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Family Therapy, Family Practice, and Child and Family Poverty: Historical Perspectives and Recent Developments

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ABSTRACT. This paper assesses the engagement of family therapy and family practice with families with children, who are living in poverty. It analyzes four promising models from two perspectives. The first perspective relates to critiques, which have been made of the practice of family therapy with families living in poverty; and the second relates to the implications of the theoretical and empirical literature on the impact of poverty on children. To place this discussion in context, the history of family therapy's involvement with families living in poverty is described and the relevance of the cause versus function debate is highlighted. doi:10.1300/J039v10n04_03 *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

KEYWORDS. Family therapy, family practice, child poverty

Throughout its history, the field of family therapy has had an ambivalent relationship with the issue of child and family poverty (Rivett & Street, 2003). On the one hand, at least one major school of family therapy was developed for families living in impoverished urban neighborhoods

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(Minuchin et al., 1967), and the significant effects of the social and economic environment on family functioning have long been acknowledged (Geismar & La Sorte, 1964). On the other hand, the main focus of intervention has generally been on intra-familial issues, processes, and organization.

Over the last three decades there has been a virtual explosion of research documenting the effects of poverty upon the experiences of families and developmental outcomes for their children (Ripke & Huston, 2006; Gershoff, Aber, & Raver, 2005; Duncan & Brooks-Gunn, 1997; Mayer, 1997). Despite these findings, only recently have approaches been developed that simultaneously target change in families living in poverty, in how they interact with various aspects of an impoverished and impoverishing environment, and sometimes, in ameliorating the sources of these negative environmental impacts.

FAMILY THERAPY AND FAMILY SOCIAL WORK PRACTICE

Almost since the inception of family therapy, social work has embraced family therapy per se as well as family therapy-informed practice models, and indeed social workers were well represented among the pioneers of family therapy (Nichols & Schwartz, 2007). Family therapy has long been an important component of family social work and social work education (Collins, Jordan, & Coleman, 2007; Hartman & Laird, 1983). The ambivalent relationship between family therapy and poverty can be seen to intersect with the historic debate about whether the profession of social work can combine both cause and function. In a classical statement, Lee (1930), a leading social work educator, argued that service, or what he called the function of social work, could not coexist with social reform, or what he called a cause orientation. Lee felt that cause naturally transformed into function once the former helped to secure the material and moral resources required to create a direct service response. He acknowledged no possibility of social work involvement in further structural change, and certainly did not recognize the possibility of a service response inclusive of social change activities.

After many years of debate, Schwartz (1969) argued that Lee's dichotomy between cause and function was false because "a private trouble is only a specific example of a public issue" (p. 25). Therefore, he reasoned that there could be no option as to whether to serve individual needs or deal with social problems. Schwartz favored the combination

of these two activities, arguing that a division of professional labor between them was inappropriate.

From a somewhat different perspective, Specht and Courtney (1994) argued that many social workers had become "unfaithful angels" as "the popular psychotherapies have diverted social work from its original mission and vision of the perfectability of society" (p. 27). Although they favored the group as the medium of choice in social work practice, Specht and Courtney regarded family therapy theorists as "at the forefront of efforts to place individual human behavior in an individual and social context" (p. 46). However, they saw family therapy as limited in that it identified the family as the main source of individual psychopathology.

This paper examines the interface between family therapy and child and family poverty, with special emphasis on the tension between psychological adjustments to poverty through largely intra-family change versus a simultaneous focus on helping families living in poverty to change the environments in which they live. It begins by describing the impact of poverty on children and how the family has been implicated in transmitting this impact, as a lens through which to view the appropriateness of how family therapy has been adapted for families with children living in poverty. It then goes on to briefly describe the history of family therapy's engagement with child and family poverty. Finally, four recent specialized approaches to working with families living in poverty are described and analyzed.

POVERTY: ITS DEFINITION AND MEASUREMENT

Despite the significant body of research on child and family poverty, its definition continues to be contested. In general, poverty refers to a particular standard of living located toward the bottom of a multidimensional socioeconomic status hierarchy. This construct suggests that income, educational level, occupational type, and residential location influence a family's social position, and through this, its life experience (Oakes & Rossi, 2003; Miller & Salkind, 2002). However, poverty is almost always constructed and measured only in terms of income (the flow of resources into a family), with little consideration for variations in financial demands (e.g., debt servicing) or available assets (the stock of resources accumulated by a family; Glennerster, 2002; Ross et al., 2000).

There is a great deal of controversy about how and exactly where to establish the level of income, which indicates a poverty standard of living, the poverty line (Mendelson, 2005). Often a distinction is made between absolute (Sen, 1983) and relative measures (Townsend, 1985). Absolute measures focus on the goal of physical subsistence, generally based upon expert norms, and without reference to social and cultural needs (Gordon, 2000; Gordon & Spicker, 1999). Relative measures focus on the goals of social role performance, participation in socially sanctioned relationships and activities and adherence to culturally sanctioned behavioral norms (Townsend, 1993). Both absolute and relative poverty can be measured subjectively, based upon public perception, allowing for societal rather than expert definition of poverty status (Gordon, 2000). Similarly, a deprivation index can be developed based on socially perceived necessities determined from either an absolute or relative approach, and average income levels of households lacking these necessities can be determined (Mack & Lansley, 1985). In more objective terms, absolute poverty is often operationalized by costing the purchase of an essential basket of goods and services for physical subsistence in a relevant market (Ross et al., 2000). Relative poverty is operationalized either as a percentage of median income or as a higher than average proportion of expenditure on basic necessities (Mendelson, 2005; Bradshaw, 2000). Clearly, there is significant controversy and complexity related to the concept and measurement of poverty. Yet, this does not obviate the fact that living in poverty involves serious consequences for the development and well-being of children.

THE IMPACT OF POVERTY ON CHILDREN

The family experience of poverty can vary along a number of dimensions. These include the duration and episodic pattern of poverty, the depth of poverty, the source of income (government transfer payments, work or the combination of the two), the age of children during periods of poverty, the presence of downward mobility, and the density of the concentrations of households in poverty surrounding the family residence. Nevertheless, all children in families living in poverty experience an elevated risk for deleterious physical, emotional, cognitive, social, educational, and other developmental outcomes (Brooks-Gunn & Duncan, 1997). In fact, Maluccio et al. (2002), based on a review of relevant research, argue that poverty is the greatest of all threats to the well-being of families and their members. Similarly, Waldegrave (2005) states that the

accumulated research over the last two decades consistently shows a strong relationship between poverty and physical and mental ill health.

These deleterious effects of poverty on children flow from several sources. One important source is discrimination and stigmatization of those living in poverty, which is pervasive throughout most of the social structure (Gans, 1995). Another relates to risk and protective factors in community and neighborhood formal institutions and informal groups. For example, proximate social support has been found to be an important protective factor and the amount of economic inequality an important risk factor (Brooks-Gunn et al., 1997).

Families, in themselves, play a significant role in the expression of much of the impact of poverty on children and several theoretical approaches have been used to explain this role. In this context, family stress theory has been applied to suggest how a family can mediate societal, community, neighborhood, institutional, and informal group stressors through the way family members appraise them and apply internal and external coping resources (Boss, 2002). Beyond this, the family has been seen as the origin of some of the effects of poverty on its members, especially by those who see the family as presenting risk and limitations. For example, family investment theory is a version of human capital theory, which explains the effect of families living in poverty on their children as a function of a combination of inferior genetic endowment and a lower capacity than upper income families to invest in their children (Becker & Tomes, 1986; Becker, 1981). Role model theory, based on a culture of poverty approach, suggests that many parents living in poverty socialize children into values and sanctioned behaviors that are inconsistent with well-being because of their immersion in a cultural adaptation to living in poverty (Mayer, 1997; Deglau, 1985). Mayer (1997) has also hypothesized that parental factors, at least partially explain both an increased risk of unemployment, which leads to family poverty, and limitations in parenting, which contribute to poor developmental outcomes.

From an empirical point of view, the effects of poverty upon children are transmitted through material, psychosocial, and behavioral pathways. One important materialist path flows through poor nutrition, home environments with limited opportunities for stimulation, deleterious pregnancy outcomes, and poor health related to disease agents in the physical environments to which poor children are exposed (Aber et al.,1997). Behavioral paths are exhibited by the high rates of smoking in response to poverty environmental factors among adolescents living in poverty and among single mothers, who are over-represented among the poor (Jarvis &

Wardle, 2006; Flint & Novotny, 1997). Psychosocial paths, which may be more malleable to family intervention, result from the broad effects of income poverty on the multiple ecologies effecting children in families living in poverty. These include the interaction between parents and other adults, which can improve parenting through social support (Jack, 2000), interactions between parents and children, and management of the risk and protective factors presented by neighborhoods. For example, Gutman et al. (2005) have demonstrated that income poverty predisposes parents to financial strain and perception of a stressful neighborhood environment characterized by disorder and neglect, which can lead to increased parental psychological distress (anxiety, depression, anger), increased negative parenting behavior, decreased positive parenting behavior, and poor adolescent adjustment. Attree (2004) has reviewed qualitative research from the perspectives of children growing up in poverty, especially in relation to what they perceive as resources and protective factors. In all of the studies reviewed, functional family relationships were found to be a central resource for children both in meeting daily needs and in enhancing emotional security. The friendliness of neighbors was also important in children's perceptions of their own well-being, and parents may have a role in improving relationships between their children and neighbors.

