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## Making Meaning Together: An Exploratory Study of Therapeutic Conversation between Helping Professionals and Homeless Shelter Residents

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## **Making Meaning Together: An Exploratory Study of Therapeutic Conversation between Helping Professionals and Homeless Shelter Residents**

### **Abstract**

This exploratory study examined the nature of therapeutic conversation between helping professionals and homeless persons as an intervention to optimize health. Meaningful conversation occurred in relationships where there was a sense of connection and the presence of rapport. Emergent facilitators of therapeutic conversation included respectful engagement, casual nature of conversation, alternative settings for therapeutic conversation, effective listening, and establishing trust. Barriers included prejudging homeless persons, fear of punishment and authority, and academic and professional intimidation. Central to the study findings was the acknowledgement of the client's personhood. Acknowledgement of personhood is a critical element in engagement between homeless persons and helping professionals.

### **Keywords**

Therapeutic Conversation, Meaningful Conversation, Homeless, Helping Professionals, and Personhood

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# **Making Meaning Together: An Exploratory Study of Therapeutic Conversation between Helping Professionals and Homeless Shelter Residents**

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## **Greg's Story**

Until recently, Greg was a foreman in a successful construction company. After suffering from frostbite on the job, osteomyelitis set in with the resulting loss of several fingers and both of his legs just below the knees. Unable to work or get fair compensation for his injuries, Greg lost his home, his partner, and ended up at a homeless shelter. "I dream in Technicolor..." Greg said. "...I am running and playing sports. Then I wake up and see my wheelchair at the end of my bed and look at my legs...Mornings are the hardest for me, and I don't always know if I can make it..." Greg's gift freely offered was the living example of being real, or authentic, and the inherent call for respectful acknowledgement of him as a person.

## **Introduction**

Interventions designed for the optimal health of persons who are homeless have been initiated with a broad range of goals varying from addressing basic physical needs and improving mental and emotional health to eradicating homelessness altogether

(Christensen, Hodgkins, Garces, Estlund, Miller, & Touchton, 2005; Shinn, Baumohl, & Hopper, 2001; Toro, Rabideau, Bellavia, Daeschler, Wall, Thomas, et al., 1997). Within the realm of mental and emotional health, therapeutic conversation is a means of empowering individual persons who are homeless (Bohn, Wright, & Moules, 2003; Levy, 1998) to meet the challenges of their present circumstances or to ultimately escape the cycle of homelessness. Under the auspices of a community-university partnership and the mentorship of an interprofessional leadership team, two undergraduate students from nursing and social work faculties explored the use of therapeutic conversation as a means for optimizing health of homeless shelter clients in Calgary, Alberta. The *Making Meaning Together* study produced knowledge regarding therapeutic conversation with individuals who are homeless.

### *Therapeutic conversation*

Sluzki (1992) describes therapeutic conversation as conversation in which opportunities for personal transformation take place through a healing change/alteration in the way in which people perceive their life circumstances. According to Weingarten (1992), therapy consists of the connection and collaboration that takes place between client and helping professional within conversation. The conversation becomes therapeutic when meaning, and thus intimacy, is created together by both client and helping professional (Weingarten). Conversation requiring the exchange of both attentive listening and respectful response is the necessary therapeutic venue in which positive personal transformations take place (Bakhtin, 1984; Levy, 2004; Seikkula & Trimble, 2005).

For a conversation to be truly therapeutic, there cannot be one sole monological expert (the therapist) devising solutions for and acting upon a non-contributing subject (the client; Bakhtin, 1984; Seikkula & Trimble, 2005). Therapeutic conversation, it is argued, requires the helping professional/therapist to relinquish the right to speak from an expert position of power and authority and to engage as a partner in healing conversation (Bakhtin; Guilfoyle, 2003; Seikkula & Trimble). For a life-giving or healing exchange to occur there must be a sense of equality, of kindred and equal participation, of giving and receiving; qualities constituting true dialogue (Bakhtin; Guilfoyle; Seikkula & Trimble).

