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Maslow and Mental Health Recovery: A Comparative Study of Homeless Programs for Adults with Serious Mental Illness

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Abstract

This mixed-methods study uses Maslow's hierarchy as a theoretical lens to investigate the experiences of 63 newly enrolled clients of housing first and traditional programs for adults with serious mental illness who have experienced homelessness. Quantitative findings suggests that identifying self-actualization goals is associated with not having one's basic needs met rather than from the fulfillment of basic needs. Qualitative findings suggest a more complex relationship between basic needs, goal setting, and the meaning of self-actualization. Transforming mental health care into a recovery-oriented system will require further consideration of person-centered care planning as well as the impact of limited resources especially for those living in poverty.

Keywords

Maslow; Mental health recovery; Housing first; Homelessness; Serious mental illness

Introduction

For over 50 years Abraham Maslow's hierarchy of needs has been one of the most cited theories of human behavior (Kenrick et al. 2010). Maslow's theory is often depicted as a pyramid that places physiological needs (such as food, water and air) at the base, followed

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by safety, belonging, and esteem needs moving up the pyramid (Kenrick et al. 2010). At the top of Maslow's pyramid is the need for self-actualization, described as the desire "to become everything that one is capable of becoming" (Maslow 1943). This has striking similarities to the overarching goal of the mental health recovery paradigm, which is for people to "strive to reach their full potential" [Substance Abuse and Mental Health Administration (SAMHSA) 2011].

Maslow's theory has been applied to empirical research in a variety of fields, including education and management (Kiel 1999), social and emotional well being (Gorman 2010), and behavior change in relation to health (Freund and Lous 2012; Roychowdhury 2011). Although Maslow's theory is cited within the literature on recovery from serious mental illness (SMI) (Clarke et al. 2012; Ochocka et al. 2005) there has been limited discussion, and even less empirical support, about how material deprivation, or a lack of basic needs such as housing, affect one's recovery potential (Draine et al. 2002a, b; Padgett et al. 2012). Most would agree that having basic needs met supports or promotes recovery. SAMHSA (2011) identifies such things as *health, home, purpose* and *community*, as important to the overall recovery process. What is less clear, however, is the way in which not having certain needs met affects or precludes the recovery process (Clarke et al. 2012; Nelson et al. 2001).

For persons with SMI who are homeless there is a clear need for basic shelter. One could also identify many other needs given that this population disproportionately experiences unemployment, incarceration, and health disparities (Viron et al. 2013), but ordering them within a hierarchy towards recovery may prove difficult. The two predominant approaches to homeless services for persons with SMI—housing first (HF) and treatment first (TF)—both address the basic need for shelter, but differently position the order in which other needs can be met (Henwood et al. 2011). Proponents of HF describe the model as oriented towards recovery and have explained that "In keeping with Maslow's (1947) hierarchy of needs, the model is based on the assumption that until an individual has a home, and unless their basic safety and security needs are met, she or he will not have an adequate platform from which to successfully address other challenges, such as psychiatric symptoms, addiction or employment" (Greenwood et al. 2013, p. 648). HF programs, therefore, provide immediate access to subsidized, permanent housing options along with community-based supports that usually provide assertive community treatment (Tsemberis et al. 2004). Permanent housing is regarded as an essential resource to address material deprivation (i.e. homelessness) and establish a foundation of ontological security (Padgett 2007). Once permanent housing is secured, consumer preference drives whether tenants focus on issues regarding employment, addictions, psychiatric symptoms, relationships, or any other priority.

In contrast, a TF approach refers to traditional programs that prioritize the need to address psychiatric symptoms, addictions, and socialization skills before accessing permanent housing or employment. TF programs, which continue to be a default approach, have a more prescribed and less flexible staircase model in which permanent housing is seen as a higher order need that comes after more basic life skills and healthier habits are achieved. Without claiming to be recovery oriented, a TF approach has been described as primarily shaped by the belief that consumers should "earn" housing by demonstrating their moral worthiness

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(Dordick 2002; Kertesz et al. 2009)—a belief that can be seen as deeply embedded within U.S. social welfare policies (Trattner 1998).

There is a significant body of empirical evidence showing that the HF model is a cost effective approach that can achieve residential stability rates beyond those achieved in TF services (Collins et al. 2013; Culhane 2008; Pearson et al. 2009; Stefancic and Tsemberis 2007; Tsemberis and Eisenberg 2000; Tsemberis et al. 2004). In fact, the vast majority of people who enroll in HF services stay engaged. Research has shown that a large proportion of enrollees in TF programs are not able or willing to follow the prescribed trajectory and disengage from services. Many return to the “institutional circuit” of shelters, jails, and hospitalizations (Hopper et al. 1997).

