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Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters

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## Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters

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*This article draws upon three years of ethnographic research within an emergency homeless shelter in Massachusetts to explore the subject-making effects of routine shelter helping practices. A medicalized discourse of deviancy is uncovered that provides the dominant conceptual framework within which both concerned homeless people and shelter staff remain enmeshed. As a result, helping practices focus on detecting, diagnosing, and treating understood deviancy within the bodies or selves of homeless people. The dominant discursive practices produce homeless subjects who learn to look within their selves for the “cause” of their homelessness. Treatment focuses on reforming and governing the self. Alternative discourses suggesting the need for practices challenging broader political economic processes are thus marginalized as peripheral and unreasonable. [homelessness, subjectivities, ethnography, political economy, homeless shelters]*

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“Sometimes I just can’t believe how stupid people here are. They know they’re being oppressed, but they won’t say anything about it.”

Raymond, a homeless African American man in his late forties, spoke those words to me one evening in 1996 as we sat in the living room of an emergency homeless shelter in Northampton, Massachusetts.<sup>1</sup> We had just left another in a long series of shelter meetings where many staff and guests advocated increased staff surveillance of homeless people’s individual behaviors as the most reasonable means for responding to increasing local homelessness. They appeared to be suggesting that surveillance was a key tool for uncovering “causes” of homelessness that need to be treated if we hoped to decrease homelessness.

Raymond, a man with a long history of social activism focused on racism and poverty, was one of the few people at the shelter to openly question routine shelter practices. Many guests complained about shelter rules, but Raymond was nearly alone in characterizing the staff counseling and training efforts as misplaced, insofar as they did not work against systemic inequities in the community. Consequently,

Raymond spent much time arguing against staff “helping” practices, which he characterized as inhumane for misplacing attention on individual homeless people. At the meeting we had just left, Raymond had been the only person staying at the shelter to argue against a proposal to initiate drug testing of shelter residents and another to begin using “workfare” recipients as “volunteers” within the shelter. He could not understand why he and I were the only people at the meeting voicing opposition to those policies. He read the compliance of other homeless people as the result of their being too stupid or uninformed to know any better.

I told Raymond I shared his sentiment that efforts to resolve homelessness through disciplining homeless people and reforming their perceived deviancy were misplaced. We both interpreted such practices as ignoring increasing structural violence as well as the historical and political-economic context within which homelessness has become a “normal” feature of life in the United States. But I also suggested an alternative interpretation to Raymond. I asserted that it doesn’t really help us either understand or work against consent to domination if we simply think of people who disagree with us as lacking the intelligence to see “the truth” about homelessness and inequality. Instead, we need to analyze how particular understandings and practices are constituted and come to make sense to those embracing and enacting them. This article is a part of that effort.

As recent work by Susan Ruddick (1995), David Wagner (1993), and Talmadge Wright (1997) makes clear, homeless people are active social agents who respond to homelessness in a variety of ways. Wright and Wagner document how responses sometimes take the form of open defiance. But I have observed that many people who find themselves homeless often engage in more individualized strategies of coping and accommodating. This article analyzes these strategies and the seeming acquiescence to the systemic conditions of homelessness they represent by ethnographically exploring how homelessness is medicalized through the discourses surrounding it. I accomplish this by examining the everyday practices of staff and guests within one homeless shelter.

### **Medicalizing Social Inequity**

Scholarship has demonstrated clear links between tactical business and governmental decisions and the recent production of homelessness in the United States. The increasing globalization of capital, deindustrialization (Hopper et al. 1985), the growth of temporary labor, altered tax policies, declining union membership, the growth of non-unionized service sector employment, institutionalized racism, gentrification in the name of community development (Marcuse 1989; Williams 1996), and a changing political landscape all have contributed to the production of increased economic inequality and homelessness during the past 20 years. In addition, neither the public nor private housing markets have managed to keep up with the growing demand for affordable housing (Burt 1992). In short, homelessness has become routine during a two-decade period characterized by growing inequality in wealth and income in the United States.

Despite these clear connections, very few practices aimed at resolving homelessness have specifically addressed such conditions. The implementation of emergency shelters was the initial dominant response, as homelessness first became widespread in the 1970s and 1980s. These shelters simply provided a “safe” place

to sleep, often a meal, and sometimes a shower and place to store one's belongings.<sup>2</sup> However, large emergency shelters did little to address homelessness and were often unsafe, inhumane, and degrading places that warehoused poor people (Dordick 1997; Gounis 1992; Liebow 1993). Often shelter rules even made it nearly impossible for a person to maintain employment and still reside at the shelter (Roofless Women's Action Research Mobilization 1996).