### *Therapeutic conversation with persons who are homeless*

Engagement is a necessary prerequisite of therapeutic conversation and relationship development, with the quality of this phase being critical to the success of therapeutic conversation (Levy, 1998). Therapeutic conversation with persons who are homeless requires trust and the formation of a common language through open dialogue between client and helping professional (Levy, 1998; Seikkula & Olson, 2003).

Open dialogue, a therapeutic function grounded in the belief that healing ultimately lies in the elements of conversation and the social connections it strengthens, allows the participants to tolerate uncertainty in the conversation (Bakhtin, 1984; Seikkula & Olson, 2003). This tolerance constrains the participants from jumping to conclusions or declaring solutions to the situation in order that direction and ultimately healing may arise naturally (Bakhtin; Seikkula & Olson). In turn, meaning, new ideas,

and understanding are created as each member offers up words and, in return, responds to the words of others (Bakhtin; Seikkula & Trimble, 2005). As participants seek to understand the meaning portrayed and the personal value attached by each other to spoken words, a mutual and commonly understood language eventually develops within the therapeutic conversation (Bakhtin; Levy, 2004). This new understanding transcends barriers that may have existed between the language of the professional and that of the client, thus constituting an invaluable tool to form connections with people who are homeless and to facilitate linkages with pertinent services by using a language to which they can readily relate (Levy, 2004). According to Levy (1998), this new, commonly understood language is essential in building a therapeutic relationship that is both empowering for the person who is homeless and conducive to the formation of self-directed goals for success and optimal health.

Barriers to therapeutic conversation with homeless persons include the preeminence of basic survival activities for homeless persons and the subsequent difficulty with maintaining scheduled appointments, lack of trust and established therapeutic relationship, and hostility or suspicion towards helping professionals (Calsyn, Morse, Klinkenberg, Trusty, & Allen, 1998; Levy, 2004). Thus, the helping professional must be conscientious in establishing a relationship built on trust in order to facilitate a relational space where autonomous and empowering change may be explored by the client (Levy, 2004). According to Burnard (2003), a formal tone may also present as a barrier to therapeutic conversation, indicating that the professional intends to focus on the gathering of information or the accomplishment of tasks of business, rather than to take the time to engage in an open and welcome dialogue with a client. A less formal tone may facilitate the acknowledgement of the client's personhood and be an effective tool for engagement in therapeutic conversation (Burnard).

A study conducted by Thompson, Pollio, Eyrich, Bradbury, and North (2004) concluded that a significant intervention in the empowerment of individuals who successfully came out of homelessness involved access to helping, supportive conversation within positive relationships with helping professionals such as therapists, counselors, priests, and service providers. In this latter study, the clients characterized the supportive relationships as being a welcoming refuge within which they could have conversations, be encouraged, have their personhood affirmed, and be directed to other helpful services. Despite this promise, there is a dearth of research examining therapeutic conversation with persons who are homeless.

We are a team of four researchers interested in understanding how to develop the types of relationships with individuals experiencing poverty and homelessness in order to inform clinical practice and research. It is our intention that through this work we may foster the types of engagement to support participatory action forms of research aimed at promoting voice for marginalized and disenfranchised members of our community. It is through these partnerships that we hope to create relevant, effective solutions. Christine Walsh became interested in issues of homelessness and poverty subsequent to obtaining her position in the Faculty of Social Work. In leading this research project, she was concerned with developing appropriate approaches to carry out research with members of the homeless community. During this investigation Kristina (Ahosaari) Sarafincian, was completing of her Bachelor of Nursing and Sabine Sellmer was completing her Bachelor of Social Work at the University of Calgary. Pursuing her interests of community nursing

and working with diverse people groups, Kristina is now serving as Community Health Nurse, RN, on a First Nations Community in Saskatchewan. As a student researcher and now as a caseworker for Alberta Children's Services, Sabine's interests include issues such as poverty, mental health, homelessness, and domestic violence related to marginalized populations, particularly women and children. Gayle Rutherford was the project coordinator for the Downtown Community Initiative, a community-university partnership between the Faculties of Nursing and Social Work at the University of Calgary and a large inner city homeless shelter, which provided the setting for this study and her doctoral work examining interprofessional education and co-learning. She is a Registered Nurse with a background in public health nursing and working with vulnerable populations. She provided guidance and support to Kristina and Sabine during the research study and is now an Assistant Professor at the Faculty of Nursing University of Calgary where she is engaged in participatory action research with Aboriginal woman experiencing homelessness and incarceration.