Although these findings favor a HF approach and suggest that HF enrollees are more likely to focus on self-actualization and recovery, a recent critique noted that improved residential outcomes are offset by the suffering that results when individuals isolate in their homes (Hopper 2012). From this perspective, HF functions more as a form of social control than as an intervention that promotes recovery. In order to situate and address mental health recovery within empirical studies comparing a HF and TF approach, this study uses Maslow’s hierarchy as a theoretical lens to investigate the experiences of newly enrolled clients of both program models over a one-year period.

Maslow’s Theory

Maslow’s original hypothesis stated that having one’s basic needs met is a necessary prerequisite to pursuing a fulfilling life (Maslow 1943). Maslow posited that a person’s ability and desire to grow is related to his or her unmet needs. Behavior is goal-oriented, with unsatisfied needs constituting proximal goals that motivate people to act. Based on the idea that people’s needs can be categorized in a hierarchical fashion, Maslow’s early work suggests that one must fulfill lower level needs and work up through the hierarchy in a linear fashion before higher level needs emerge (Freund and Lous 2012). Self-actualization that is at the top of the hierarchy is described as a “being need” distinct from other types of needs at the base of the pyramid, known as “deficiency needs.” Once a deficiency need is fulfilled, the individual can move up the hierarchy to pursue goals and meet higher level needs. Attempts to address a being need create an on-going process of human motivation and self-discovery that increases over time (Maslow 1970). This aligns closely with the description of recovery as a process of growth involving hope and resiliency (Jacobson and Greenley 2001; Onken et al. 2007).

A common criticism of Maslow is that while self-actualization makes sense at the top of the hierarchy, and physiological needs such as food, water and air belong at the bottom, the nature and ordering of levels of need between the two is subjective or arbitrary (Wahba and Bridwell 1976). If there is a set of “primary goods” or needs necessary to achieve self-actualization, it is unclear whether and how to place them within a hierarchy (Nussbaum 2006; Rawls 1971). Another criticism of Maslow’s theory is that a linear process is at odds with mental health recovery which has been defined as recursive and iterative (Ridgway 2001). Interestingly, Maslow’s later work (1970) suggests that the pursuit of self-

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actualization may manifest from frustration over not having one's needs met rather than from their gratification. That is, facing adversity and failure can lead to self-actualization. Whether this signals an abandonment of a linear hierarchical model or merely an exception to it is not clear.

The goal of this mixed methods study is to examine the trajectories of new enrollees in homeless services for persons with SMI using Maslow's theory as a theoretical framework. Specific research questions to be answered using quantitative analysis include: (1) Given limited material resources, do enrollees of HF and TF programs focus exclusively on deficiency needs at baseline and/or 12-months?; (2) Does meeting deficiency needs at baseline make it more likely to identify being needs at 12-months?; and (3) Are there differences between HF and TF enrollees in meeting deficiency needs or identifying being needs?

Research questions to be answered using qualitative analysis include: (1) Given low program retention documented within the literature, in what ways is the staircase of the TF approach problematic?; (2) What kind of hierarchy of needs, if any, emerges within a HF approach once someone has permanent housing?; and (3) In what ways do material resources, or lack thereof, affect the pursuit of higher order needs in either group?

Answering these questions will help to introduce a recovery framework for those who access formal services because of a clear material deprivation (i.e. homelessness) and who continue to live with limited resources even after receiving services.

Methods

Sampling and Recruitment

This study used data from in-depth qualitative interviews with 63 participants of the New York Services Study (NYSS) conducted between 2004 and 2008 and funded by the National Institute for Mental Health. The sample consisted of serial admissions of new enrollees at four New York City programs (one HF and three TF programs). All of the programs in the study served homeless adults with SMI and all shared the same low-threshold process of intakes, the latter consisting of self-referrals as well as referrals from street outreach workers, shelters, jails or hospitals. Residences associated with the programs—whether congregate or scatter-site—were located in working class or poor neighborhoods in New York City. Eligibility for this study required individuals to have a DSM Axis-I diagnosis and a history of substance abuse, and staff at the programs invited every eligible client to participate in the study. DSM Axis-I diagnoses included schizophrenia, bipolar disorder, major depression and schizo-affective disorder. All but one gave informed consent and all participants were paid an incentive of $30 per interview and $10 each month for tracking and retention check-in calls. All protocols were approved by a University Institutional Review Board.