Family therapy may not be able to directly effect structural factors. Yet, is clear from the empirical and theoretical literature that when family therapy engages with families with children living in poverty, it should take into account at least four factors in addition to the conventional focus on internal family relationships. The first is the material circumstances of the family because some of the effects of poverty on children flow through the materialist path. The second relates to a focus on enhancing the family's coping and stress management capacities in order to assist it to cope with the significant stress related to poverty without resorting to health damaging behaviors. The third factor involves the need to assist the family to develop and maintain good relationships with neighbors and community members who can provide useful social support both to parents and children. Finally, family therapists must focus on the mental health of parents and the resulting effects on their relationships with children.

Evidence from Canada

Ross and Roberts (1999) provide a comprehensive picture of the impact of poverty on the well-being of Canada's children and their families. Based on data from the National Longitudinal Survey of Children and

Youth (Human Resource Development Canada/Statistics Canada, 2006) and the National Population Health Survey (Statistics Canada, 1999) the authors examine the relationships between low income and multiple dimensions of child development and experience. The rationale for family therapy is clear as Canadian families with children living in poverty report higher rates of family dysfunction than higher income families. Also, an examination of some of the behavioral attributes of children living in poverty reveals a number of issues for which family therapy is typically indicated. Ross and Roberts (1999) found that low-income parents were much more likely to report that their children tended to instigate conflict among peers or family members than were parents at middle and high-income levels. When combined with the findings that parents living in poverty report increased rates of depression and chronic stress, this perception of their children may be indicative of a pathway linking poverty to negative relationships with children as described by Gutman and her colleagues (2004).

Families with poverty-level incomes clearly experience stress generated both from the environments in which they live and from the histories of their members. For example, in addition to the finding that these parents are more likely to experience chronic stress, Ross and Roberts (1999) found that they are more likely to have experienced childhood trauma. Thirty percent of children living in poverty have changed schools at least three times before the age of 11. Not surprisingly, frequent school changes put these children at risk for more academic problems and higher levels of behavioral difficulties. While frequent school changes may be precipitated by already stressful conditions such as unemployment, family dissolution, and poor housing, its sequella have the potential for adding new challenges, including involvement with interventions that may implicitly or explicitly deem children and parents as inadequate or problematic (Madsen, 2001; Molnar & Lindquist, 1989).

The importance of safe and supportive communities and neighborhoods for positive child development, provision of proximate social support to parents living in poverty and their children, and improving the quality of family life has been well established (Brisson & Usher, 2005; Garbarino et al., 2005; Farrell et al., 2004; Pinderhughes et al., 2001; Bowen et al., 2000; Chaskin, 1997; Furstenberg & Hughes, 1997). Canadian children living in poverty are more likely to be residing in neighborhoods where substance misuse, crime, vandalism, and social tensions exist than are their more affluent counterparts (Ross & Roberts, 1999). Children are at risk of becoming involved in these activities and are also vulnerable to becoming victims. As described above, the nega-

tive impact of problematic neighborhoods can sometimes be mediated through the availability of informal social supports. Data from parents in low-income neighborhoods, however, indicates that help from neighbors is less likely to be available than in higher-income neighborhoods (Ross & Roberts, 1999).

Ross and Roberts (1999) also found that children living in poverty were more likely to experience the mental health impacts of poverty. These include the display of behaviors that are typically associated with emotional disorders at rates that are higher than those reported for children living in more affluent families. Similar patterns were found for hyperactivity and delinquent behaviors. Overall, the behavioral picture of children living in poverty suggests the potential for difficulty in social relationships and learning environments. These children are much more likely to come to the attention of teachers, social workers, and other helping professionals, and their parents are likely to be directly or indirectly involved in a variety of attempts to make their behavior more manageable. Unfortunately, such interventions often imply that the problem resides within the child, within the parents, or within the family (Madsen, 2001).

FAMILY THERAPY: ITS HISTORY AND ENGAGEMENT WITH POVERTY

The dominant story of the development of family therapy portrays a mental health revolution that offered an alternative to what was considered to be the repressive and oppressive practices of mainstream mental health services, with the poor often experiencing the worst of these practices (Riessman, Cohen, & Pearl, 1964; Hollingshead & Redlich, 1958). It depicted systems theory as a scientifically based new way of viewing the world that would free mental health practitioners from focusing exclusively on individuals, their intra-psychic processes, and pathologies. The reasoning was that this new formulation would allow mental health professionals to devote more attention to families' social worlds, although there was little specific focus on economic circumstances (Nichols & Schwartz, 2007; Kaslow, 1980; Haley, 1962). Given this discourse, it is no surprise that many social workers and other professionals embraced family therapy as a more contextually coherent, human, and humane way of helping. Another less popular and less romantic view of the development of family therapy suggests that the shift to a focus on the family was a conservative reaction to a perception that

the nuclear family, and therefore, the foundation of modern Western society, was under siege (Totton, 2000; Brodkin, 1980). This ideological perspective may go some way toward explaining the relative lack of attention to families' economic circumstances.

Although somehow maintaining the cache of a radical, counter-culture approach, family therapy grew rapidly into the mainstream (Sprenkle et al., 1999). Different schools and associated training centers emerged and family therapy became central to the curricula of many academic programs in the helping professions, and especially in Canadian and American social work programs. Large conferences were held, where the leaders in the field demonstrated their approaches. Many of the new and emerging family therapists who attended these programs were, primarily white, middle-class, young, and liberal-minded (Rivett & Street, 2003). The notions of family health promoted by the field likely fit with their own experiences, and techniques for repairing unhealthy families based on middle-class norms were embraced. Fueled by this enthusiasm and with support from influential bodies such as the U.S. National Institutes for Mental Health, family therapy was applied to an ever-widening range of populations and problems.

Family therapy can, therefore, be understood as both a conformist and a radical force in the helping professions (Rivett & Street, 2003). While it challenged the individually oriented, intra-psychic and deficit-focused base of traditional psychotherapy, it also promoted a mainstream view of the family that was not consistent with the experiences of many of its consumers. This unitary view of the family, along with an adherence to systems theory, led to assessment activities that were designed to locate the dysfunction, generally within the boundaries of the nuclear family, so that reparative interventions aimed at family functioning could be applied (Walsh, 2003). Social, structural, and ecological factors were largely ignored. In a sense, this was the medical model, family style.

Given this co-mingling of conformist and radical elements, it is not surprising that critiques of family therapy emerged from within and outside of the field. Feminist writers, including family therapists, argued that family therapy preserved patriarchy. Its leaders were mostly males in positions of authority who promoted traditional sex roles and applied interventions that tended to be coercive or manipulative toward women (Luepnitz, 1988; Walters et al., 1988). Writers representing racial and ethnic minorities argued that family therapy did not recognize their historical, familial, or help-seeking realities (Hansen & Falicov, 1983; McGoldrick et al., 1982). Overall, models of family functioning were

based on white, middle-class families, there was little consideration of the impact of social marginalization, and interventions were often inconsistent with valued cultural practices. There is little doubt that the feminist and cultural critiques of family therapy have had an impact on the field through its literature, training programs, and accrediting bodies (Nichols & Schwartz, 2007; Goldenberg & Goldenberg, 2004). This has taken the form of the development of specific practice models, as well as the inclusion of gender sensitivity and cultural competency, in existing models. Of course, it is more difficult to determine the impact on actual practice.

Nevertheless, the elaboration of explicit approaches for working with families with children living in poverty has received comparatively little attention from family therapists (Brown, 2002; Ziemba, 2000; Epstein, 1991). Although there certainly has been some focus on clinical populations that are over-represented among the poor, the central focus of these models is not explicitly on poverty and its consequences. Minuchin and his group's groundbreaking *Families of the Slums* (1967) remained the only major work that explicitly addressed family therapy and families in poverty until the late 1990s. This book reflected the optimism of the times, specifically that family therapy could solve most problems (Johnson, 2001; Roy & Frankel, 1995). It focused primarily on the problematic executive functioning of families living in poverty in the inner cities of large metropolitan areas, and emphasized active techniques for restoring order. Essentially, the intent was to find ways to help families living in poverty to organize themselves to function like middle-class families. Other structural family therapists such as Aponte (1974) followed suit.

It would, therefore, be inaccurate to suggest that family therapy does not deal at all with families living in poverty. The point is that most approaches to family therapy fail to view poverty as a key etiological or contextual factor in the way difficulties are understood and interventions are applied. Moreover, the limited empirical evidence that exists suggests that family treatment involving families living in poverty has not been successful (Proctor et al., 1995). This has led to a number of critiques. For example, Epstein (1993) argued that despite a plethora of traditional and new models, family therapy has become disconnected from the lives of its clients and potential clients, especially those who are living in worsening social conditions. He suggested that family therapy, like most psychotherapies, was unconcerned with the relationships between therapy and larger political, economic, and cultural contexts.