As the limitations and abuses of the emergency shelter approach have been documented in recent years, advocates and policy makers have searched for more effective methods of addressing the homelessness crisis. While many cities have opted to criminalize homelessness, federal agencies and some local communities have responded by advocating a "continuum of care" approach. Under this model, communities develop programs and services to treat the myriad symptoms thought to create homelessness, and shelters offer the services understood to be needed to help people obtain (and maintain) housing.<sup>3</sup> The move toward this model is part of a broader effort undertaken by some advocates and policy makers to reframe homelessness as a condition afflicting those victimized by disease and dysfunction rather than the result of bad individual choices. For example, efforts have been made to publicly represent people who find themselves homeless as suffering from the effects of traumatic episodes in their youth or during military service, a poorly functioning foster care system, depression or schizophrenia, the disease of alcoholism and substance abuse, domestic abuse, or similar ailments that restrict their capacity to remain employed and housed. The goal is a more effective and caring response to homelessness.

However, the move toward a disease model often has ambiguous and conflicting impacts (Singer et al. 1992). On the one hand, recent efforts may have facilitated increased services to reform, treat, and retrain individualized homeless people, and such efforts do improve the lives of some individuals who are homeless. On the other hand, however, the "continuum of care" approach also does not fundamentally address questions of access to and distribution of resources in the community. In fact, I argue here that the focus on "disease" within the discourses of "helping" actually obliterates discussion of alternative explanations and thus hinders developments aimed at resolving homelessness through altering class, race, or gender dynamics. When homelessness is individualized and medicalized, those concerns remain peripheral to the central work of normalizing perceived shortcomings or deviancy within homeless people.

Undoubtedly, this outcome is partly the result of a combination of both dominant imaginings and stigmatized perceptions about homeless people (Dear and Gleeson 1991) and the impact that federal funding concerns and religious organizations have on influencing public priorities and sheltering industry practices (Lyon-Callo 1998). Yet these are only small pieces needed to understand the complex puzzle of social processes and social relations that produce widespread homelessness. What is also needed is an understanding of how such understandings and practices have come to be so common. One small part of that larger project involves examining how medicalized and individualized understandings about homeless people as deviant are constituted, reproduced, and reinforced through discourses and practices.

It is hardly surprising that a medicalized conceptual framework guides responses to homelessness at this moment in history. Homelessness is just one social

condition among many that have been medicalized in recent years. Conditions and behaviors ranging from sexual decision-making, depression, credit card debt, sexuality, drug use, gambling, weight problems, and teen pregnancy are increasingly portrayed in popular and scientific discourses as the results of pathology or disorders within particular bodies or the bodies of groups of people. One effect of conceptualizing social problems through a lens of diseased bodies is often a neglect of systemic inequality. Consideration of the material and historical conditions that might contribute to the production of problems is silenced or marginalized by a focus on individual traits and habits.

As Vicente Navarro describes it, the medicalization of social problems plays the ideological function of legitimizing existing class relations and serves to “depoliticize what is intrinsically a political problem. Thus, within a medical framework, what requires a collective answer is presented as an individual problem, demanding an individual response” (1986:40). Navarro argues that much of what is thought of as illness is in fact the result of a fundamentally disproportionate distribution of resources. Yet, rather than working collectively to alter class relations and the distribution of health services, many health care and social service efforts focus on treating perceived disorders within individual bodies.

Critical medical anthropologists writing from the perspective of political economy have produced much work related to Navarro’s arguments. Paul Farmer et al. (1996) stress the degree to which AIDS research and social policy efforts focus on discovering and treating behaviors. They argue that such practices have the effect of silencing work against the class and gender processes that also contribute to illness. Other scholars have analyzed how racial, class, and gender inequities are often manifested in terms of alcohol abuse, AIDS, poverty, physical illness, mental illness, and homelessness (Morsy 1990; Singer and Baer 1996). Merrill Singer, for example, argues that to understand a “disorder” such as alcohol abuse, one needs to consider the broader historical and material conditions that produce the behavior (Singer et al. 1992).

Similar dynamics apply to homelessness. In her study of the medicalization of homelessness in New York City during the 1980s, Arline Mathieu (1993) discusses how representations of “the homeless” by government officials as mentally ill served to marginalize the political-economic context of homeless people. She details how press releases from the mayor’s office in support of a policy of randomly taking homeless people off the streets by force emphasized that the people still living on the streets were homeless due to mental illness. Mathieu argues that as long as homeless people were biomedically represented as deviant, their living on the streets could be “solved” by housing them in shelters and forcing them into treatment programs. Attention to systemic inequities that contribute to producing widespread homelessness was thus deemed unnecessary.

Through my work on homelessness, I have come to agree that systemic inequities contribute to the production of many behaviors that are commonly read as pathological disorders in people without permanent shelter.<sup>4</sup> Reading these behaviors as individual disorders certainly plays a role in silencing work against exploitative social conditions and in limiting our ability as medical anthropologists to work more effectively against the conditions the work documents (Hopper 1988; Singer 1995). However, there is another component that deserves analytical attention. Something much more subtle and insidious than simply mystification takes

place when homelessness is medicalized. It is my contention that routine, everyday practices undertaken by shelter staff and guests to resolve “diseases” actually reproduce and reinforce dominant imaginings about homelessness and homeless people and, thus, contribute to producing particular subjectivities, experiences, self-images, and behaviors among homeless people.