Data Collection Procedures

Three in-depth, semi-structured qualitative interviews were conducted with program enrollees at 0-, 6-, and 12-months starting approximately 1 month after program entry;

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monthly retention check-in calls were also made to update their status in the program. Of the 75 people who enrolled in the study and who were interviewed at multiple time points, 63 had complete baseline and follow-up data. Interviews were conducted at the study offices or the participant's residence by four graduate student interviewers who had previous research and clinical experience with dual diagnosed populations. All interviews began with a conversational update and then inquired about current needs, service experiences, social relationships, substance use and mental health status. Relevant to this study, participants were asked open-endedly to prioritize significant areas of need (i.e. "what are your most pressing needs?") and to discuss what areas of their life they intend to focus on (i.e. "what are your next steps?").

Data Analysis

We used a sequential design (QUAL > quant > QUAL) in which case summaries based on individual interviews across all three time-points were first developed to understand each participant's trajectory over the course of the year. Case summaries were formatted to: (a) document participants' perceived needs upon entry into the program and at 12-month follow-up; (b) capture whether and how participants were able to address these identified needs; and (c) describe how and why participants changed goals as indicated by their needs identification over time. Initially, 13 case summaries were composed and reviewed by two members of the research team. For purposes of further data reduction, parts of the qualitative data entered into the case summaries were transformed – or "quantitized"—into variables (Sandelowski 2001; Stake 1995). This included categorizing domains of deficiency needs at baseline and 12-months, documenting whether or not they were able to meet their baseline needs, and determining whether participants identified "being needs" at baseline or 12-months. The remaining 50 cases were then logged directly into the case summary matrix by one member of the research team, with both the qualitative case summaries and the quantitative variables verified by another team member.

Quantitative Analysis

Variables for different domains of deficiency needs at baseline and 12-months included: health, housing, employment, education, finances, social relationships, and other. A variable for whether or not participants met their baseline needs was determined through drawing upon the case summaries and using all available data. Determining whether or not participants identified a being need at baseline or 12-months was based on their making a clear statement related to pursuing a meaningful life that could not readily be attained by providing additional resources. Examples include participants who wanted to "have a balanced life…" or "become a productive citizen out here in this mainstream."

To compare both baseline versus 12-month data and HF versus TF, Chi square statistics were used for dichotomous variables (McNemar and Fisher's exact). Independent and paired-sample *t* tests were used to compare the average number of deficiency needs identified at baseline and 12-months and to examine differences between HF and TF. A bivariate correlation was used to examine the relationship between meeting baseline needs and identifying a being need at 12-months.

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Qualitative Analysis

In order to complement and expand on the quantitative findings (Palinkas et al. 2011), thematic analysis informed by sensitizing concepts (Charmaz 2006) derived from Maslow's theory was conducted based on the case summary matrix (Miles and Huberman 1994). Within- and between-case comparisons resulted in thematic findings that were independently developed by at least 2 of the first 3 authors before reviewing as a team and refined through consensus (Padgett 2008).

Results

Quantitative Findings

Table 1 displays the demographic characteristics of the TF (n = 39) and HF (n = 24) group. Over the course of the year TF participants were more likely to leave their program than HF participants (49 vs 13 %, p = .003).

Table 2 shows that on average the number of deficiency needs that participants identified did not change between baseline and 12-month follow-up. The most frequently cited deficiency needs at baseline were housing and health and at 12-months were housing and employment. Significantly fewer participants identified health needs at follow-up as compared to baseline. The average number of deficiency needs identified by HF and TF participants did not differ at baseline, but at 12-months significantly more TF participants identified the need for housing and employment as compared to HF participants. Significantly more HF than TF participants had their baseline needs met.

In addition to deficiency needs, 18 % of all participants identified as having a being need at baseline, with a significantly higher percentage (41 %) identifying being needs at 12-months. Categorizing being needs based on participants making a clear statement or expression related to pursuing a meaningful life, which could not be readily attained by providing additional resources, was usually straightforward. Occasionally, however, this task proved more difficult. One person who described his life as "going better" since program enrollment invoked "being free" as a goal but further explained, "I've been locked up before for ten years. I couldn't handle it…That's what I was. I wasn't free. I couldn't go anywhere. I couldn't do things that are…like general people do. I was locked up." Consensus among the research team was that this participant was referring to "being free" from involuntary commitment, and coded as a deficiency need. Another person who invoked "needing help with freedom" explained this in terms of needing help to "coordinate myself around people in public…[being] active in society," and was coded as identifying a being need. Once coding such examples through consensus occurred, it was found that having baseline deficiency needs met and identifying a being need at 12-months was moderately correlated, r(61) = − .276, p = .014.