Epstein (1993) drew a parallel between modernist, systemic family therapies and cultural deprivation theory in that both were based on the assumption that there is an individual and family developmental process that leads to normal or healthy functioning. Deviations are seen as a result of individual and/or family pathology. This kind of decontextualization blames those living in poverty for their own troubles and leads to interventions that address the socially disturbing behavior of the poor, rather than their social and economic conditions (Gans, 1995; Ryan, 1976). Epstein (1993) noted that even the post-modernist models relied on modernist authority and interventions, while using the language of post-modernism. Those living in poverty were seen to be in need of input from experts, with or without their consent, as they were considered to be unaware of what contributes to their own well-being.

Westbrooks (1995) made a similar critique from a somewhat different perspective. She noted that a shift had occurred in family therapy practice and research. This shift involved the articulation of the characteristics of well-functioning families, along with a clinical emphasis on identifying and accessing family strengths. However, she argued that these approaches to identifying the characteristics of well-functioning families focused almost exclusively on Caucasian, middle-class families, and assumed that all families required the same skills in order to be healthy. She reasoned that this implied a narrow, unitary definition of family health that did not attend to context, including the particular demands of an impoverished environment. Although families living in poverty have also been studied, Westbrooks (1995) contended that the focus in this research had been, and continues to be, on pathology. She argued that contemporary constructs of healthy family functioning excluded the possibility that a different set of normative characteristics are required for families living in poverty to function effectively.

For the purpose of exploring this contention, Westbrooks (1995) examined the compatibility of traditional constructs of healthy family functioning as set out by family process theory (Skinner et al., 1983) with those articulated by a sample of 50 parent and grandparent heads of families living in poverty. She interviewed participants about their families' priorities, strengths, and weaknesses; administered a scale asking respondents to rate the strengths and weaknesses of their families; and administered the Family Assessment Measure III (Skinner et al., 1983), which was developed directly from family process theory. The themes identified by families (respect, love, faith in God, education, working together, perseverance, and survival) were found to overlap with the family process theory themes related to internal family functioning.

Most discrepancies were apparent in domains related to families' interactions with their environments. A similar pattern of overlap and discrepancy was found in the comparison between Family Assessment Measure scores and respondent self-ratings.

Based on these findings, Westbrooks (1995) argued that traditional constructs of family functioning did not pay sufficient attention to the skills required for families living in poverty to successfully engage with their external environments, and did not consider how such dynamics affected the internal processes of family functioning. She maintained that interaction with external systems requires the family to interpret the impact of external dynamics and prepare for actions that preserve the integrity of the family. Weak external interaction skills, therefore, have the potential for resulting in problematic internal processes. Consequently, families living in poverty are at risk of being considered internally dysfunctional, when the focus should be on external conditions and the families' skills to deal with them. Ultimately, Westbrooks called for the development of a new paradigm that allows for a diversity of definitions of healthy family functioning and associated characteristics; thereby leading to a new understanding of the strengths, weaknesses, and functional requirements of families living in poverty.

Recently, Waldegrave (2005) claimed that the family therapy community has not served families living in poverty well. He also argued that therapists have a strong preference for viewing presenting problems in terms of individual or family dynamics. If family therapists recognize the relevance of social conditions, they most often view dealing with them as somebody else's job. When family therapists draw such boundaries around their work, they not only run the risk of treating social problems as family problems, but they also communicate a disempowering view to the families they serve. Even when therapists manage to alleviate, some of the symptoms of distress that people in families living in poverty experience, they are further oppressing these families by helping them adjust to poverty.

Waldegrave (2005) observed that helping institutions often apply negative labels to families. Over the years, those living in poverty have been labeled as resistant, multi-problem, disorganized, under-organized, multi-serviced, unmotivated, untrusting, and hostile. Negative labels, combined with the effects of social marginalization, can become demoralizing and self-fulfilling, thereby providing further evidence that those living in poverty are dysfunctional (Gans, 1995). It is not difficult to imagine, therefore, how families living in poverty and those who serve them sometimes form less than optimal relationships.

In an attempt to provoke the field into action, Waldegrave (2005) suggested that several issues be examined in light of the continuing failure to address poverty. He argued that the field should consider whether it was dominated by individuals, who subscribe to neo-conservative ideologies, or whether therapists are paid to be silent, or whether therapists are invested in making money from people's distress.

Collectively, these critiques set the stage for new approaches, which should have at least four characteristics. First, they would certainly not ignore the economic or social context in which poor families live, but would focus upon helping them to manage its deleterious impact, and, perhaps play a role in changing these environments. Passive adjustment to poverty would be eschewed, and the boundaries among therapy, community action, and social change would be blurred. Second, these new approaches would not impose unitary mainstream middle-class norms of family functioning, strengths or health, but would be based either on the post-modern view that each family is unique, or on a sound empirical understanding of the characteristics and circumstances of successful families living in poverty. Third, new approaches would focus on the strengths of poor families in responding to poverty and avoid pejorative labeling. Fourth, new approaches would reject the authority of an expert stance and would substitute an ideology of seeking to support family empowerment in the face of poverty and oppression through a collaborative relationship.

PROMISING MODELS

The recent literature contains four examples of family intervention models that explicitly address the issue of poverty. These models, representing modernist and post-modernist traditions, do not address all of the critiques already cited, but they are sufficiently innovative to warrant examination. They will first be described and then analyzed in terms of their coherence with the critiques and the literature on the role of the family in transmitting the negative effects of poverty.

Systems-Oriented Family-Centered Approach

Structural family therapists returned to the issue of poverty in the 1990s (Minuchin et al., 1998; Aponte, 1994) for the first time following

the publication of *Families of the Slums* in 1967. Although the main thrust continued to be toward helping families adjust to poverty, there were important new emphases on empowerment, family-agency interactions, and family-therapist interactions.

For example, Minuchin et al.'s (1998) more recent work acknowledged that services for those living in poverty have not been effective because they are fragmented and uncoordinated, focus on individuals and their pathologies, and ignore the potential resources that can been found in families and their networks. They also described the destructiveness of many conventional human services directed to families living in poverty, and even discussed the need for such families to make their boundaries less open to these interventions.

They articulate a model that focuses on families rather than individuals and which adopts a systems approach for understanding families, agencies, and service systems. Minuchin et al. (1998) observed that the involvement of multiple professional helpers in the lives of those living in poverty creates duplication and requires individuals to repeat their stories, thereby creating an atmosphere of resentment and dependency. They argued that a case brokerage system that connects each family member to resources according to their specific needs wrongly keeps the focus on individuals and excludes the family. They also recognized that access to such services is often governed by policies that are contradictory and disempowering.

Minuchin et al. (1998) identified the social service bureaucracy, inadequate professional training, and societal attitudes as key barriers to effective work with those living in poverty. The health and social services system is viewed as a collection of individually oriented services that are isolated from one another, rather than as parts of an interacting system. Funding formulae, eligibility criteria, and expectations placed on service providers serve to reinforce what already exists. Professional training emphasizes individual personalities, pathologies, and treatment, whereas regulation of professional practice encourages conformity, rather than creativity. Finally, moralistic social attitudes blame people living in poverty for their plight, and imply a narrow definition of who deserves to be helped. Even when families are not blamed for their poverty, they tend to be identified as the cause of their own difficulties.

Consequently, current services are often preoccupied with individual risk, while ignoring family affection and bonding. Interventions do not consider the impact on other family members, and professional assessments deprive families of the opportunity to tell their own stories. Minuchin et al. (1998) argued that families living in poverty have fluid

boundaries, making it relatively easy for professionals to intrude and assume considerable power. Although not denying that many of these families develop patterns of internal violence, they point to the violence done to families through intrusion, control, disrespect, dismemberment, and an adversarial system.

Despite a broader social and political analysis, the Systems-Oriented Family-Centered Approach restates much of what is contained in traditional Structural Family Therapy, but also adds important notions related to recognizing family strengths, empowerment, and the need for service agencies to change the way they operate. Families are continued to be viewed as social systems that constrain their members by rules, boundaries, and expectations that come to represent preferred, but changeable, patterns of behavior. Since individuals are simultaneously autonomous and connected to their families, the control over symptoms is often located in the interactions among family members. Families sometimes have difficulty changing their preferred patterns during periods of transition. Transitory periods of disorganization may result and families may require assistance to move on.

According to Minuchin et al. (1998), intervening professionals become part of the family system and can be helpful only if they conduct themselves in ways that emphasize the family's capacity for change. This is accomplished by exploring how family members define the problem and by introducing alternative definitions through questioning, re-framing, and a variety of other techniques. This model depicts the professional as the catalyst for change, helping family members to recognize dysfunctional patterns and explore new ways of relating. Families are empowered by emphasizing strengths, but conflicts must also be identified so that safe patterns of responding to stress are developed. In a departure from traditional Structural Family Therapy, Minuchin et al. (1998) call on therapists to "restrain their expertise" (p. 65) and encourage families to turn to each other and their networks as resources for change. The extended family is considered the primary resource, and links to other professional services should be considered carefully because of the potential for confusion.