To make this argument, I draw upon insights coming out of the critical-interpretive approach in medical anthropology represented by Robert Desjarlais (1997), Margaret Lock and Nancy Scheper-Hughes (1990), and Alan Young (1995), as well as by scholars outside of anthropology writing on the production of medicalized knowledge (Hacking 1995, 1996), governmentality, and the practices of self-making (Rose 1990, 1996). These scholars demonstrate how all knowledge of society, normality, illness, and self is socially produced and determined and that all knowledge about the body, health, and illness is constituted through historically situated cultural negotiations (Scheper-Hughes and Lock 1990). To analyze that process it is imperative to examine the techniques and practices through which people who are without a permanent place of residence are made into subjects to be governed by their selves, social workers, social planners, and medical experts. In this article, therefore, I outline a strategy for considering the ways in which the homeless body (the social body and the body politic regarding homelessness, as well as individualized homeless bodies) is, in part, produced and reproduced by social practices within homeless shelters.<sup>5</sup>

Even prior to being connected with the facility, many of the people who volunteered, worked, or lived at the shelter I observed articulated understandings supporting the dominant conceptual framework in which homelessness is viewed as embodied deviance. This is hardly surprising given the preponderance of public discourses that pathologize poor people as well as dominant stigmatized images of homeless people as deviants. Yet, in analyzing precise practices in the shelter setting, I uncover how the well-intentioned efforts within the shelter actually work to reproduce and reinforce the image of homelessness as a social problem with an origin in individual deviancy. Reformatory efforts often focus on “treatments” that fit within constructed views of “normal” and “deviant.” These practices produce subjects who come to understand reform of the individualized self as the most “reasonable” and “realistic” ways of resolving homelessness. Through their experiences in the shelters, many homeless people are thus produced (and reproduced) as political subjects who are more likely to engage in self-blame and self-governing than in collective work against structural violence.

### **Producing Homeless Subjects: An Exploration of Routine Shelter Practices**

From 1993 through 1997, I conducted activist ethnographic research at a 20-bed emergency homeless shelter in Northampton, Massachusetts, where I was also employed as a staff member.<sup>6</sup>

This setting was an ideal location for investigating the effects of the “continuum of care” and disease model for at least two reasons. First, Northampton, like much of the northeastern United States, has undergone vast economic changes in the past two decades. Lost manufacturing jobs have been replaced by low-wage, often part-time employment in food services, social services, and retail trade. Recent gentrification and redevelopment of the downtown area has created a bustling

urban core but has led to the loss of one-half of the city's single-room-occupancy units. Housing costs are out of reach of many citizens, while waiting lists for housing assistance are closed for years at a time.

Northampton was also an ideal setting for the study because local shelter providers and policy makers strongly embraced the "continuum of care" concept. As a result, staff members at the shelter counseled people on a wide range of issues as well as referring "guests" to outside experts. Likewise, community planners and policy makers developed a broad array of "helping" services in the community. Such services included increased substance abuse treatment programs, enhanced access to mental health services, veteran's services, job training, increased shelter beds, and an assortment of counseling options and workshops within shelters. Consequently, the city and the shelter were both often described by guests as the best place in the entire state to try to resolve one's homelessness.

In this setting, I conducted archival research on economic and housing conditions at the local level, which provided a systemic context within which I could better contemplate local responses to homelessness. I also spent over 6,000 hours ethnographically detailing how homeless people, shelter staff, local advocates, and local policy makers responded to homelessness. I observed and participated in a broad range of shelter activities, including weekly staff meetings, case management efforts, the daily enforcement of shelter rules, statistical record keeping, the development of shelter policies, intake interviews, staff hiring, efforts to locate housing and income, the development of grant applications, and staff training. Data from these activities were supplemented by a series of open-ended interviews with nine staff members, several dozen homeless people, shelter administrators, local advocates, and local policy makers.<sup>7</sup>

I employed an explicitly activist position while conducting this research. By activist ethnographic research I do not mean a simple stance of advocacy for a particular position or understanding. Rather, I engaged in a constantly evolving dialogue with the community members with whom I worked. The goal was not simply to find data to support my views, nor was it my intention to impose my views or visions upon these people, as if I had "the solution" to homelessness.<sup>8</sup> Homelessness is much too complex for any simple social policy change to "solve." By activist research, what I am referring to is an ethnographic method of openly challenging each other's ideas in an effort to think more critically about all of our views and practices. My intention was to facilitate our learning from each other through engaging in debate and dialogue regarding the effects of our routine, well-meaning practices and by asking how to understand homelessness in as comprehensive and complex a fashion as possible. It was my hope that this engagement might stretch the parameters of what was thinkable and doable and, thus, create the possibility for new discourses, new practices, and new subjectivities to emerge.<sup>9</sup>

Through engagement of this sort, I uncovered and challenged an underlying hegemonic hypothesis of deviancy functioning within the local sheltering industry. I found that routine practices focus primary attention on developing techniques for detecting, diagnosing, and treating pathological disorders within individual homeless people.

