income earner's recovery. A possible result of long periods of greatly reduced income related to unemployment, with little or no social support, can result in homelessness.

An anti-oppressive social work practice can be viewed as unrealistic as the breadth of the social work profession seems to depend upon the welfare system in which it operates, such as neo-liberal or social democratic environments (Rush & Kenan, 2013). Nonetheless, anti-oppressive social work involves educating clients in the ways that oppression affects them (Mullaly, 2010). However, social workers might suggest that many homeless clients are already aware prior to therapy that they are oppressed and moreover actually have an understanding of the challenges they face and the ability of others to improve their circumstances.

In other situations where clients are homeless and disabled, social workers may view social problems as not the result of faulty social structures. Theoretically, if all social problems originate from structural issues, it suggests that personal responsibility for bad choices that result in poor outcomes is overlooked. However, it can also be argued that western society has set guidelines when it comes to assessing and maintaining an individual or family in a realistically affordable, socially acceptable standard of living (Statistics Canada, 2013). Thus, it can be concluded that when a certain segment

of a population is not able to afford an acceptable quality of life, the problem can be considered structural, regardless of how the problem arose. Expanding on structural issues solely related to income, people may become part of that structurally oppressed demographic as a result of bad personal choices. However, once they become part of, for example, the homeless population, one can argue they have also become part of a structural social problem. Individual issues that can accompany structural problems, such as addiction or mental health, amongst a structurally oppressed group can be treated with other social work theories and approaches. However, the cure to large social ills, such as homelessness, poverty, environmental destruction, and the oppression of the disabled and mentally ill, will likely require an alteration to social structures (Mullaly, 2010). In short, when oppression negatively affects clients, the theory and principles of structural social work should be put to use, while combining it with other therapeutic models to help the client deal with individual issues such as depression and addiction.

Although Mullaly (2010) presents the view that anti-oppressive practice is necessary if social work is to honour the values presented in the general concept of social justice, applying anti-oppressive theory to direct practice in the real world can be a difficult and possibly unrealistic process (Sinclair & Albert, 2008; Carey & Foster, 2011; Healy, 2001). Mullaly (2010) suggests "how-to-do-it recipes do not help the social worker engage with complexity and individuality" (Mullaly, 2010, p. 221). Carey and Foster (2011) question the ability of front line social workers to practice anti-oppressive social work practice as structural social work fails to provide concrete methods for front line social workers to apply to their practice. They suggest that social workers often act on their own in finding ways to lessen the oppressive realities of the social system rather than following a radical uniformed paradigm, such as social workers who work to make policies more flexible to acquire what homeless individuals with disabilities need. Such social workers experience the possibility of macro change through collaborative direct anti-oppressive work. They see their environments filled with diverse clients who are oppressed for different reasons, realizing anti-oppressive social work is a framework to be interpreted by individual workers in accordance to the structure of their practice environment, not as a holistic "how to" paradigm.

Conclusion

Social workers need to avoid viewing all homeless clients with disabilities in the same way and to look beyond the circumstances of the client to someone who had a story of hopes, dreams, and skills despite becoming stuck in oppressive, unexpected life circumstances. The use of language can oppress clients by using terms unfamiliar to them or expressing unrealistic expectations that may confirm or coincide with practices in the dominant culture. For example, when working with a disabled person stuck in poverty, the expectation for them to travel to meetings, or buy appropriate clothing and food, may be unrealistic to achieve for a disabled person deep in poverty. Effective communication and direct social work practice with disabled individuals that are homeless requires the development and maintenance of a therapeutic relationship that combines person-centred approaches with structural social work approaches that can be applicable at the cultural level as well as the personal level. These approaches allow practice to be about individual change as well as societal change, a duality that is a core principle of structural social work.

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