Interestingly, Minuchin et al. (1998) suggested that working toward organizational change in the service system could be one of the most helpful interventions. Essentially, they are challenging therapists to use their skills to intervene in their own environments, while placing far less emphasis on changing family organization. In fact, they argued that changing the relationships between professionals and family members is more important than efforts to change legislation, social policy or

availability of funds because the daily activities of service providers are central to effectively working with families in poverty. Although this position expands the domain of therapy, it also places unnecessary boundaries between therapy, community action, and advocacy or activism.

Minuchin et al. (1998) argued that family-centered practice must be supported by an agency structure, with appropriate policies and procedures. They suggested that intake procedures should include the entire family and result in clients feeling that the staff are respectful, supportive, and concerned, while regarding clients as partners in creating change. Emphasis is placed on the importance of family involvement and information sharing. Once the family and therapist agree on a plan, it is up to the therapist to keep families engaged. Policies and procedures that support outreach, home visits, and flexibility are essential. Similarly, procedures for termination should be viewed as a transition that requires preparation, should introduce new services, when required, and should assure the family that it will have ongoing supportive access to the agency, at its request. According to the model, these practices and other procedures that support a Systems-Oriented Family-Centered Approach must be seen as agency policy, rather than practice preferences of individual workers.

Perhaps in recognition of the fact that they have presented a model that is essentially apolitical, Minuchin et al. (1998) offered an epilogue that highlights important issues. They observed that attitudes toward the poor continue to be blaming, racist, and sexist. The general population and politicians are critical of past efforts to eradicate poverty and pessimistic about proposed measures. They maintained that it is essential to reverse these trends, as a prerequisite to changing ineffective and destructive interventions. Sadly, they offered no suggestions for action.

Just Therapy

Just Therapy (Waldegrave et al., 2003) has its origins in the 1980s, when a group of culturally diverse practitioners at the Family Centre in Lower Hutt, New Zealand, began to explore ways of moving beyond the limitations of modernist thought in family therapy (Walderave, 2000). They observed that despite the fact that many of the families seeking service were experiencing stress and illness while living in contexts characterized by poverty, racism, and/or sexism, the Centre was treating them as if they were internally dysfunctional. Although therapy was somewhat successful in terms of symptom relief, families were returning to their problem-generating environments, and eventually developed similar symptoms.

Just Therapy has evolved into a unique approach that respects both local knowledge and conventional social science, while placing culture, gender, and, socioeconomic status at the center of all activities. Organizationally, the Agency is composed of three autonomous cultural sections (Maori, Pacific Island, & Pakau [white]). Steps are taken to make sure that the Pakau section does not dominate, by maintaining lines of accountability with the other cultural sections. There are also a series of caucuses that provide support, accountability, and oversee the work of the Centre. In recognition that not all cultures embrace hierarchical organizations, the Agency is jointly managed by three cultural coordinators (Tamasese & Waldegrave, 1993). The approach is informed by an understanding that therapy transcends individuals, couples, and families to involve communities, cultures, societies, and nations (Waldegrave, 2000). This is reflected by the fact that the staff is simultaneously involved in family therapy, community development, policy advocacy, and social policy research. For example, they have been involved in community housing projects, policy development on family violence, and research on poverty measurement.

Spirituality, justice, and simplicity are the underlying assumptions for Just Therapy. The emphasis on spirituality takes the form of focusing on the sacredness of life and the essential quality of relationships between people, and between people and their contexts, heritage, and sense of spirituality. Therapy is regarded as sacred and therapists are expected to honor clients' stories. The emphasis on justice focuses on equity and involves recognizing the forces that threaten it. The emphasis on simplicity demystifies therapy and therapists by recognizing that people with formal and informal credentials can engage in exchanges that can lead to new possibilities (Waldegrave, 1990).

The family therapy encapsulated by Just Therapy can be viewed as a constructivist approach that drew on the work of Bateson (1972); Friere (1970); Maturana and Varela (1987); and White and Epston (1990); along with feminist family therapists and local knowledge from a variety of groups. Culture, gender, and socioeconomic factors are central to this work, so therapists are selected according to the family's context. The clinical processes of Just Therapy are deceptively simple, but require considerable skill in respectful questioning that elicits the family's web of meaning, analysis of the problem-centered story, and designing messages that are meaningful and offer new possibilities for hope and action. In the first session, the therapist aims to elicit the story and the associated meanings that family members assign to it, while showing concern and respect. The story is analyzed to identify meaning patterns and the

dominant problem focus. Therapists then offer an alternative meaning, in the form of a message or comment, which is designed to open up alternative ways of understanding and action. It is assumed that the impact of a well-designed message will unfold as the family continues to live its life. This message is refined and adapted in subsequent sessions, as the family offers new information (Waldegrave, 1990).

Waldegrave (2000) suggests that Just Therapy is an expression of the interrelationships among belonging, sacredness, and liberation. The first refers to identity, ancestry, and cultured and gendered histories. The second refers to respect for people and the environment, and the third refers to freedom, wholeness, and justice. People living in poverty may present with a variety of mental health, emotional, behavioral, or relational symptoms. According to Just Therapy, these problems are not indicators of individual or family dysfunction. Instead, they are viewed as symptoms of poverty. The unproductive web of meaning is one that encourages feelings of failure and self-blame. While the clinical symptoms are addressed, Just Therapy also presents clients with a broader analysis that includes the role of economic and political structures. The language of strength and survival is introduced and community organizations are identified. According to Waldegrave (1990), Just Therapy integrates political concepts and clinical concepts by identifying problems as symptoms of injustice, thereby giving new meaning to problems that were formerly seen exclusively in terms of individual weakness. This enables individuals and families to view their situations differently, feel differently, and act differently; including the possibility of social action.

Waldegrave (2005) suggested an additional role for therapists, regardless of their orientation. He argued that human service professionals are in the unique position of being thermometers of pain, as they are regularly exposed to the experiences of those who live on the margins of society. According to Waldegrave (2005), these professionals have an ethical responsibility to publicize what they have witnessed, so that public debate can affect social policy.

Just Therapy is a comprehensive framework, based on principles of social justice that permeate throughout the Agency's organizational structure, community work, and social policy research. The team is well respected internationally and locally and has the ability to directly affect social policy in New Zealand, and indirectly throughout the world, and have created a model that they maintain can be adapted to a variety of contexts.

The Multilevel Social Systems Model

Vosler's (1996) Multilevel Social Systems Model grew out of the recognition that family systems approaches were seriously flawed because of their assumption that changes in the family would lead to the resolution of all problems. She observed that these approaches incorrectly assumed that the services and structures families needed were widely available, and that therapists simply had to mobilize families to take advantage of them. According to Vosler, this almost exclusive emphasis on internal family functioning requires revision to incorporate a view that considers families in the context of larger systems and conceptualizes change at multiple levels of the family's ecology.

The Multilevel Social Systems Model sees individuals as direct or indirect participants in a widening series of nested social systems. Individuals live in families that are situated in neighborhoods, which are embedded in localities, which are, in turn, embedded in larger social structures. It is recognized that the relationships between persons and social systems are reciprocal, although the traditional view has emphasized how social systems limit individual and family opportunities. The Multilevel Social Systems Model essentially extends family systems thinking to include larger social systems. It proposes that localities, and even societies, develop patterns, rules, and values that are fairly predictable. Accordingly, Vosler and Nair (1993) maintained that this perspective requires that poverty be assessed at individual, family, and larger system levels. This makes it possible to identify structural inadequacies and understand family functioning in context, through language and conceptualizations that are already familiar to family systems practitioners.

This perspective parallels Bronfenbrenner's (1979) ecological view of child development. He traced developmental influences flowing from various sources. These range from those directly involved with the child to those whose influence is indirect and flows through pathways of various lengths, culminating in transmission through those directly involved with the child.

The Multilevel Social Systems Model proposes seven levels for assessment and potential action: the person; the family; the neighborhood or community; the state or province; the nation; and the global socioeconomic system. The individual is first assessed in the context of her or his family, and then the limits and opportunities in the broader environment are assessed. Vosler and Nair (1993) depict this as a complex, but optimistic, perspective since social systems are created by people who can change themselves, or change their relationships with larger

social structures and ultimately, the structures themselves. Like many systems-based analyses, however, there is little consideration of differentials in power between those living in poverty and those who control the larger systems that affect their lives (Mullaly, 2002).

The case studies presented by Volser (1996) portray respectful, collaborative family systems work that focuses on problem-solving, identifying strengths, and connecting family members to community resources, all with the aim of keeping the family intact. This is based largely on a family stress theory, which identifies external economic stressors and external resources, as well as internal family capacities related to routines and household financial management. She acknowledges that interventions to meet family survival needs are necessary, but insufficient, and argues that practitioners must begin to recognize the larger systems realities. She suggests that practitioners begin to collaborate with one another and the families they serve to plan for multilevel long-term measures that assure access to needed resources.