Detecting and diagnosing disorders begins the moment a homeless person first enters the shelter. The new shelter guest is quickly directed into the staff office for an intake interview. The intake interview serves several functions. On one

level, it is simply an opportunity for the staff to compile basic statistical and demographic data while detailing the shelter rules and procedures. A case history, used to guide case management, is also started. Of paramount importance, though, is that the intake interview is the first opportunity for the staff and guest to diagnose the disorder(s) of the self that caused the person to be homeless.

In addition to the required components of the intake, the staff member works to comfort the recently homeless person, who is often quite nervous about being in a shelter. A caring staff member uses this opportunity to develop a sense of rapport with the new guest. Through this more informal discussion and from the homeless person's mannerisms and articulations, the staff member attempts to gather additional data on possible disorders within the person. If, for example, the staff member detects what he or she perceives to be possible mental illness or substance abuse, these observations are noted in the person's case folder and in the staff log. Other staff can thus be made aware of the diagnosis and look for possible supporting symptoms.

Staff gathers this information in a variety of ways. One specific question during the intake asks the recently homeless person to state his or her "reason for homelessness." The intake form includes a number of suggested reasons, each particular to that individual. As most homeless people have already learned a great deal of self-blame prior to entering the shelter, many guests will respond by disclosing a behavioral or training problem as the cause of their homelessness. For example, 39 percent of the people at this shelter during 1995 stated that they were homeless due to "substance abuse." Thus, overcoming that individualized problem became the focus of their subsequent efforts to become housed.

Formal efforts to diagnose possible causes of homelessness continue throughout the person's stay at the shelter. Within one week, a case management meeting is scheduled for the new arrival to meet with staff for a second intake. This setting is more clearly defined as establishing a counseling relationship. Here, the staff and guest meet privately for a prolonged discussion about the "issues" that brought the person to the shelter and the resources available to help with those needs. A more detailed case management intake form asks about the level of education, employment history, medical history, past therapy or counseling experiences, and any background with substance abuse or mental health treatment programs. This information is used to determine what issues the homeless person should "work on" while at the shelter. Detected problems range from mental illness to a need for employment training, but all are understood as situated within the homeless person.

With the initial diagnosis in hand, the shelter staff and homeless person proceed to look for evidence to support, refute, or augment the initial diagnosis. This evidence is gathered through both formal case management meetings and less formal surveillance mechanisms. Surveillance takes place while monitoring the guest's obedience to shelter rules, counseling guests, resolving conflicts, and engaging in informal discussions in the shelter. As Ann, an ex-staff member, summed it up, "Whenever you are at the shelter, you are supposed to be monitoring the guests."

The monitoring is understood as a vital function through which the staff and guests can garner information for diagnosing the disorder needing treatment. For example, when staff monitoring or guest disclosure reveals an infraction of the rules, the offending person is called into the staff office to discuss the incident. A



written warning describing the transgression is placed in the guest's case file. More importantly, a conversation follows wherein the staff member uses the violation of shelter policies as evidence of an issue the homeless person needs to resolve if he or she hopes to become housed. This is portrayed as a mechanism by which homeless people can be made to come to grips with the issues (always disorders within their selves) causing their unstable lives and homelessness.

These practices initially seemed like common sense to many staff and guests. Because such sentiments are currently so ubiquitous in the United States, they make sense as the normal way to resolve homelessness. Thus, neither the majority of guests nor staff tended to question them. In fact, many shelter guests often sought more stringent staff surveillance and urged stronger disciplinary rules in the shelter. They understood surveillance of their selves as a mechanism for "helping."

Through the application of these shelter practices, the homeless person is turned into a case history, someone known via these diagnostic techniques as a set of individual disorders and symptoms. The staff and guest's determination of cause "types" the homeless person as a "kind" of client defined by "signs" of his or her "disorder." This "typing" thus drives subsequent treatment responses.

Once the staff and guests have detected and diagnosed the disorder(s) within a homeless person, they begin treatment. Gloria, a shelter staff member, explained this process: "I think many staff take the sort of disease model approach. Well, you know, if that's your problem, we'll hook you up with meetings, you'll do this, you'll go into this program, and that will cure your problem and fix you."

Within the shelter, biomedical language and practices focusing attention on diagnosing and treating pathologies understood to cause social problems are augmented by pseudo-scientific discourses arguing that the only "reasonable" way to help many people is through programs aimed at self-help. As a result, one of the first steps in developing a case history is to have the guest and staff look for the factors that caused that person to turn out the way he or she did. A defining feature of the diagnosis is that the homeless guest must be a willing collaborator in self-diagnosis. Guests are taught to ask, "How did I come to be this way?" It is this reflexive inquiry about the self that is at the heart of future reform efforts.