Qualitative Findings

Although HF participants were more likely than TF participants to have met their baseline deficiency needs, a diverse set of inter-related factors contributed to a limited number of participants from either program able to meet their baseline needs during the course of the

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year. These factors included: leaving the program resulting in reduced support, needing to complete schooling before getting a job, bureaucratic delays in processing paperwork for housing or benefits, disruptive residential relocations, and needing in-patient care for acute medical or mental health conditions and/or relapse. Having permanent housing through HF, however, resulted in a fundamentally different trajectory than those who enrolled in TF, nearly half of whom left the program during the course of the year.

TF Trajectories: Waiting for Housing Security

Obtaining permanent housing remained an identified deficiency need for the majority of TF participants regardless of whether they remained enrolled in the program. For TF participants, substance use relapse also meant a set back in accessing housing. A 49-year old African-American man suffered an overdose 5 months into the program and remarked, "When you relapse, it sets you back… I got a roof over my head even though it's just temporarily at [the TF program]…that's still one of my achievements that I have to make, to get housing so I can get out of [the TF program]. Go on with my life." Some participants also expressed concern that transitional (TF) housing would not necessarily alleviate this problem:

> [Y]ou'll still be under them…If, God forbid, you relapse, they take the apartment from you and you have to start all over again. You have too many decompensations, they take the apartment from you, you have to start all over again. That's stress.

TF participants who endorsed employment as a deficiency need expressed concern that high program fees as depleted most of their public entitlements. One paid $1,072 each month to her program for rent and fees, leaving $160 from her Social Security Disability Insurance (SSDI) for other expenses. Also problematic were program expectations that she attend day treatment groups; the stipend job that she obtained through the program paid $2 an hour.

A focus on housing also remained a central concern for the majority of TF participants who left the program. Some reconsidered the idea of living with family or friends in a less than ideal situation after struggling in the TF program. For example, a 28-year old Latino man who reported feeling "trapped" sharing an apartment with other TF participants returned to live with his mother. Their volatile relationship, however, resulted in her filing a restraining order against him and his being admitted for in-patient psychiatric care; at follow-up he was on the streets living under a railroad trestle. The select few who were able to establish income benefits and secure housing after leaving the program also described ongoing housing insecurity, with one participant explaining, "I have a place to live on my own, but it's not affordable. I can't sleep when I open the mailbox saying, 'Final notice that this will be cut off.'" For those who left the program, the focus on employment as a deficiency need was largely regarded as a means to address a need for stable housing.

Despite few TF participants having met baseline deficiency needs during the course of the year, almost half identified a being need at 12-months. For some, ongoing struggles with homelessness, addiction, chronic disease, unemployment, and/or limited social support resulted in participants focusing on what it meant to become a better person, invoking their larger dreams to become a "productive member of society" such as one woman who hoped

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to regain custody of her children. For other TF participants it was the perceived limitations or critiques of the TF program that caused them to focus on their greater potential:

> I have enough experience in life, like I've been to jail. I've been to prison. I've been…you know what I'm saying. I've been on drugs. I've been in the street. I've been in college. I've been in the military. I've been through a lot. And I've studied philosophy and psychology and all of that. I know a little about some of everything, and I've been pretty much anywhere that anybody who needs help. So I can try and use some of my experiences, maybe help some other, some younger kids. So that's basically where I'm coming from. And can't do that being in a room at the program, you know what I'm saying.

Some participants invoked the importance of a higher meaning when reacting to the prescribed expectations of program staff, with one person explaining,

> I'm sick of being looked down upon like I'm being judged by them, 'Well, you're not here. You need to get there.' I'm like okay well fine, in my due time… I am where I am right now because that's where I need to be and where I go with this in the future is up to God or by how my higher power feels I need to go in the efforts that I put into it. Like this is what I want to do, God help me plan for this."

Another person who expressed growing tired of the program's monitoring and surveillance identified wanting to be more self-sufficient and competent, explaining that, "I'm a grown man, first of all, and nobody's gonna be there to hold my hand when I go into housing. And I actually don't want nobody to be there to hold my hand. I want to be able to do it on my own."