Like Waldegrave (2005), Vosler (1996) argues that family practitioners can no longer restrict their roles to micro-level practice. She suggests that, minimally, they can expand their roles as professionals and citizens to include involvement in their agencies, professional associations, neighborhoods and local communities. Practitioners can take measures to educate themselves and the public about the causes and consequences of poverty. They can ensure that their agencies' policies and procedures are consistent with that understanding, and can influence their professional organizations to highlight the issue of poverty. They might also involve themselves in a variety of roles related to developing or nurturing community-based family support programs. Practitioners can also participate in knowledge building by engaging in or supporting research such as needs assessments, program evaluations, and pilot projects. Vosler (1996) argues that changes to the social structure have already begun, as a result of the growth of the global economy. The Multilevel Social Systems Model challenges practitioners and the public to collaborate in an effort to influence what is already happening at all levels so that social systems can support families and, therefore, benefit all.

Community Family Therapy

Community Family Therapy was developed specifically for urban families living in poverty (Rojano, 2004; Markowitz, 1997). Based on an interesting blend of family therapy techniques, motivational theory,

community mental health models, developmental theory, and economic development and community mobilization strategies, Community Family Therapy seems to blend notions of traditional helping with ideas from constructivism, human capital theory and personal responsibility perspectives into an integrated model.

According to Rojano (2004), the initial development of the model drew on Erickson (1950) to emphasize the need for individuals to grow into mature, productive adults and to understand that many adults living in poverty have yet to attain that level of development. From Sullivan (1953) came the focus on clients' interpersonal realities and the development of inner power through social interaction, and from Lewin (1948) came the person-in-environment view and the recognition that social fields can trap individuals into playing certain roles. These concepts were combined with practice experimentation based on elements of Structural (Minuchin, 1974) and Strategic (Haley, 1976) family therapies, along with a focus on social support and social networks (Sluski, 1996; Imber-Black, 1988) and McGoldrick's (1998) work on culture and gender. Rojano (2004) reported that Community Family Therapy was consolidated beginning in 1993 into a comprehensive model that included interventions outside of conventional mental health services.

Community Family Therapy is based on the premise that traditional professional roles and boundaries are counterproductive (Psychotherapy Networker, 2004). It assumes that difficulties experienced by people living in poverty are intertwined with social issues and that, partnerships between families living in poverty and community agencies can lead to upward mobility for the families and can also affect social issues. Clients must be motivated and should assume personal responsibility. It is theorized that problems are also related to personal and family underdevelopment and that people experience difficulties because of a lack of internal and external resources. There is an emphasis on leadership development and community engagement for both clients and therapists (Rojano, 2004).

The Model aims to free people from poverty, improve connections with needed resources, promote self-sufficiency through individualized skill development plans, and promote altruism. The intervention includes an assessment which seeks to quantify problems and strengths through a series of instruments that provide practical organization and classification according to three treatment goals: development of a narrative that leads to action and self-development; development of an effective community support network; and leadership development. The therapeutic plan is based on the client and therapist agreeing on initial

scores and contracting to increase them. The intervention simultaneously focuses on three levels, which can typically be addressed in 12 to 25 sessions over 1-2 years, with half of the sessions occurring within the first 3 months (Rojano, 2004).

The first level of engagement is heavily influenced by constructivist and narrative therapies, and is aimed at helping clients to improve their overall mental health status. Various techniques are used to support clients, working as individuals, couples, or families, to re-author their stories of hopelessness into future-oriented narratives of optimism. Ideally, clients become empowered as they begin to work on a personal and occupational development plan that flows from their narrative and, ultimately, results in labor force attachment or increased participation. The second level of engagement focuses on resources to meet family material and developmental needs. Case management, outreach, and networking strategies are employed to mobilize community resources, personal networks, and an individualized service providers network, all of which are aimed at supporting the client's plan. The third level of engagement requires clients and therapists to become involved in community change that will contribute to the establishment of a better surrounding environment. Preparation includes leadership training, advocacy, and networking. As a result, clients become active, feel empowered, and increase their connections to their community, while therapists are able to learn more about the neighborhoods that surround their work (Rojano, 2004).

Rojano (2004) regards Community Family Therapists as facilitators and coaches, who are also expected to become involved in community social action. He maintains that therapists must be motivated to work with families, regard clients as equals, know about community resources, have personal connections with community service providers, and possess a basic level of cultural competence.

DISCUSSION

There is no doubt that significantly reducing the rate and depth of poverty requires large-scale social change. At the same time, it is important to recognize that families living in poverty are suffering and require assistance with their day-to-day struggles for material, psychological, and emotional survival. Conventional models of family therapy and family practice have not served people living in poverty well. These models have tended toward a unilateral focus on internal family dynamics, thereby implying that individual and family dysfunction are the

primary causes of distress. Family intervention may alleviate situational difficulties for a time, but it also contributes to those living in poverty becoming adjusted to their situations. This, in turn, can lead to victim blaming, demoralization on the part of families living in poverty, and a perception that human service professions are unconcerned about structural injustice.

For many years, most human service professions have essentially abandoned the poor by adopting an almost exclusive emphasis on positivist psychological theory (Specht & Courtney, 1994). This is beginning to shift as some human service educational programs start to adopt models such as Anti-Oppressive Practice (Mullaly, 2002), Just Practice (Finn & Jacobson, 2003), Strengths-Based Practice (Saleebey, 1997), and Empowerment Practice (Wise, 2005). Programs that educate social practitioners have an obligation to equip their students with the tools for understanding the ideologies and mechanisms that create and maintain the conditions experienced by their future clients. These programs also have an obligation to recruit and support students from marginalized groups.

Models for direct family practice have traditionally been based on social science theory and professional practice wisdom, while ignoring local and indigenous knowledge. For the most part, they have been presented as class, culture, and ideologically neutral. The fact that poverty and its social and emotional impact have been under emphasized is understandable, to some extent. Practitioners may be comfortable with "repairing" a dysfunctional family, but have little guidance about how to deal with that family's poverty. Consequently, family therapy and family practice are at risk of becoming irrelevant to a large portion of the population that human service professionals serve.

The models presented in this paper might be usefully compared and contrasted from at least two perspectives. The first relates to their congruence with some of the key findings from the social science literature on poverty, as already described , and the second involves whether and how they address the critiques which have been raised about the engagement of family therapy with families living in poverty. With regard to the former, Table 1 displays an analysis of whether and how each model considers four important aspects of family life under impoverished conditions: (1) the presence of high levels of environmentally generated stress; (2) the importance of supportive relationships with neighbors and other community members; (3) the significance of material resources; and (4) the causal path from parental psychological distress to negative

TABLE 1. Congruence of Promising Models with Selected Findings from the Social Science Literature on Poverty

	Systems-Oriented Family-Centered Approach	**Just Therapy**	**Multilevel Systems Therapy**	**Community Family Therapy**
Intervention includes focus on stress management and coping	*Indirect*: Acknowledges impact of environment, but is not focused on managing particular stressors. Main focus is on improving family organization to meet demands from internal and external environments.	*Indirect*: Acknowledges effects of stress of poverty, but is not focused on managing particular stressors. Main focus is on transformation of meaning from personal pathology to symptoms of poverty.	*Direct*: Focus on assessing environmental and intra-familial stressors and developing internal and external coping resources.	*Direct*: Focus on developing networks to ameliorate social stressors.
Intervention includes focus on relationships with neighbors and community members	*None*: Focus is on internal organization of the family and relationships with formal helpers.	*None*: Unless issues with neighbors or position in community are central to the family's narrative	*Indirect*: Considered in third level of assessment. Would be addressed if neighbor or community relations are identified as stressors.	*Direct*: Focus is on building social networks, civic engagement, and development of leadership capacity.
Intervention includes focus on material resources	*None*	*Indirect*: Not at level of individual families; Focus on community development, research and policy advocacy related to material resources.	*Direct*: Assesses family financial status and helps families to secure benefits; focus on general policy advocacy and research related to material resources.	*Direct*: In the short-term is a task in second level of engagement. In the long-term upward class mobility is the focus.
Intervention includes focus on parental psychological distress and negative relationships with children	*Indirect:* Focus on parental relationships with children in terms of executive functioning	*None*: Unless parental affect or parental relationships with children is central to the family's narrative	*Indirect*: Individual, including parent, is a focus of assessment; Intervention if parental affect or parent-child issues are defined as stressors.	*Direct with regard to parental psychological distress*: Component of assessment and first level of intervention. *None:* With regard to relationships with children.

relationships with children and eventually to poor child developmental outcomes.

Looking through this poverty lens, it should be noted that none of the models completely addresses all four of these dimensions, but Community Family Therapy comes the closest. It adopts a strategy for stress management through helping families to create and maintain supportive social networks. This intersects with improving relationships with neighbors and other community members. In addition, families are supported to engage in civil society, partially through leadership training. In the short-term, there is a focus on connecting families with public and voluntary sector financial and material assistance, and in the long-term the emphasis is upon upward mobility through education and employment. The elevated risk of psychological distress among parents in poor families is acknowledged through inclusion of screening for symptoms of distress in the assessment protocol and providing a therapeutic response, if required. Perhaps ironically, Community Family Therapy does not explicitly focus on parental relationships with children, which is a hallmark of conventional family therapy.