The vast majority of routine shelter treatment plans fall under the rubric of self-help and governing of the self. As Barbara Cruikshank concludes in her work on self-esteem programs for poor women, self-help and self-government promise "to deliver a technology of subjectivity that will solve social problems like homelessness and inequality by waging a social revolution, not against capitalism, racism, and gender inequality, but against the order of the self and the way we govern our selves" (1996:231). Let me illustrate this process with a few ethnographic examples.

Jerry, a 24-year-old white man, tried his hardest to work his way out of homelessness through paid employment. He came to the shelter shortly after being honorably discharged from the military and maintained a job at a local branch of a supermarket chain for over nine months. Jerry's strategy of attempting to resolve homelessness through paid employment is far from unique. In 1995, 74 (38 percent) of the 193 people who stayed at the shelter were employed. However, over 90 percent of those employed worked in either food service or in retail trade jobs with unsteady work schedules, low pay, and no health benefits. Those are the jobs available in this community.<sup>10</sup> Consequently, only four of the 193 shelter guests were

able to secure an apartment or house in Northampton that year. When rents average approximately \$650 per month for a one-bedroom apartment (Watson 1996:16) and there are thousands of people on the waiting list for subsidized housing, it is fairly difficult to afford rent with an income less than \$200 per week.

Jerry was one homeless person who understood his low pay as the result of broader political-economic processes. After one particularly frustrating evening of work at the supermarket, Jerry and I had a long conversation about his working conditions. At one point, he argued, "It's just shit. If this was the 1950s, I wouldn't be homeless. My uncle graduated from high school and got a job right away in doing tool and dye work. They gave him good pay and benefits and he was able to buy a house. There just aren't good jobs like that anymore. I work just as hard and I'm still stuck in this job and in the shelter."

Feeling powerless to alter the wages paid in the existing jobs in the community, he desperately wanted to go to college as a path toward a better job and more financial stability. However, he couldn't figure out a way to pay for school. He couldn't afford to rent a room in a rooming house, let alone pay for college. Jerry tried to hold down a second food service job, but the two sets of work hours conflicted too often and he was forced to quit the second job. He also persistently searched for better paying jobs in the community, but was unsuccessful in obtaining one.

After Jerry had been in the shelter several months, staff began to worry about how to help him move out. Weekly discussions at staff meetings ensued focusing on how to help Jerry. Some staff began to pressure him to work more closely with them on diagnosing the reasons for his homelessness and his inability to find a higher-paying job. Several staff members suggested that his inability to save enough money to move out of the shelter was a "sign" of deeper problems than simply a low-paying job. When Jerry and I countered that he was working long hours but was just not being paid enough to afford local rents, he was urged to think "realistically" about what he could do to afford a place to live.

When I again suggested that the problem might not be within Jerry but with the wages being paid locally, I was seen as diverting attention from "realistic" solutions. As Karen, a newer staff member, commented, "I agree that those are problems, but I wouldn't know where to start to solve those problems. I feel like all I can do is to do what I can to really help people on a practical level. And people here have real problems with personal issues." It was suggested that Jerry was unable to obtain a higher-paying job because of lingering depression and substance abuse. I then suggested that perhaps these conditions were the result of his current life circumstances. A few staff members thought that made sense, but, again, they had to be practical and work on what they could change. What they could change was Jerry.

Increased staff attention focused on helping Jerry resolve his "issues" of substance abuse and depression. At case management meetings, he was urged to look at past behaviors as possible indicators of disorders. In particular, drunken episodes in high school and the military were portrayed as symptoms of a substance abuse disorder. Even though he had only drunk alcohol two times during the previous two months, it was suggested that staff mandate that Jerry have bi-weekly meetings with a therapist and attend at least three Alcoholics Anonymous meetings each week as conditions for receiving further extended stays at the shelter.

He was encouraged to understand his homelessness as the result of traumatic stress related to his youth, insecurity about his sexuality, depression, and substance abuse. In fact, he was rewarded with extended staff "help" and extra time at the shelter for doing so and threatened with expulsion from the shelter if he did not work to reform his self. Several staff members urged him to quit his job so he could focus more energy on his self. He did not comply with that suggestion, but he did agree to seek therapy, to take antidepressant medication, and to attend self-help programs. Through these efforts, he soon came to articulate his problem as being within his self. What else could he do, but struggle to change his self? Clearly, nothing could be done about the fact that 45 percent of new jobs in the region are projected to pay wages below the federal poverty level for a family of two (Turner 1998). Likewise, nothing could be done about the fact that the supermarket chain Jerry worked for made \$73 million in profits in 1995 and paid its CEO a base salary of \$1.19 million while paying its workers wages inadequate to afford housing (Spain and Talbott 1996:1351). It was understood that nothing could be done about those circumstances. Therefore, the only reasonable path was to teach Jerry to reform his self.