HF Trajectory: Figuring out Next Steps

Significantly fewer HF participants cited housing at a deficiency need at 12-months as compared to baseline (58 vs 33 %, $p < .05$). Most who identified housing described needing to fix problems in their apartment, wanting a condo, or hoping for a cuter apartment with better paint and furniture. Some, however, cited more basic concerns of safety. A 57-year old Caucasian man indicated that housing remained a need at 12-months explaining that, "I don't even feel safe when I'm locked in the apartment. Sometimes I imagine a bullet coming in the window straight at where I'm sleeping at. Last night I heard six shots." Having housing enabled many HF participants to focus on other deficiency needs identified at baseline or establish new ones. For example, a 39-year old African-American man attributed meeting his baseline goal to re-establish contact with his estranged daughter to having an apartment. At 12-month he discussed needing to improve the quality of this relationship.

Although a specific hierarchy of needs did not emerge, many HF participants described a step-wise strategy in approaching their needs. Some described needing to go back to school before getting a job, or needing to get a job before pursing social relationships. Limited resources, however, were often identified as impeding the possibility of meeting these needs:

> I know that the programs are there, but I just can't maintain going to a program because half…probably less weeks I'm broke. I can't even afford a mint. How am I

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> gonna go to school hungry? I can't even probably afford a book to buy to go to school. So why is there a reason to start if you can't finish.

Despite only being required to pay 30 % of whatever income they had, HF participants continued to live in poverty. As one person explained,

> I get 700 dollars a month. Rent…but it's not just rent. Rent is only 213, but I got electric bill, you know phone bill, then I got the cell phone…Mainly, my ConEd bill gets me and I have food. Food, I never…I'm always spending over. I always need to get my money. The food stamps never make it and now they're talking about cutting it.

Nevertheless, four HF participants indicated that they had been able to save some money for their future, with one person noting his dilemma that he had managed to save over $2,000, which was the maximum amount allowed for those receiving Supplemental Security Income (SSI).

When invoked, being needs were often embedded within a discussion about deficiency needs. As one person explained, "I would like a job where I would be able to take care of my daughter and my kids whenever they need me, be financially stable, and be active as far as having a job and be gainfully employed, and feel good about me, self-esteem wise." Identifying a goal of self-actualization, however, was less common then participants describing appreciation of their life now that they have an apartment, with one person describing contentment with "Seeing people going to work, getting on the trains, saying 'Good morning' to people I walk past, just being part of life." Yet limited resources continued to affect participants' ability to meet both their proximal and distal goals. A 41-year old Latino man explained:

> I would like to get either schooling or…a trade so I can get…do something with my life and be a better father to my kid, maybe. You know. Just normal, be normal. Be a normal person. Have my little apartment, maybe meet a girl, a nice girl. You know? One day…I mean, I can't…I won't even go out ask 'em. What am I gonna do? 'Oh yeah, come sit in my house and watch TV.' I haven't even been trying.

This did not prevent HF participants from discussing a desire to being more a part of society, with one persons explaining, "I get up and I walk along with the people of New York and if I see someone that needs help I help them."

Discussion

The conceptual overlap between mental health recovery and Maslow's notion of self-actualization is difficult to ignore and offers a strong theoretical, albeit intuitive, roadmap to consider how material deprivation, including homelessness, may affect one's recovery potential. Maslow's theory would suggest that more basic needs must first be addressed before undertaking a process of recovery or self-actualization (i.e. a "being need") that is recursive and iterative. Yet the findings from this study suggest a more complicated picture. For those enrolled in TF programs, for example, a focus on self-actualization seems to occur when more basic needs were not met, which supports Maslow's later hypothesis that being

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needs may emerge from the frustration, not fulfillment, of basic needs (Maslow 1970). For those enrolled in HF programs, permanent housing facilitated a step-wise approach to thinking through subsequent goals to improve one's life, but characterizing this as a hierarchy would be misleading.

Of course identifying being needs or a desire for self-actualization is different than achieving such goals. TF participants who focus on self-actualization as a way to escape their current reality may have a more difficult time planning for incremental but necessary steps towards change. On the other hand, aspirations about one's future even if identified through critiquing the shortcomings of social service programs may help sustain motivation and a commitment to change. Further, simply because participants did not identify a desire for self-actualization does not mean they are not striving for it, as may have been the case with many HF participants who focused on more readily attainable goals.