The conceptual basis of the Multilevel Social Systems Model is the family stress paradigm. Therefore, it focuses directly on helping families to cope with the stress often associated with living in an impoverished environment. The inadequacy of material resources is understood as a key stressor for these families. Intervention is aimed both at helping families to secure benefits and at structural change through policy advocacy and research. Neighbor and community relations, parental psychological distress, and parent-child relationships are addressed if they are assessed to be sources of stress.

Even though the Systems-Oriented, Family-Centered Approach is an extension of Structural Family Therapy, an approach originally developed to work with inner-city families living in poverty, it seems to take little explicit account of many of the dimensions of poverty found to be most salient in their effects on families. The focus is largely upon improving both the capacity of families to respond to environmental and internal demands, and decreasing the intrusiveness of formal helpers through organizational change and systemic coordination. Therefore, identifying and modifying environmental stressors are not emphasized, and coping and stress management are not identified as central intervention strategies. The executive functioning of parents in the family's internal structure is a central concern of the Systems-Oriented Family-Centered Approach, but interruption of the causal pathway flowing from parental psychological distress to poor developmental outcomes through negative

parent-child relationships is not stated as a therapeutic goal. Similarly, improving relationships with neighbors and community members, and helping families to improve the adequacy of material resources are not emphasized.

Just Therapy differs from the other models by the centrality of a post-modern perspective in how it is conceptualized. Post-modernism is notoriously difficult to define and its meaning is contested (Best & Kellner, 1991). Nevertheless, some aspects of the post-modern approach to knowledge, which informed the development of Just Therapy, are relevant to this analysis. Post-modernism does not privilege scientific knowledge over family, community or cultural knowledge and, indeed, is critical of the role of science in allocating power to helping professionals (Dewees, 2004). Post-modernism views all knowledge as socially constructed rather than defining professional knowledge as a separate class based upon immutable truth. In fact, in post-modern thought truth is de-centered and localized so that many truths are possible, depending on the context (Ungar, 2004; Chambon & Irving, 1994). Therefore, Just Therapy is philosophically more oriented to familial, cultural, and indigenous knowledge than to generalizations from social science research. That is why its therapeutic approach is ideographic, with each episode of therapy being co-constructed with the family, and based upon the family narrative. For this reason, there is less space available for attention to scientifically derived standardized general knowledge about the dimensions of poverty that affect families. Nevertheless, Just Therapy acknowledges the stressful nature of poverty, and seeks to re-define its impact as symptoms of poverty, rather than as personal pathology. Furthermore, Just Therapy combines family intervention with policy advocacy, community development, and research related to equalizing the distribution of material resources.

Another view of Table 1 suggests that none of the models focuses comprehensively on the causal chain which begins with stress related to financial strain and deleterious neighborhood characteristics, and results in parental psychological distress, negative relationships with children, and finally, poor developmental outcomes and maladjustment. This causal chain has been broadly supported in research on the effects of poverty on children over the last several decades. Presumably, family therapy approaches tailored to poor families with children should, by design, target at least the last two links in the causal chain. Yet, this is not the case with the models reviewed.

The models reviewed in this paper have, in some sense, been developed partially in response to the perceived limitations of conventional

family therapy and family practice for intervention with families living in poverty. Table 2 displays an analysis of the adequacy of this response. The most basic poverty-related critique of conventional family therapy is that it does not acknowledge the role of structural and economic factors in the etiology of family problems. All of the promising models respond to this critique, but integrate these factors into assessment and intervention to different degrees. Just Therapy and the Multilevel Systems Model implicate structural and economic factors as primary causes of the problems of families living in poverty. Community Family Therapy assigns these factors a more limited role in that they are seen as powerful contributing elements, but in combination with individual and family characteristics. The Systems-Oriented Family-Centered Approach acknowledges structural and economic factors in the most limited way, and does not articulate a specific etiological model, which centrally incorporates them.

A second critique of conventional family therapy is that, even if structural and economic factors are acknowledged, the therapeutic emphasis remains on intra-familial factors. Again, all of the promising models respond to this critique, but in different ways. The response of the Systems-Oriented, Family-Centered Approach is most limited. The primary emphasis remains on internal family organization, but there is also attention paid to changing the fragmented and invasive interaction of multiple service systems with families living in poverty. In Just Therapy, the main therapeutic interaction is with the family, but incorporating an outward-looking focus on structural, economic, and political factors. In addition, therapists are involved in community development, action research, and policy advocacy related to poverty reduction, but families involved in therapy are not necessarily integrated into these activities. The Multilevel Social Systems Model involves seven systemic levels as targets of intervention and explicitly rejects an exclusive emphasis on intra-familial intervention. Community Family Therapy includes interventions with individuals, families, the families' formal and informal networks, and in the families' engagement in political and civil society processes.

A related critique is that conventional family therapy does not focus on helping families to manage the poverty environment. The Systems-Oriented Family-Centered Approach focuses on the external service environment of poor families through recommending system re-design to decrease the fragmentation and intrusiveness of services, and through encouraging families to rely on nuclear and extended family members for help as a means of limiting professional intrusion. Just Therapy has a

TABLE 2. Response of Promising Models to Critiques of Family Therapy and Family Practice

	Systems-Oriented Family-Centered Approach	Just Therapy	Multilevel Systems Therapy	Community Family Therapy
Family therapy does not acknowledge the role of structural and economic factors	General acknowledgment, but main focus is on internal family organization and interaction with service systems.	Structural and economic factors are seen as main etiological elements.	Structural and economic factors are seen as the major source of family stressors.	Low income and social marginality increase vulnerability to negative health, mental health, and developmental outcomes.
Family therapy emphasizes intra-familial factors to the near exclusion of structural and economic factors	Primary emphasis is on internal family organization and interaction with the service system.	Utilizes a contextual and political approach which considers family factors in relation to larger systems which are relevant to the family's narrative, and considers intervention at multiple levels.	Explicitly rejects assumption that problems will yield to intra-familial change and applies systems-based intervention at seven levels, including global socio-economic systems.	Multi-focused. Includes civic engagement and development of peer and service networks as well as individual and family issues.
Family therapy does not focus on helping families to manage the poverty environment	Focuses on helping families to maintain boundaries in the face of multiple and uncoordinated interventions from various systems.	Uses consciousness raising and external attribution of responsibility for problems to help families re-author their futures.	Focuses on management of external stress through problem-solving and resource assembly.	Focuses on environmental management through resource linkage, civic engagement, and informal support in the short-term. In the long-term the focus is on skill development, upward mobility and exiting the poverty environment.
Family therapy does not focus on the family role in social change	No focus on family role in social change.	No explicit involvement of families in community development or policy advocacy, but consciousness raising and externalization provide a rationale for families to be concerned about social change.	General call for therapists and families to work together on social change.	Accepts current social structure as given, and focuses on enhancing capacities of families for civic engagement and social action as a means of achieving upward social mobility.

	Systems-Oriented Family-Centered Approach	Just Therapy	Multilevel Systems Therapy	Community Family Therapy
Family therapy assumes middle class norms of family health and development	Assumes mainstream normative standard of family organization and distribution of power.	Supports each family to construct its own definition of health and optimal development.	Assumes mainstream normative family routines and approaches to problem resolution and stress management.	Explicitly adopts Eriksonian view of development and goal of helping families to move to middle class status.
Family therapy focuses on deficits	Eschews allocation of individual deficits, but focuses on family deficits in the form of dysfunctional organization.	Explicitly rejects deficit focus through avoiding labels, externalizing the causes of problems and defining problems as sacred stories to be re-authored.	Focuses on empowering families to correct failures in their management of stress. Also acknowledges failures in problem-solving by larger systems.	Identifies individual and family deficits, but defines them in terms of opportunities for development.
Family therapists disempower families by acting as experts	Partially collaborative approach based on therapist expert assessment and intervention applied to activation of family capacities. The integrity of family boundaries is also respected.	The family is seen as the main source of expertise, with therapist's skill focused on eliciting the narrative and offering alternative meanings.	Partially collaborative, based on therapist expertise in locating stressors and helping families to improve their stress management capacities.	Role of therapist is to use her or his expertise to enhance jointly identified developmental opportunities.

more comprehensive approach aimed at changing families' psychological responses to the privations of poverty through externalizing responsibility for the families' problems and raising family members' consciousness of the impact of factors related to poverty. The Multilevel Social Systems Model intervenes in the skill domain of improving families' capacities to manage poverty-related stressors and through helping them to assemble material resources to ameliorate financial stress. Community Family Therapy uses the long-term strategy of helping families to leave the poverty environment through upward mobility. In the short-term, families are helped to assemble resources and to enhance informal and formal networks, partially through civic engagement, as a means to

manage the poverty environment and to remove barriers to upward mobility.

Another critique of conventional family therapy is that it does not conceptualize a family role in social change activities. The Systems-Oriented Family-Centered Approach appears to have no explicit response to this critique. Just Therapy raises the potential and probability of family involvement in social action by demonstrating the relevance of such activities through introducing a structural framework for the families' understanding of their experiences. The Multilevel Social Systems Model provides the family with an appreciation of external stressors and encourages therapists and families to join together in social action. Community Family Therapy is the only model, which directly intervenes in families' involvement in social action through enhancing leadership capacity and facilitating civic engagement.