A second example details a similar subject-making effect. On a June night in 1996, Maria came down the stairs of the shelter and asked if she could speak with me. Maria had entered the shelter approximately two months earlier. Like Raymond, she had a fairly extensive history of social activism around racial inequality in the region. She had also worked for many years in social service jobs. When she entered the shelter, both Maria and the staff believed she would quickly find a job and move out of the shelter. After two months of unsuccessful job searches, some staff began to understand Maria's problems as the result of a disorder within her self. At the same time, her relationship with the father of her children began to become difficult. Several staff counseled Maria and urged "self-empowerment" through focusing on the "issues within her own life." Maria was urged to stop seeking a job and to focus on her "issues."

Our conversation began with Maria stating that she was now willing to address a disorder of the self that a staff member had previously diagnosed. She explained that she was now willing to seek counseling and therapy for her depression. She said, "I'm starting to feel really low. It started at the end of the week, and by Friday and Saturday I didn't want to see anyone."

When I asked her why she now thought she needed therapy, she explained,

I feel stuck here. I need a job. I've done everything I can think of to get a job. I even applied at Burger King for an assistant manager. I've sent out my resume to a thousand places, but I can't get a job. I'm starting to think that I must be doing something during the interviews to turn these people off. I know sometimes it's discrimination, because I'm someone who speaks my mind and people don't like Puerto Rican women who speak up, but I'm starting to blame myself also. Thinking that there's something wrong with me. . . . I think I'll call this woman I used to talk to on Monday. She was pretty good, except she tried to push the pills on me. A job don't come in no pill. If you got a pill that gets me a job, I'll take it.

Both Maria and Jerry are strong, bright, energetic people. After a few months of working with the shelter staff, however, both were contemplating medication for mental health problems. As Maria stated, "A job don't come in no pill," but neither

she nor Jerry were provided with any way of understanding their inability to resolve homelessness that did not involve focusing on treating the individualized self. Within the dominant medicalized conceptual framework, it becomes common sense to understand the coping strategies of people surviving in homeless shelters as symptoms and evidence of mental illness. These people are thus understood as passive victims of biological disorders rather than situated social agents. Rather than providing a collective, social, or political understanding, shelter practices help to reproduce self-blame and self-governing.

People who come to believe that the solution to homelessness lies in treating or reforming the self are unlikely to engage in collective action. Within that discursive framework, collective action makes little sense because it does not involve working on individual issues. However, as Raymond Williams (1977) elucidates, hegemony is never totalizing. Peripheral discourses, although marginalized, do provide possibilities for resisting. Some shelter staff and some people who find themselves homeless, like Raymond, do voice a profound desire to change systemic conditions. Like Maria, they often articulate an analysis linking homelessness to class exploitation and social discrimination. However, these noncompliant staff and homeless people also remain enmeshed within the dominant medicalized discourse. In fact, any resistance to medicalizing discourses and practices is often itself medicalized and diagnosed as misplaced attention and further evidence of pathology. "The medical gaze is then a controlling gaze, through which active (although furtive) forms of protest are transformed into passive acts of 'breakdown' " (Lock and Scheper-Hughes 1990:68). Let me demonstrate this with an example.

After Raymond had several bouts with homelessness, a small majority of staff members voted to not allow him to return to the shelter. At the time, the shelter had a long waiting list, and the decision to bar Raymond was based on the argument that the shelter needed to prioritize those people they could really help. It was argued that it would be a waste of resources to allow him to return because he did not cooperate with prior case management procedures designed to "help" him. As Karen argued, "We can only help people if they are willing to work with us."

I suggested that maybe the staff was projecting a politically dangerous message by prioritizing who was worthy of shelter. Instead, I urged, we should argue that everyone was deserving of a safe place to live and engage in practices to accomplish that goal. Two other staff members, however, disagreed. They reminded us of what had happened a few years earlier when the shelter had let in everyone requesting a bed. They correctly reminded me that, at the time, I had agreed with them that it was an unhealthy and unhelpful effort.

I then stated that perhaps I was not being clear. I was not suggesting more shelters but, rather, that we work to decrease poverty and inequality and lessen the actual demand for shelters. They agreed with the sentiment but argued that they felt the shelter would alienate supporters with such practices and that we needed to be "realistic" and cognizant of the public sentiment that only those willing to help themselves were deserving of housing.

As one staff member, Leopoldina, reminded me, the shelter had just begun to obtain adequate funding from the state. A condition of the funding was that the shelter submit a monthly summary of how many guests staff had referred to treatment programs, job training programs, and similar reformative efforts. Leopoldina pointed out that it was quite telling that nowhere on the monthly form were there

questions about efforts to politically organize homeless people, facilitate the development of collaborative efforts to decrease economic inequality in the community, alter the local wage scale, or address issues of housing cost or availability. In her mind, the state agency was sending a clear message about priorities and what practices the shelter staff must engage in if they wished to continue to receive funding. Not wanting to risk losing funding and, thus, the ability to shelter anyone, most staff complied with this message. No one was happy about turning away 20 to 40 people each night, but prioritizing those seeking shelter was understood by some as the most "practical" and "reasonable" response available.