These findings highlight the importance of and difficulties with implementing person-centered care planning that has been identified as a fundamental component of a recovery-oriented system of care (Tondora et al. 2012). Questions about the purpose of care plans, the importance of goal setting, and consumer involvement in developing care plan goals continue to be discussed. Within the care planning process there is still limited understanding of how providers can foster hope, and whether this is a skill set that develops as part of recovery-oriented training (Fukui et al. 2011). Whether concrete, proximal, and readily attainable goals or more distal, abstract, and aspirational goals has a differential impact on a person's hopefulness remains unclear.

Limited resources even after engaging in services and accessing income benefits such as SSI or SSDI, however, continued to limit participants' ability to achieve their goals. For TF participants, program requirements and lack of affordability resulted in ongoing housing insecurity. Even with housing security (Padgett 2007), HF participants struggled to afford pursing potential next steps such as school or dating. Although the pursuit of self-actualization and recovery nevertheless persists, it is not clear whether a participant's claim to recovery in this context represents an authentic, self-determined outlook or diminished expectations resulting from cumulative adversity and lack of societal accommodation (Hopper 2007; Padgett et al. 2012)

Strengths and Limitations

There are a number of strengths of this study including its mixed-methods design in order to better capitalize on longitudinal qualitative data collection that compared two distinct program models. Although the quantitative analysis was limited by a small sample size, it served to sharpen the focus of the qualitative analysis. Strategies of rigor within qualitative methods were noteworthy and utilized both during data collection and analysis (Padgett 2008). The former including prolonged engagement and peer debriefing and the latter included the co-coding of qualitative data, independent thematic development, negative case analysis, team debriefing, and consensus-driven findings.

Important limitations of the study include: (1) participant perspectives were not triangulated with those of other people in their lives (e.g. family, friends, providers) and, (2) a one-year

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follow-up period represents a limited time frame to assess the relationship between providing resources (in the context of significant material deprivation) and the process of recovery. Future studies should consider the longer-term impact of how recovery trajectories might vary depending on when and how resources are allocated, vis-à-vis a HF or TF approach, and methods that are not based solely on participant report (e.g. use of ethnographic approaches or triangulation of perspectives within a participant's social network).

Conclusion

Maslow's theory has been included in nearly every psychology textbook for decades and counting (Kenrick et al. 2010). Although the theory has been applied to empirical research in a variety of fields, an investigation of what Maslow's theory has to offer research on mental health recovery or mental health services design has not been attempted. This study provided an unusual opportunity to do so and to compare individuals whose lack of a basic need for housing was addressed by two different approaches. Invoking Maslow understates the complex relationship between one's basic needs, goal setting, and the meaning of self-actualization. Transforming mental health care into a recovery-oriented system will require further consideration of person-centered care planning as well as the impact of limited resources especially for those who have experienced cumulative adversity and disadvantage.

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References

Charmaz, K. Constructing grounded theory: a practical guide through qualitative analysis. Los Angeles: Sage; 2006.

Clarke S, Oades LG, Crowe TP. Recovery in mental health: A movement towards well-being and meaning in contrast to an avoidance of symptoms. Psychiatric Rehabilitation Journal. 2012; 35:297–304. [PubMed: 22491369]

Collins SE, Malone DK, Clifasefi SL. Housing retention in single-site housing first for chronically homeless individuals with severe alcohol problems. American Journal of Public Health. 2013; 103(S2):S269–S274. [PubMed: 24148063]

Culhane D. The costs of homelessness: A perspective from the United States. European Journal of Homelessness. 2008; 2:97–114.

Dordick GA. Recovering from homelessness: Determining the "quality of sobriety" in a transitional housing program. Qualitative Sociology. 2002; 25(1):7–32.

Draine J, Salzer M, Culhane D, Hadley T. Poverty, social problems, and serious mental illness. Psychiatric Services. 2002a; 53:899. [PubMed: 12096181]

Draine J, Salzer MS, Culhane DP, Hadley TR. Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. Psychiatric Services. 2002b; 53:565–573. [PubMed: 11986504]

Freund KS, Lous J. The effect of preventive consultations on young adults with psychosocial problems: a randomized trial. Health Education Research. 2012; 27(5):927–945. [PubMed: 22473217]

Fukui S, Starnino VR, Susana M, Davidson LJ, Cook K, Rapp CA, et al. Effect of Wellness Recovery Action Plan (WRAP) participation on psychiatric symptoms, sense of hope, and recovery. Psychiatric Rehabilitation Journal. 2011; 34(3):214. [PubMed: 21208860]

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Gorman D. Maslow's hierarchy and social and emotional wellbeing. Aboriginal and Islander Health Worker Journal. 2010; 34:27–29.