### Methodology

The *Making Meaning Together* study examined the use of meaningful/therapeutic conversation in promoting health among clients and residents, hereafter referred to as clients, of an inner city homeless shelter. Specifically, the questions under study included: (1) What is meaningful conversation from the perspective of clients? (2) What facilitators and barriers to therapeutic conversation exist? An exploratory qualitative research method was chosen for this study based on the method's ability to discover additional information and understanding about a social issue of concern in which exhaustive research data does not yet exist, and to allow an exploration of human experiences that is rich and revealing (Marshall & Rossman, 2006; Yiu & Twinn, 2001).

Within the context of the research study, the two senior undergraduate research assistants (RAs) from nursing and social work served as helping professionals in the homeless shelter from May to September, 2006. The RAs were trained in research, had previous experience working with vulnerable populations, and were aware of the sensitive nature of trust with many persons who are homeless (Koegel, 1992; Levy, 1998). Prior to data collection, engagement activities included traditional practices of the social work and nursing disciplines, as well as non-traditional activities such as playing volleyball, playing piano and watching a civic parade with clients. As trust, comfort, and meaningful conversation evolved in these relationships, the RAs invited clients to participate in the study.

Following ethics approval, data were collected through individual in-depth qualitative interviews and focus group interviews with clients of the shelter (Marshall & Rossman, 2006). A flexible interview guide consisting of 12 questions was utilized by the RAs. Included were questions that intended to elicit the participant's description of meaningful conversation and discover if such conditions as setting and interviewer-traits enhanced or impeded therapeutic conversation. Participants for the individual interviews and client focus groups were recruited by verbal invitation, through posters displayed at shelter facilities, and through shelter staff who were provided information about the study. Individuals were included if they could speak English well enough to carry on a

conversation, were over 18 years of age, and were either a client or staff member of the homeless shelter.

Individual client interviews (n=10) were conducted with eight men and two women. Focus groups were conducted with clients (two groups with men [n=6, 14] and one with women [n= 7]). Interviews were conducted in a private location at a convenient time for participants and semi-structured field guides were used to facilitate discussion. In addition, the RAs maintained journals with field note observations and reflections throughout the study. The participation and contribution of client participants were acknowledged with \$5 (CAD) gift certificates for a local coffee shop.

### **Data Analysis**

Interviews were audio-taped, transcribed verbatim, and augmented by post-session field notes. Following transcription of interview data, a software program for qualitative research data analysis (ATLAS.ti) was used to facilitate open-coding of the qualitative data. All data were coded independently by both RAs and then cross-compared to ensure that themes were consistent and to identify new themes as they emerged. Themes were verified and enhanced in collaboration with the investigators. Pertinent excerpts from the transcriptions were then embedded in corresponding themes to further articulate those themes.

### **Results**

Among the ten individual interview participants, three each were between the ages of 25-34, 35-44, and 45-54 years, and one was 55 years or older. Eight of the participants were men and two were female. Two were Aboriginal, and eight were Caucasian. Participants in the men's focus groups (n=6, 14) were younger (with six under 25 years of age; nine between 25-34; four between 35- 44; and one between 45-54 years of age); three were Aboriginal and 17 were Caucasian. Three of the participants in the women's focus group were Aboriginal; four were Caucasian. One woman was within the age range of 26-34 years, with three each between 35-44 years and 45-54 years of age.

Study findings reveal, from the first-hand perspectives of clients, the ways in which helping professionals can engage in meaningful conversation with clients of homeless shelters and the essence of meaningful conversation with these clients. Sub-themes fall under two broader themes: facilitators of and barriers to therapeutic/meaningful conversation between helping professionals and persons who are homeless. Facilitating themes include: (a) respectful engagement; (b) casual nature of conversation; (c) alternative settings for therapeutic conversation; (d) effective listening; and (e) establishing trust. Barriers to therapeutic conversation include: (a) prejudging homeless persons; (b) fear of punishment and authority; and (c) academic /professional intimidation faced by persons who are homeless.