As a result, Raymond's attention to the collective and racialized experience of homelessness was portrayed as an expression of his unwillingness to help himself. In fact, his focus on historical and political-economic conditions was sometimes represented as a symptom of a mental health disorder both by other shelter residents and by several staff. Other staff read Raymond's noncompliance (and perhaps his race) as a sign of drug use, and he was portrayed in staff meetings as a drug dealer and pimp despite the absence any concrete evidence. In any case, he was punished for not complying with the idea that the proper way to respond to homelessness was through treating individualized deviancy. Other noncompliant guests have had similar experiences.

If a homeless person openly questions shelter helping efforts, he or she is understood as a problem. Staff use a variety of mechanisms to lessen the significance of such critiques. The homeless person is diagnosed as misplacing attention on "political" matters and not focusing on real individual issues. Often, these "political" concerns are understood as symptoms of mental illness and paranoia. Medication has been suggested as a means of "helping" more than a few people who spoke out against what they saw as misplaced shelter practices.

A slightly different set of practices surround a second noncompliant guest. Ariel, a white woman in her late fifties, first came to the shelter in May of 1993. Ariel had maintained a lower-middle-class life, doing light clerical work until the mid-1980s. When she was no longer able to find such work because of her age and computerization, she began to try to support herself through house cleaning. In 1993, she lost her room at a local rooming house when she was no longer able to secure enough work to pay rent. As soon as Ariel entered the shelter, staff members went to work trying to help her. The strategy used was that of uncovering the disorders within Ariel that resulted in her homelessness.

As with most of the hundreds of homeless people I have met, Ariel was full of self-blame and, consequently, was quite angry and upset over her situation when we first met. As she put it, "I didn't know what to do with this anger, so I blamed myself." Ariel's feelings of anguish would be manifested in her sometimes losing her patience with a fellow guest, becoming distraught, crying, and feeling unable to concentrate at times. She was clearly in a great deal of emotional pain. A few times, she was forgetful in the kitchen, and tea kettles were left on the stove unattended.

Ariel's emotions and behaviors were read by most staff as symptomatic of a mental illness. She was characterized as "clinically depressed" or suffering from post-traumatic stress disorder. Further evidence of a mental health disorder was gathered from her frequent suggestions for improving shelter policies and practices. Ariel's seemingly helpful suggestions, for example, that staff save dinners

for shelter residents working the second shift, or her offer to wash the window curtains were read as directing attention away from the "cause" of her homelessness and as symptoms of her disorder. Staff members often did not respond to her suggestions because they did not want to "encourage her denial."

During July of 1993, this diagnosis resulted in a group of shelter staff developing a treatment plan for Ariel. The first step was to get her into counseling and on anti-depressant medications. When she resisted, staff devised a second plan to obtain money for Ariel by having her declared mentally disabled so that she would be eligible for social security disability payments. Ariel wanted nothing to do with that form of help. She explained that she was poor, not mentally ill.

Staff at the shelter continued to push the plan on Ariel. She was routinely called into a staff office for counseling sessions. At these sessions, well-meaning staff members would point out to Ariel how she was unable to care for herself. They would explain that they were concerned about her, but she could not stay at the shelter forever if she did not want to "help herself." Ariel told me how, during these meetings, staff members would tell her she was going to freeze to death or lose limbs from frostbite that winter if she did not comply with their helping efforts. When she still refused to comply, Ariel was denied further time at the shelter.

As a result of her resistance to medicalized shelter practices, Ariel was kicked out of the shelter for being difficult. *Being difficult* was defined as not claiming a mental health disability. The hope of the staff was that living on the streets would "break through her denial" once Ariel "hit bottom." Instead, her resistance to the medicalization of her body resulted in physical hardship. She survived outside from August through mid-December, when my constant advocacy, the empty shelter beds, the extreme cold, and the guilt of the Christmas season led staff to allow her to move back into the shelter. But then the efforts to push Ariel toward self-reform began anew.

Ariel described to me how some staff would ask her why she just wouldn't go along and comply. They could not understand how she could "keep living like this." Ariel told me, "The alternative is to commit suicide, and I'm not going to commit suicide. I'm willing to walk around with no place to live because I have no place to live. Because I'm willing to keep on living, that's why. I'm willing to walk around all night or sit up in Stop and Shop [a regional supermarket] because I'm not willing to jump off a bridge. Those are my options."

I asked, "And you think that getting social security payments so you can have a room in a rooming house wouldn't be living, it would be giving up?"

Ariel replied, "Right. I'm not going to lie. I'm going to tell them the truth. They better not declare me mentally disabled. I am not mentally disabled, but I do need money to get a place to live. It's like they're saying, 'We can't change the economy, so we have to change you.'"

Everyone in this situation did the best they could. Clearly, Ariel was resisting, but her resistance remained quite constrained. Let me be clear: I am not simply describing a case of mystification or false consciousness. Not everyone I worked with believes that homelessness is simply the result of deviancy within homeless people. As Stuart Hall notes, hegemony functions such that "ruling ideas may . . . set the limit to what will appear as rational, reasonable, credible, indeed sayable or thinkable" (1988:44). The hegemony of the medicalized discourse of deviancy operating within the homeless sheltering industry produces everyday practices of

self-disclosure and self-government as routine habits that are accepted as “common sense.”