Greenwood RM, Stefancic A, Tsemberis S. Pathways housing first for homeless persons with psychiatric disabilities: Program innovation, research, and advocacy. Journal of Social Issues. 2013; 69(4):645–663.

Henwood BF, Stanhope V, Padgett DK. The role of housing: a comparison of front-line provider views in housing first and traditional programs. Administration and Policy in Mental Health. 2011; 38:77–85. [PubMed: 20521164]

Hopper K. Rethinking social recovery in schizophrenia: what a capabilities approach might offer. Social Science and Medicine. 2007; 65(5):868–879. [PubMed: 17499900]

Hopper K. Commentary: the counter-reformation that failed? A commentary on the mixed legacy of supported housing. Psychiatric Services. 2012; 63(5):461–463. [PubMed: 22549534]

Hopper K, Jost J, Hay T, Welber S. Homelessness, severe mental illness, and the institutional circuit. Psychiatric Services. 1997; 48(5):659–665. [PubMed: 9144820]

Jacobson N, Greenley D. What is recovery? A conceptual model and explication. Psychiatric Services. 2001; 52:482–485. [PubMed: 11274493]

Kenrick DT, Griskevicius V, Neuberg SL, Schaller M. Renovating the pyramid of needs. Perspectives on Psychological Science. 2010; 5:292–314. [PubMed: 21874133]

Kertesz SG, Crouch K, Milby JB, Cusimano RE, Schumacher JE. Housing first for homeless persons with active addiction: are we overreaching? Milbank Quarterly. 2009; 87(2):495–534. [PubMed: 19523126]

Kiel JM. Reshaping Maslow's hierarchy of needs to reflect today's educational and managerial philosophies. Journal of Instructional Psychology. 1999; 26:167.

Maslow AH. A theory of human motivation. Psychological Review. 1943; 50:370–396.

Maslow, AH. Motivation and personality. 2. New York: Harper & Row; 1970.

Miles, MB.; Huberman, AM. Qualitative data analysis: An expanded sourcebook. Los Angeles: Sage; 1994.

Nelson G, Lord J, Ochocka J. Empowerment and mental health in community: Narratives of psychiatric consumer/survivors. Journal of Community & Applied Social Psychology. 2001; 11:125–142.

Nussbaum, MC. Frontiers of justice: disability, nationality, species membership. Cambridge: Harvard University Press; 2006.

Ochocka J, Nelson G, Janzen R. Moving forward: Negotiating self and external circumstances in recovery. Psychiatric Rehabilitation Journal. 2005; 28:315–322. [PubMed: 15895914]

Onken SJ, Craig CM, Ridgway P, Ralph RO, Cook JA. An analysis of the definitions and elements of recovery: a review of the literature. Psychiatric Rehabilitation Journal. 2007; 31:9–22. [PubMed: 17694711]

Padgett DK. There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. Social Science and Medicine. 2007; 64(9):1925–1936. [PubMed: 17355900]

Padgett, DK. Qualitative methods in social work research. Los Angeles: Sage; 2008.

Padgett DK, Smith B, Henwood BF, Tiderington E. Life course adversity in the lives of formerly homeless persons with serious mental illness: context and meaning. American Journal of Orthopsychiatry. 2012; 82:421–430. [PubMed: 22880980]

Palinkas LA, Horwitz SM, Chamberlain P, Hurlburt MS, Landsverk J. Mixed-methods designs in mental health services research: A review. Psychiatric Services. 2011; 62(3):255–263. [PubMed: 21363896]

Pearson C, Montgomery AE, Locke G. Housing stability among homeless individuals with serious mental illness participating in Housing First programs. Journal of Community Psychology. 2009; 37(3):404–417.

Rawls, J. A theory of justice. Cambridge: Harvard University Press; 1971.

Ridgway P. Restorying psychiatric disability: Learning from first person recovery narratives. Psychiatric Rehabilitation Journal. 2001; 24:335–343. [PubMed: 11406984]

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Roychowdhury A. Bridging the gap between risk and recovery: a human needs approach. The Psychiatrist. 2011; 35:68–73.