Critics have argued that conventional family therapy erroneously applies middle-class standards of family development and health to families living in poverty. The promising models differ a great deal in response to this critique. Community Family Therapy un-apologetically rejects this argument in the service of supporting the upward mobility of families living in poverty. The Multilevel Social Systems Model and the Systems-Oriented Family-Centered Approach are unresponsive to this critique in that they do not differentiate family norms, routines, or coping strategies according to strata of family economic status. Conversely, Just Therapy adopts a post-modern response in rejecting any universal or even class-based standards of family health and development in favor of the view that each family constructs its own definitions.

Another element of the critique of conventional family therapy's engagement with poverty is that it is focused on personal and family deficits. Only Just Therapy explicitly rejects all identification of personal and family deficits as inherently pejorative. The family narrative, and not the family, is seen as insufficient. On the other hand, Community Family Therapy explicitly seeks to identify areas of individual and family underdevelopment, but puts a positive frame on them by defining their alleviation as presenting opportunities for upward mobility. Both, the Systems-Oriented Family-Centered Approach and the Multilevel Social Systems Model, eschew the identification of individual deficits, but are more conventional in assessing limitations in family structure and processes. Once identified, these limitations become targets for empowering change. Furthermore, both balance this view of intra-familial limitations by identification of deficits in larger systems external to the family.

A final criticism of conventional family therapy when applied to families living in poverty is that, therapists disempower families by taking an exclusive expert stance that privileges professional knowledge while not acknowledging the competencies of families. All of the promising models are at least partially collaborative and empowerment-based, but Just Therapy is unique in privileging the family's expertise based on local and cultural knowledge. The role of the therapist is to elicit this expertise and to suggest how its influence might be expanded. The three other models conceptualize the therapist as possessing the expertise to assess the families' problems, and seek to intervene in ways that empower families and enhance their competence. The Systems-Oriented Family-Centered Approach encourages therapists to limit their role in family problem resolution and respect family boundaries as family organization becomes more functional. The Multilevel Social Systems Model focuses on enhancement of family stress management capacity. Community Family Therapy explicitly requires collaborative family-therapist planning, but defines the therapist as possessing the expertise to achieve the plan through her or his coaching and facilitation roles.

All of the critiques of the engagement of conventional family therapy with families living in poverty have been incorporated to some extent by most of the innovative models, but at various levels of comprehensiveness. The critique, which is least thoroughly addressed, refers to the role of families in social change. This is entirely ignored in the Systems-Oriented Family-Centered Approach. The family therapy component of Just Therapy increases the potential for family involvement in social change through consciousness-raising, externalization, and contextualization, but these particular families are not necessarily involved in policy advocacy or community development. The Multilevel Social Systems Model only mentions the desirability of families and therapists engaging together in social change. Community Family Therapy takes current structural arrangements as given, and, therefore, does not focus on social change.

Another view of Table 2 suggests that none of the promising models completely addresses all of these critiques. The Systems-Oriented Family-Centered Approach adheres to the framework of traditional Structural Family Therapy, but with the important addition of a focus on improving the service system. The Multilevel Social Systems Model uses a similar systemic theoretical framework, but combines it with family stress theory to access a connection between stressors located at higher systemic levels and stress experienced by the family. The post-modern and constructivist elements of Just Therapy lead to the most comprehensive response to the

critiques. Community Family Therapy differs from the other models in its acceptance of current structural arrangements and its objective of helping families to achieve middle-class status (The Hartford Current, August 27, 2001). This leads to an unapologetic adoption of middle class developmental norms, re-framing of deficits and valuing of professional interventional expertise.

CONCLUSION

This paper began by identifying the intersection of the ambivalent historical relationship between family therapy and poverty with the long-standing debate about whether cause should be combined with function in social work practice. One aspect of this combination is whether family therapy direct service practitioners are involved in social change activities. All of the promising models reviewed incorporate these dual roles to some extent. The most limited is the Systems-Oriented Family-Centered Approach, which explicitly invokes therapists to influence change only at the organizational and service system levels. Community Family Therapy requires therapist activity in social action at the local level, but does not contemplate change in larger social and economic structures. Conversely, both Just Therapy and the Multilevel Social Systems Model require that, as both professionals and citizens, therapists are obliged to become involved in community development, policy advocacy, action research, and social movements aimed at change at the community and structural levels.

This paper also viewed the promising models through two lenses, and found that different models dominated, depending on the lens. Community Family Therapy was most congruent with salient findings from the social science literature on poverty, although the post-modern basis of Just Therapy made it difficult to evaluate it according to this criterion. Just Therapy was most responsive to critiques that have been made of the engagement of conventional family therapy with families living in poverty, although the acceptance of the current socioeconomic order by Community Family Therapy implicitly rejects some of these critiques.

Finally, data to assess the models according to perhaps the most important criteria are not available. With the exception of the Structural Family Therapy origins of the Systems-Oriented, Family-Centered Approach, the literature contains no evaluations of the effectiveness or

cost-effectiveness of the models discussed in this paper. Although the logical analysis presented here may be useful, practitioners and policy-makers cannot make rational decisions about the incorporation of these models in their work with poor families in the absence of findings from such studies.

REFERENCES

Aber, J.L., Bennett, N.G., Conley, D.C., & Jiali, L. 1997. "The Effects of Poverty on Child Health and Development." *Annual Review of Public Health,* 18, 463-483.

Aponte, H.J. 1994. *Bread and spirit: Therapy with the new poor.* New York: W. W. Norton.

Aponte, H.J. 1974. "Psychotherapy for the Poor: An Eco-Structural Approach." *Delaware Medical Journal,* 46, no. 2, 134-144.

Attree, P. 2004. "Growing Up in Disadvantage: A Systematic Review of the Qualitative Evidence." *Child Care, Health and Development,* 30, no. 6, 679-689. doi: 10.1111/j.1365-2214.2004.00480.x

Bateson, G. 1972. *Steps to an ecology of mind.* New York: Ballantine.

Becker, G.S. 1981. *A treatise on the family.* Cambridge, MA: Harvard University Press.

Becker, G.S. & Tomes, N. 1986. "Human Capital and the Rise and Fall of Families." *Journal of Labor Economics,* 4, no. 3, s1-s39.

Best, S. & Kellner, D. 1991. *Postmodern theory: Critical interrogations.* New York: Guilford.

Boss, P.G. 2002. *Family stress management: A contextual approach,* 2nd edition. Thousand Oaks, CA: Sage.

Bowen, G.L., Martin, J.A., Mancini, J.A., & Nelson, J.P. 2000. "Community Capacity: Antecedents and Consequences." *Journal of Community Practice,* 8, no. 2, 1-21. doi: 101.1300/j125v08n02_01

Bradshaw, J. 2000. "Child Poverty in Comparative Perspective." In D. Gordon & P. Townsend, eds. *Breadline Europe: The measurement of poverty,* pp. 223-250. Bristol: Policy Press.

Brisson, D.S. & Usher, C. 2005. "Bonding Social Capital in Low-Income Neighborhoods." *Family Relations,* 54, no. 5, 644-653. doi: 10.1111/j.1741-3729.2005. oo348.x

Brodkin, A.M. 1980. "Family Therapy: The Making of a Mental Health Movement." *American Journal of Orthopsychiatry,* 50, no. 1, 4-17.

Bronfenbrenner, U. 1979. *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Brooks-Gunn, J. & Duncan, G.J. 1997. "The Effects of Poverty on Children." *The Future of Children,* 7, no. 2, 55-71.

Brown, S.L. 2002. "We Are, Therefore I Am: A Multisystems Approach with Families in Poverty." *The Family Journal: Counseling and Therapy for Couples and Families,* 10, no. 4, 405-409. doi: 10.177/106648002236759

Chambon, A.S. & Irving, A. eds. 1994. *Essays on postmodernism and social work.* Toronto: Canadian Scholars' Press.

Chaskin, R.J. 1997. "Perspectives on Neighborhood and Community: A Review of the Literature." *Social Service Review*, 71, no. 4, 521-548.

Collins, D., Jordan, C., & Coleman, H. 2007. *An introduction to family social work.* Belmont, CA.: Thompson Brooks/Cole.

Deglau, E. 1985 "A Critique of Social Welfare Theories: The Culture of Poverty and Learned Helplessness." *Catalyst*, 5, no. 19, 31-55.

Dewees, M. 2004. "Postmodern Social Work in Interdisciplinary Contexts: Making Space on Both Sides of the Table." *Social Work in Health Care*, 39, no. 3/4, 343-360. doi: 10.1300/J010v39n03_08

Duncan, G.J. & Brooks-Gunn, J. eds. 1997. *The consequences of growing up poor.* New York: Russell Sage Foundation.

Epstein, E.K. 1993. "From Irreverence to Irrelevance? The Growing Disjuncture of Family Therapy Theories from Social Realities." *Journal of Systemic Therapies*, 12, no. 3, 15-27.

Erikson, E.H. 1950. *Childhood and society.* New York: W. W. Norton.