The themes emerging from the data are presented with supporting statements of the participants. When extracting quotes from the transcribed data, the quote will be identified by the following: (a) source of data-- individual interview or focus group interview, designated by an I or F, respectively; (b) the gender of the participant-- male (M) or female (F) and (c) participant number. Statements have been edited minimally to

ensure preservation of meaning. The removal of irrelevant information in such statements is indicated by ellipses (...) and the addition of text is indicated by the placement of words in square brackets.

### *Therapeutic conversation*

Undergraduate research assistants purposefully developed relationships over an extended period of time. The process of prolonged engagement arises from anthropological fieldwork in which researchers spent extensive time with their participants in order to increase rapport leading participants to be more open in their interactions with the researcher (Creswell, 1998, 2003; Lincoln & Guba, 1985; Padgett, 1998). In this case prolonged engagement was used to increase trustworthiness of the data (Lietz, Langer, & Furman, 2006), to authentically represent the meaning of the participants, and to facilitate an ongoing therapeutic relationship conducive to therapeutic conversation.

Initial engagement often took place through clients seeking assistance from the RAs with social service and health matters, such as referrals to social services and health agencies and assistance with accessing welfare supports. Less traditional activities were initiated by both clients and RAs, including lunch and coffee conversations, participation in singing and music sessions, and assistance with computer work. During this time, relationships with clients had become supportive to the therapeutic conversation, as indicated by the presence of rapport and ease of conversation, frequency of client visits to the RA office, and thicker descriptions of clients' life stories within conversations. Over time and repeated contact, conversations unfolded about such matters as tragic losses of loved ones, unfortunate declines in health, or untimely events that had brought clients face to face with homelessness. Conversations often deepened to reveal clients' personal fears and challenges with living in a homeless shelter, and their aspirations for a life once again beyond homelessness. Clients also made comments alluding to the types of connections that support therapeutic conversation. According to IM5, "You guys just have a good ear for me just to let off whatever it is. I can leave here and I can feel good... You sit and listen. That's fair enough for me." Another respondent suggested that conversations with the RAs were "...beneficial...there was help, and feeling comfortable...understanding." (IM1)

Consensus existed among participants both in the difficulty of defining therapeutic conversation and also in knowing when meaningful conversation had occurred. Meaningful conversation seemed to occur at the level of interpersonal connection and comfort mediated through relationship building. As one client described: We seemed to click, so... I think I have to reach my comfort zone, and once I reach that comfort zone, I'm okay. ... It's a matter of testing the waters and feeling it out. Is this person really helping me or do I like this person? (IM1)

### *Facilitators of therapeutic conversation*

The five predominant conditions that facilitate meaningful conversation between persons who are homeless and helping professionals were revealed as sub-themes within



the data as follows: *respectful engagement, casual nature of conversation, alternative settings for therapeutic conversation, effective listening, and establishing trust.*

Within the first sub-theme, participants suggested that *respectful engagement* plays an important role in drawing persons who are homeless into therapeutic conversation. *Respectful engagement*, according to the respondents, is comprised of three elements-- warm connection, genuine interest, and honesty. Participants offered that establishing a warm connection can take place through a smile, a handshake, or eye contact, which acknowledges equality or common ground shared between the helping professional and the person who is homeless. As articulated by IF1, "...one of the basic things is that this is not a gimmick, or not to approach us as 'clients' but as a person." Another client, in a personal interview, echoes this desire to respectfully engaged. "We're people, we're normal." (IM5) Warm connection was further delineated as follows:

Basically what I just said, if someone is very personable, down to earth and relaxed, you can have more of an in-depth discussion with them, where if it's someone who's cold or abrasive or upfront, then it's alright, get me the hell away from them, you know. (IM3)

Within the element of genuine interest, clients revealed the importance of helping professionals eating with them in the cafeteria or spending time talking with them on the smoking patio as ways to further establish respectful engagement. One client states:

It's, it's getting involved with them, somehow or some way. So if you're out in the smoking area for a break, someone may pick up on you and you may pick up on them, or – it's pretty easy I think. You just gotta get over some of the stigma. (IM1)

*Honesty* was illustrated by the need for members of the helping professions to be direct, authentic, and "upfront" with clients regarding the purpose of involvement and to provide honest and straightforward responses to the comments and questions of clients: "Um, you gotta break the ice and be honest with them right as soon as they walk through the door. You know. 'Cause if they know who you are and basically what you're about, they'll be more comfortable." (IM1) One client advised helping professionals:

...just be upfront about what you're saying, you know...You'll get a lot farther than trying any other little sneaky tactics. (IM3)

Another client illustrated an aspect of honesty desired by clients.

Eye contact, uh, listening, and giving honest comments about what I'm saying... Well, you know, um, an honest comment would be, "Look at, um, I don't have the resources but I can look them up and maybe get you some answers or I can talk to someone. (IF1)

The second major sub-theme facilitating meaningful conversations related to a preference for the *casual nature of conversation*. Within this context, participants emphasized that having ready access to staff was important for this to occur.

One client described his concept of casualness as,

...approachable, maybe kind of casual, not look too professional because that way they'll sense you as a corporate person kind of, and they'll say, 'Well, these people snub me off on a daily basis, do I want to talk to this person'...keep that up and then maybe people will be more approachable. They'll see a difference; ok this person isn't that, they always say 'Hi' no matter what I say to them, they're always ready to talk to me, and one day they will come step up to you and say, 'Ok I'm ready to talk.' (IM2)

Feeling comfortable with conversation was also described by participants as akin to the casual nature of conversation: "No, we just clicked. It was like I felt comfortable the minute I walked in." (IM1) Client participants listed such factors as non-threatening eye contact, gentle or calm tone of voice, being "laid back," and open body language as sending invitational messages towards establishing a "comfort level" conducive to meaningful conversation. While one client stated a preference for more structure in conversation, other respondents stated that conversations that occur naturally and informally are often more comfortable than those pre-arranged.

The third sub-theme that emerged, *alternative settings for therapeutic conversation*, exposed a variety of locales and activities in which therapeutic conversation could take place. In terms of alternative settings for "getting involved" with clients, some participants suggested activities such as offsite walks or meeting for coffee outside the shelter:

I think you've seen him a couple of times. He sneaks by. He works at [another homeless shelter]. Well, when working with somebody and he wants to have a personal conversation and deal with whatever he's trying to be their friend and counsel on. Sitting in a little booth... He's got two coffees in front of you. He's sitting on one side. You're sitting on the other side. You can smoke..."How can I help you?" And those are some of the most therapeutic conversations. (IM4)

Reactions to office-based conversations were mixed. Some respondents stated that they felt it was important for confidentiality purposes that conversations of a sensitive nature be conducted within the privacy of an office environment, cautioning that rumors and gossip move quickly through the shelter. However, others indicated that rumors may also start if they were observed by other clients when entering or leaving a private office. "A closed door is only so helpful...being removed from the residents is the most important thing..." (IM4) Respondents also suggested that therapeutic conversation should occur within the context of other activities such as music, art and sports. One client described the invaluable impact of meaningful conversation that took place during a sports event:

The one gentleman comes in here Tuesday and Thursdays, opens up the gym and gets a couple of the guys and plays basketball. It's not like sitting and talking...Sportsmanship, leadership, you know – talk like that – really great to bring people together I think. I come personally from a very athletic background and that always, always a role that I am close to, like a leadership role, at the same time, it's spiritual...like taking time after the game last night to talk to him a little bit. "Have you been in our position before?" "No, but I've been really close." And, people like that ... for me at the time, it made me feel more real. (FGM1)