The combination of a dominant medicalized discourse of deviancy, the belief in the naturalness and inevitability of capitalist exploitation, and widespread feelings of powerlessness to alter systemic conditions produce practices within the narrowly defined parameters of what is “reasonable” and “realistic” to think and do. The actual practices, even of noncompliant homeless people, remain enmeshed within the hegemony of the discourses of deviancy. To paraphrase Michel de Certeau, everyday practices enacted by noncompliant homeless people often allow them to “escape domination without leaving it” (1984:xiii). They are resisting the hegemony of the biomedical discourse by refusing to comply and collaborate in their oppression, but are not working collectively to escape or alter the systemic oppression that results in widespread inequality and homelessness.

Agents within the sheltering industry develop diagnostic tools, statistical representations, treatments, and reforms to make the homeless person into a new kind of self-blaming and self-governing person. Under these discursive conditions, the staff and guests function as institutional agents whose job it is to govern “the homeless” through a regime of surveillance, discipline, and personal enhancement. In short, a “normal” person is to be made by governing a “deviant” homeless person.

Those advocating governing the self as the solution to homelessness do not pay attention to the extent to which personal life is governed. The self (like poverty, homelessness, inequality, and racism) is not only personal but also the product of power relations, the outcome of strategies and technologies (Cruikshank 1996:248). Self-help, self-fulfillment, and self-reform are technologies that produce certain kinds of selves and marginalize the possibilities of producing alternative subjectivities. When statistical typologies and case histories diagnose disorders within homeless people and, thus, reinforce knowledge about homeless deviants, it becomes only “common sense” that helping efforts focus on treating these disorders of the self. Homeless subjectivities are made up through shelter helping practices such that it makes perfect sense for many people living in shelters to willingly comply with more surveillance and reform of their bodies and selves.

If we are to understand the durability of homelessness despite the well-meaning efforts of the sheltering industry, we must contemplate how *the homeless* and *homelessness*, as categories, are produced and resisted. These categories are products of discursive conditions that give rise to concrete ways of thinking and acting. This article focuses on one particular community and one shelter. Although not representative of all shelters, it does provide a case study by which to examine the ambiguous effects of adapting the “disease” model for responding to homelessness. We need to examine practices designed to validate the categories of *homelessness* and *the homeless* in a range of settings. Through that work, we can begin to uncover how dominant discursive conditions reinforce routine practices that normatively silence or devalue other possible ways of perceiving and being in regard to homelessness.

## NOTES

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1. The names of all homeless people and shelter staff referred to in this article have been changed. Everyone quoted formally agreed to take part in this study.

2. Many shelters were created as charitable institutions by religious organizations. In these shelters, a homeless person also often received a lecture or gospel reading as a condition for a night's stay.

3. As one example, New York City instituted a program in 1998 whereby the city paid shelter operators bonuses for moving homeless families and individuals into permanent housing. This was represented as an incentive to the shelters to develop more effective helping programs (Holloway 1998).

4. This is certainly not meant to suggest that some people do not display symptoms of what are commonly diagnosed as mental illnesses or substance abuse disorders prior to becoming homeless. However, I would argue that even in such cases, homelessness is a result of political and historical conditions. There is no inherent reason why mental illness or substance abuse must lead to homelessness. In fact, in other historical moments and geographic locations, it has not. Nor do all people displaying such behaviors in the United States today become homeless.

5. See Desjarlais 1997 for a related ethnographic study focused on practices within a shelter for people deemed mentally ill.

6. Activist ethnographic research, like advocacy or action research, strives to be accurate and non-biased without claiming to be value-free or neutral. For more detailed arguments on this research methodology, see Schensul and Schensul 1978 and Singer 1990.

7. I did not formally interview two staff members because of their time commitments outside the shelter. All shelter staff and regular volunteers agreed to participate in the study, sign consent forms, and allow me to tape weekly staff meetings.

8. In fact, several staff members and shelter residents frequently urged me to speak up and assert my views within the community, as if I had "the answer." I tried to explain that my goal was to push all of us to think more critically about our assumptions and practices so that we (including myself) could learn from each other.

9. Again, to be clear, I am not arguing that such engagement will lead people to see "the truth" or free them from the false consciousness hidden by ideological conditions. Instead, my hope was that new discursive practices might lead to different social outcomes, which, hopefully, would decrease the violence of structural inequalities and homelessness.

10. As in much of New England, deindustrialization has hit western Massachusetts quite hard. A 15 percent decrease in manufacturing jobs and a 12 percent increase in service sector jobs occurred countywide during the 1980s (Market Street Research 194:14). This trend continued throughout the 1990s. According to the Northampton Chamber of Commerce, 42 percent of the jobs in Northampton in 1998 were in the service sector.

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