SAMHSA. SAMHSA announces a working definition of "recovery" from mental disorders and substance use disorders. 2011. Retrieved July 11, 2012, from http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

Sandelowski M. Real qualitative researchers do not count: The use of numbers in qualitative research. Research in Nursing & Health. 2001; 24:230–240. [PubMed: 11526621]

Stake, RE. The art of case study research. Thousand Oaks: Sage; 1995.

Stefancic A, Tsemberis S. Housing First for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. J Prim Prev. 2007; 28(3–4): 265–279. [PubMed: 17592778]

Tondora J, Miller R, Davidson L. The Top Ten Concerns about Person-Centered Care Planning in Mental Health Systems. International Journal of Person Centered Medicine. 2012; 2(3):410–420.

Trattner, WI. From poor law to welfare state: A history of social welfare in America. 6. New York: Free; 1998.

Tsemberis S, Eisenberg RF. Pathways to housing: Supported housing for street- dwelling homeless individuals with psychiatric disabilities. Psychiatric Services (Washington, D C). 2000; 51(4):487–493.

Tsemberis S, Gulcur L, Nakae M. Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health. 2004; 94:651–656. [PubMed: 15054020]

Viron M, Bello I, Freudenreich O, Shtasel D. Characteristics of homeless adults with serious mental illness served by a state mental health transitional shelter. Community Mental Health Journal. 2013:1–6.10.1007/s10597-013-9607-5

Wahba MA, Bridwell LG. Maslow reconsidered: A review of research on the need hierarchy theory. Organizational Behavior and Human Performance. 1976; 15:212–240.

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Table 1

Demographic characteristics ($N = 63$)

		HF	TF
		***N* = 24**	***N* = 39**
Mean age (SD)		43.04 years (10.30)	39.26 years (9.56)
Race/ethnicity	Caucasian	5 (21 %)	6 (15 %)
	African-American	7 (29 %)	23 (59 %)
	Hispanic-American	8 (33 %)	7 (18 %)
	Asian/PI	2 (8 %)	1 (3 %)
	Mixed	2 (8 %)	2 (5 %)
Gender	Male	15 (63 %)	26 (67 %)
	Female	9 (38 %)	13 (33 %)
Primary diagnosis	Schizophrenia	6 (26 %)	11 (28 %)
	Bipolar disorder	7 (29 %)	11 (28 %)
	Major depression	3 (13 %)	11 (28 %)
	Schizoaffective	6 (26 %)	4 (10 %)
	Other	2 (8 %)	2 (5 %)
SES background	Poor/low class	7 (29 %)	14 (36 %)
	Working/middle class	17 (71 %)	22 (56 %)
	Unknown	–	3 (8 %)
Highest year of education	No H.S. Diploma	13 (54 %)	22 (56 %)
	H.S. Diploma/equivalent	9 (38 %)	15 (38 %)
	College	2 (8 %)	2 (5 %)

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Table 2

'Quantitized' variables using Maslow's framework

Domain of need (deficiency)	Baseline			12-month		
	HF (n = 24)	TF (n = 39)	Total (n = 63)	HF (n = 24)	TF (n = 39)	Total (n = 63)
Health	12 (50 %)	23 (59 %)	35 (56 %)	7 (29 %)	14 (36 %)	21 (33 %)*
Housing	14 (58 %)	26 (67 %)	40 (64 %)	8 (33 %)	24 (62 %)*	32 (51 %)
Education	12 (51 %)	11 (28 %)	23 (37 %)	9 (38 %)	15 (39 %)	24 (38 %)
Employment	10 (42 %)	13 (33 %)	23 (37 %)	7 (29 %)	26 (67 %)*	33 (52 %)
Finances	6 (25 %)	12 (31 %)	18 (29 %)	6 (25 %)	15 (39 %)	21 (33 %)
Relationships	6 (25 %)	16 (41 %)	22 (35 %)	7 (29 %)	16 (41 %)	23 (37 %)
Other	8 (33 %)*	3 (8 %)	11 (18 %)	9 (38 %)	10 (26 %)	19 (30 %)
Average number of deficiency needs	2.9 (SD=1.3)	2.7 (SD=1.4)	2.8 (SD=1.4)	2.2 (SD=1.3)	3.1* (SD=1.5)	2.7 (SD=1.5)
Met baseline needs				7 (29 %)*	3 (8 %)	10 (16 %)
Being (self-actualization need	4 (17 %)	7 (18 %)	11 (18 %)	8 (33 %)	18 (46 %)	26 (41 %)*

* $p < .05$