*Effective listening*, the fourth sub-theme and facilitator of therapeutic conversation, was described as taking the time from activity to stop and acknowledge the individual. "I understand that people are busy with their schedules but excuse me, what's with the attitude? I'm just asking a simple question. You don't have to pull the attitude." (IM3). Participants suggested that effective listening involved providing verbal response or acknowledgement of the client without interrupting. While eye contact was attributed as a sign of effective listening by some participants, one Aboriginal male client pointed out that some individuals who are homeless may find direct eye contact to be intimidating if they are not yet comfortable with the helping professional. Many respondents simply needed someone who was willing to listen, indicating that it was not important that they be given advice or answers. "That's all you can do, just listen to them." (IM5) The opportunity to have someone take the time to genuinely listen to their stories, without a hidden agenda or expectations, was defined as significant to what makes a conversation meaningful and also contributes to feelings of respect and self-worth. According to one male client, "...a lot of people are dying to be heard...a lot of people need to be heard." (IM2)

The fifth sub-theme that facilitates meaningful conversation, *establishing trust*, was recognized by participants as difficult to achieve. As one client illustrated:

A lot of us...due to our situation we have trouble opening up to people and trusting people again, you know, 'cause the reason I'm here is I trusted people and ended up going down the tube, so it's hard for me to open up to somebody else, thinking in the back of my mind it's just going to end up... (FGM1)

Insight on ways to build trust was offered by participants, as follows:

That [trust] has to be established, you can't do that overnight...Just do what you say you are going to do...if you say you are going to be there at that time, then be there at that time. (FGM2)

### *Barriers to therapeutic conversation*

Three major barriers to developing meaningful conversation identified by study participants were *prejudging homeless persons*, *fear of punishment and authority*, and

*academic and professional intimidation.* Prejudging homeless persons strongly emerged as a major impediment to meaningful conversation and engagement.

Participants expressed dislike of a *prejudging homeless persons* or having a “preconceived conception” by the helping professional labeling them as an “addict” or someone with a mental illness. One client expressed: “...they got to get to know their clients as well, without using the general guidelines that they use on everybody, regardless of who they are, where they come from, what you’re doing; it’s a very bad system to me.” (IM2) The client offered the following advice pertaining to avoiding judgment “...be more of a friend or so to speak or a neutral party as opposed to someone sitting there and being judgmental...” (IM3) Another client described therapeutic conversations and the impact of judgment:

...they’re a two-way street and uh, it’s open-minded. If somebody comes in with a pre-conceived conception, it’ll show in their attitude and in their questions and their body language, and then that’ll make the person – like, for me, the minute I see a pre-conceived notion, a stand-offish attitude, or fear, then I’m gonna get... my attitude is gonna change. (IM6)

Clients expressed a desire to be acknowledged first and foremost as simply a person, instead of being immediately judged as somebody who has done something wrong: “We’re people, we’re normal.” (IM7)

*Fear of punishment and authority* within a perceived power differential between clients and helping professionals, presented as the second significant barrier to therapeutic conversation. One client in an interview offered up advice for helping professionals seeking to engage in therapeutic conversations with persons experiencing homelessness:

More so than anything else, you want to come across as a friend, rather than a figure of authority. Be more laid back, and it’s not too hard to get someone to approach you as opposed to going up cold and approaching someone else. By how you start your subjects off, or whatever. Just more of a laidback approach would be the best bet, you know. (IM3)

Participants revealed their guardedness and reluctance to be transparent and forthcoming in conversation with most of the staff of the homeless shelter. There was a sense of a power differential or imbalance in the favor of shelter staff, and clients feared that if they were forthcoming with shelter staff about their shortcomings, struggles, or perceived misdeeds, or if they registered official complaints, they might suffer punitive consequences, such as the loss of shelter beds. One client described the effect of this power imbalance on his interaction with those in authority at the homeless shelter:

Just due to the fact that it’s an authority figure or whatever, and I prefer to keep to my own. Be polite and whatnot...Ultimately, they’re the ones that pass decisions on us if we can stay or if we can go. So, that’s why I feel I just do my thing. (FGM2)

Fear of punishment and authority was further illustrated by a participant in the mens' focus groups:

...like you've got to get something off your chest, and you don't want to run around to avoid the environment that you are in, sometimes the best people to talk to are the [University practicum] students because then you get feedback without having to worry about any repercussions. (FGM5)

Participants reiterated that, in their role as student professionals, the RAs were less "threatening" than agency staff. Client participants indicated that meaningful conversation was more likely to unfold with students. They could be more open because students did not hold a position of authority at the homeless shelter. One focus group participant acknowledged the barrier that the fear of punishment and authority presented to therapeutic conversation with shelter staff as follows:

Why do we feel it's trouble to go out and talk with them and converse with them at the same time that they're trying to help us? We have to realize that, for us to get help, we have to ask for it and be responsible enough to notice that yes all these workers around us are here for our benefit and they're not here to judge us and they're not here to impose, lay down this, that and the other. (FGM1)

*Academic and professional intimidation*, including that which comes from academic and professional jargon, also presented as a barrier to therapeutic conversation. Some participants described feeling intimidated by the presence of university students in the shelter and being interviewed within the context of research. When asked in an interview if the presence of a tape recorder was an impediment to therapeutic conversation, one male interviewee responded: "Yeah it is somewhat...I was worried about what it's going to, like I don't know if there is going to be classes hearing this..." After being reassured that all audio tapes of interviews would be erased, he continued: "Hopefully my grammar's been good enough..." (IM2)

Other respondents revealed their despairing belief that they had little to offer in terms of knowledge and expertise. In a personal interview, one male client declared: "I'm stupid," (IM8) while another stated, "...I don't know. I'm dumb." (IM1) Another client agonized that the drugs he had been addicted to had altered his cognitive ability to effectively participate in the interview. "Sometimes I don't understand what you guys [RAs] are saying. Like my brain is still mixed up from drugs, I think, and that's what makes me feel stupid sometimes. Some of the words that are in there..." (IM5) When further prompted he repeated "Hmm... I don't know what you mean. You mean what other words like...I told you I wasn't very smart." (IM5)

## Discussion

Through the four-month process of prolonged engagement, the undergraduate students in the helping professions were able to develop therapeutic relationships and engage in meaningful conversation with clients who were homeless, as evidenced by

client response and quality of relationship. The RAs were able to engage with clients in meaningful conversation through both the traditional helping functions of their disciplines/professions, as well as through the processes of relinquishing traditional professionalism (Koegel, 1992) and embracing less traditional activities and settings in which to engage in therapeutic conversation. Comfort and rapport blossomed as the RAs spent additional time engaging in casual conversation (Burnard, 2003) with clients beyond the confines of the traditional office setting.

The common thread woven through the various facilitators and barriers to therapeutic conversation as a wellness-enhancing intervention for persons who are homeless is the acknowledgement of personhood. Personhood refers to the endowment of respect, trust, significance, identity, and unique existence afforded one person by another within the context of relationship (Kitwood & Bredin, 1992). Thus it is not only what the helping professional brings to the conversation but also attention should be paid to the relationship itself. According to Rogers, there should be a greater use of self of the therapist, a greater stress of genuineness, but all of this without imposing the views, values, or interpretations of the therapist on the client (as cited in Wexler & Rice, 1974). Client's personal growth is facilitated when the counselor is what he is, that is when in relationship with his client he is genuine and without "front" or façade (Rogers & Stevens, 1967). Yet as Hubble, Duncan, and Miller (1999) argue, it is how a client experiences the characteristics offered by therapist that is ultimately more important in determining outcome than what that therapist is "objectively" offering.

In a study of homeless men accessing services of an inner city drop-in centre, Bentley (1997) found that more than 30 percent of respondents identified experiencing a "loss of human uniqueness...explicitly stating a loss of personhood with the sense of being unseen or ignored by others" (p. 205). The commonly expressed importance of being acknowledged as a unique and valuable person can be met within and serves as a necessary prerequisite to therapeutic or caring conversations. Participants who were homeless expressed their desire to have the respectful acknowledgement of their personhood placed in the forefront of each and every therapeutic encounter - from connection to engagement - in therapeutic conversation as a means of establishing trust. Respectful engagement means trying to understand the client's meaning, thus and this communicating that you value that client as a person (Rogers & Stevens, 1967).

It is through respect, empowerment of clients (Holleman, Bray, Davis, & Holleman, 2004), and co-participation of its members that conversation becomes meaningful (Goodwin, 1995). In this study, participants described therapeutic conversation as being comfortable, casual, and inclusive of connection with and listening by the helping professional. Meaningful conversation was supported by a prolonged period of engagement which allowed for multiple contacts over time. According to Holleman et al., increased time spent with clients in building family genograms yielded more detailed client life stories than the typical briefer, routine visit. The casual nature of conversation desired by participants who are homeless suggests the need for the helping professional to enter into a therapeutic relationship as an engaged and equal person, instead of as a therapeutic expert (Bakhtin, 1984; Guilfoyle, 2003; Seikkula & Trimble, 2005). According to Rogers (1951), there should be a greater use of self of the therapist, a greater stress of genuineness, but all of this without imposing the views, values, or interpretations of the therapist on the client (as cited in Wexler & Rice, 1974).

Finally, effective listening is highly valued by clients as a contributor to meaningful engagement with helping professionals, encouraging them to truly listen, bestow attention, and make room for the verbal utterances and messages of personhood (Bakhtin, 1984; Levy, 2004; Seikkula & Trimble, 2005). These conditions echo Rogers' (1967) therapeutic conditions and set the foundations for change, and self-directed integration and personal growth (as cited in Van Belle, 1980).

As articulated in the barriers to therapeutic engagement, clients viewed prejudging, fear, and intimidation as impediments to therapeutic conversation. This concurs with Rogers' (1957) sanctions against the therapist making moral judgments about the client (as cited in Duncan, Solovey, & Rusk, 1992). These elements involve apprehension or guardedness of having one's individual personhood diminished, minimized, ridiculed, or denied. "Rogers states that the individual human being has a profound need to be fully known and fully accepted...a recognition that a deep human relationship is one of man's most crying needs today" (Wexler & Rice, 1974, p. 10). In addition, the sense of vulnerability arising from power differentials (Candib & Gelberg, 2001) and the need to conceal ongoing challenges and struggles within the therapeutic relationship deny very real elements of personhood and impact negatively on the ability to develop a relationship characterized by openness and trust in which the homeless person is valued.

### **Implications for Homelessness Practice**

Although some caution is necessary in developing recommendations as a result of a relatively small, homogenous sample drawn from a single homeless shelter, study findings invite helping professionals to seek out the many ways in which their personal speech, actions, attitude, and choice of setting for therapeutic conversation acknowledge the unique personhood of the homeless individuals with whom they are working. Regardless of the therapeutic setting and clientele, all people crave the therapeutic conditions exposed in this study. Members of helping professions interested in developing opportunities for meaningful engagement are encouraged to put aside prejudgments and perceived differences, preconceived therapeutic solutions and agendas, as well as professional roles, techniques, and settings that may be incongruent with the needs and desires expressed by persons who are homeless (Bakhtin, 1984; Guilfoyle, 2003; Koegel, 1992). Interventions, including the use of therapeutic or caring conversations, must be tailored to the specific needs of the individual client and may involve engaging in those elements that simply acknowledge personhood – listening, respecting, and being in the moment (Bakhtin, 1963, 1984; Levy, 2004; Seikkula & Trimble, 2005). This will require an investment of time on the behalf of the helping professional *to build trust* (Koegel).

Study findings also suggest that the use of therapeutic conversation by members of helping professions may play an important role in optimizing the physical and mental well-being of clients who are homeless. However, there is a need for further research to explore the nature and utility of therapeutic conversation among heterogeneous populations of persons who are homeless, including women and the racially/ethnically diverse, to determine if the principles outlined here are of benefit. In addition, further research could employ participatory action methodology (Nelson, Ochocka, Griffin, &

Lord, 1998) to examine the ways in which clinicians and academic researchers can co-create meaning with individuals who are homeless in order to address this knowledge gap (Levy, 1998), impact social action (Vera & Speight, 2003), and lead to recommendations for best practices which can optimize the wellbeing of clients who are homeless.

Therapeutic relationships with homeless persons require the kindred equality of shared personhood, thus acknowledging and embracing the personhood of both members in the relationship. The underlying aim of this type of intervention is “to address the invisibility of the street homeless person and foster the emergence of the unique, psychological self” (Bentley, 1997, p. 205).

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