Farrell, S.J., Aubry, T., & Coulombe, D. 2004. "Neighborhoods and Neighbors: Do They Contribute to Personal Well-Being?" *Journal of Community Psychology* 32, no. 1, 9-25. doi: 10.1002/cop.10082

Finn, J.L. & Jacobson, M. 2003. *Just practice: A social justice approach to social work.* Peosta, IA: Eddie Bowers Publishing.

Flint, A.J. & Novotny, T.E. 1997. "Poverty Status and Cigarette Smoking Prevalence and Cessation in the United States, 1983-1993: The Independent Risk of Being Poor." *Tobacco Control*, 16, 14-18.

Friere, P. 1970. *Pedagogy of the oppressed.* New York: Herder and Herder.

Furstenberg, F.F. & Hughes, M.E. 1997. "The Influence of Neighborhoods on Children's Development: A Theoretical Perspective and Research Agenda." In J. Brooks-Gunn, G.J. Duncan, & J.L. Aber, eds. *Neighborhood poverty. Vol. 2: Policy implications in studying neighborhoods*, pp. 23-47. New York: Russell Sage Foundation.

Gans, H.J. 1995. *The war against the poor: The underclass and antipoverty policy.* New York: Basic Books.

Garbarino, J., Bradshaw, C.P., & Kostelny, K. 2005. "Neighborhood and Community Influences on Parenting." In T. Luster & L. Okagaki, eds. *Parenting: An Ecological perspective*, pp. 297-318. Mahwah, NJ: Lawrence Erlbaum Associates.

Geismar, L.L. & La Sorte, M. 1964. *Understanding the multi-problem family: A conceptual analysis and exploration in early identification.* New York: Association Press.

Gershoff, E.T., Aber, J.L., & Raver, C.C. 2005. "Child Poverty in the United States: An Evidence-Based Conceptual Framework for Programs and Policies." In R.M. Lerner, F. Jacobs, & D. Wertlieb, eds. *Applied developmental science: An advanced textbook*, pp. 269-324. Thousand Oaks, CA: Sage.

Glennester, H. 2002. "United States Poverty Studies and Poverty Measurement: The Past Twenty-Five Years." *Social Service Review*, 76, no. 1, 83-107.

Goldenberg, I. & Goldenberg, H. 2004. *Family therapy: An overview*, 6th edition. Pacific Grove, CA: Thompson, Brooks/Cole.

Gordon, D. 2000. "Measuring Absolute Poverty." In D. Gordon & P. Townsend, eds. *Breadline Europe: The measurement of poverty*, pp. 49-77. Bristol: Policy Press.
Gordon, D. & Spicker, P. 1999. *The international glossary on poverty*. London: Zen Books.
Gutman, L.M., McLoyd, V.C., & Tokoyawa, T. 2005. "Financial Strain, Neighborhood Stress, Parenting Behaviors and Adolescent Adjustment in Urban African American Families." *Journal of Research on Adolescence*, 15, no. 4, 425-449. doi: 10.1111/j.1532-7795.00106.x
Haley, J. 1976. *Problem solving therapy*. San Francisco, CA: Jossey-Bass.
Haley, J. 1962. "Whither Family Therapy?" *Family Process*, 1, no. 1, 68-100.
Hansen, J.C. & Falicov, C.J. eds. 1983. *Cultural perspectives in family therapy*. Rockville, MD: Aspen Systems Corp.
Hartman, A. & Laird, J. 1983. *Family-centered social work practice*. New York: Free Press.
Hollingshead, A.B. & Redlich, F.C. 1958. *Social class and mental illness: A community study*. New York: Wiley.
Human Resources and Development Canada/Statistic Canada. The National Longitudinal Survey of Children and Youth. http://www.statcan.ca/english/sdds/4450.htm
Imber-Black, E. 1988. *Families and larger systems: A family therapist's guide through the labyrinth*. New York: Guilford.
Jarvis, M.P. & Wardle, J. 2006. "Social Patterning of Individual Health Behaviours: The Case of Cigarette Smoking." In M. Marmot & R.G. Wilkinson, eds. *Social determinants of health*, 2nd edition, pp. 224-237. New York: Oxford University Press.
Johnson, S. 2001. "Family Therapy Saves the Planet: Messianic Tendencies in the Family Systems Literature." *Journal of Marital and Family Therapy*, 27, no. 1, 3-12.
Kaslow, F.W. 1980. "History of Family Therapy in the United States: A Kaleidoscopic Overview." *Marriage and Family Review*, 3, 77-111.
Lee, P.R. 1930. "Cause and Function." In (Eds: Marquette Bleecker, Jane M. Hoey, & Joanna C. Colcord) *Proceedings of the National Conference of Social Work, 1929*, pp. 3-20. Chicago: University of Chicago Press.
Lewin, G. ed. 1948. *Resolving social conflicts: Papers on group dynamics*. New York: Harper.
Luepnitz, D.A. 1988. *The family interpreted: Feminist theory in clinical practice*. New York: Basic Books.
Mack, J. & Lansley, S. 1985. *Poor Britain*. London: G. Allen & Unwin.
Madsen, W.C. 2001. *Collaborative therapy with multi-stressed families*. New York: Guilford.
Maluccio, A.N., Pine, B.A., & Tracy, E.M. 2002. *Social work practice with families and children*. New York: Columbia University Press.
Markowitz, L. 1997. "Ramon Rojano Won't Take No for an Answer." *Family Therapy Networker*, 21, no. 6, 24-35.
Maturana, H. & Varela, F. 1988. *The tree of knowledge*. Shambhala: New Science Library.
Mayer, S.E. 1997. *What money can't buy: Family income and children's life chances*. Cambridge, MA: Harvard University Press.
McGoldrick, M. ed. 1998. *Re-visioning family therapy: Race, culture, and gender in clinical practice*. New York: Guilford.

McGoldrick, M., Pearce, J.K., & Giordano, J. eds. 1982. *Ethnicity and family therapy.* New York: Guilford.

Mendelson, M. 2005. *Measuring child benefits: Measuring child poverty.* Ottawa: Caledon Institute of Social Policy.

Miller, D.C. & Salkind, N.J. 2002. *Handbook of research design and social measurement*, 6th edition. Thousand Oaks, CA: Sage.

Minuchin, P., Colapinto, J., & Minuchin, S. 1998. *Working with families of the poor.* New York: Guilford.

Minuchin, S. 1974. *Families and family therapy.* Cambridge, MA: Harvard University Press.

Minuchin, S., Montalvo, B., Guerney, B.G., Jr., Rosman, B.L., & Schumer, F. 1967. *Families of the slums: An exploration of their structure and treatment.* New York: Basic Books.

Molnar, A. & Lindquist, B. 1989. *Changing problem behaviors in schools.* San Francisco, CA: Jossey-Bass.

Mullaly, R.P. 2002. *Challenging oppression: A critical social work approach.* Toronto: Oxford University Press.

Nichols, M.P. & Schwartz, R.C. 2007. *The essentials of family therapy.* Toronto: Allyn and Bacon.

Oakes, J.M. & Rossi, P.H. 2003. "The Measurement of SES in Research: Current Practice and Steps Toward a New Approach." *Social Science in Medicine,* 56, no. 4, 769-784.

Pinderhughes, E.E., Nix, R., Foster, E.M., & Jones, D. 2001. "Parenting in Context: Impact of Neighborhood Poverty, Residential Stability, Public Services, Social Networks, and Danger on Parental Behaviors." *Journal of Marriage and the Family,* 63, no. 4, 941-953.

Proctor, E.K., Davis, L.E., & Vosler, N.R. 1995. "Families: Direct Practice." In R.L. Edwards, ed. *Encyclopedia of social work,* 19th edition, Vol. 2, pp. 941-950. Washington, DC: N.A.S.W. Press.

Psychotherapy Networker. 2004. "The Middle Class Express: Ramon Rojano's Mental Health System for the Poor." November/December, 34-35.

Riessman, F., Cohen, J., & Pearl, A. eds. 1964. *Mental health of the poor: New treatment approaches for low income people.* New York: Free Press of Glencoe.

Ripke, M.N. & Huston, A.C. 2006. "Poverty: Consequences for Children." In L. Balter & C.S. Tamis-LeMonda, eds. *Child psychology: A handbook of contemporary issues,* 2nd edition, pp. 521-544. New York: Psychology Press.

Rivett, M. & Street, E. 2003. *Family therapy in focus.* Thousand Oaks, CA: Sage.

Rojano, R. 2004. "The Practice of Community Family Therapy." *Family Process,* 43, no. 1, 59-77.

Ross, D.P. & Roberts, P. 1999. *Income and child well-being: A new perspective on the poverty debate.* Ottawa: Canadian Council on Social Development.

Ross, D.P., Scott, K.J., & Smith, P.J. 2000. *The Canadian fact book on poverty.* Ottawa: Canadian Council on Social Development.

Roy, R. & Frankel, H. 1995. *How good is family therapy? A reassessment.* Toronto: University of Toronto Press.

Ryan, W. 1976. *Blaming the victim.* New York: Vintage Books.

Saleebey, D. ed. 2002. *The strengths perspective in social work practice*, 3rd edition. Boston: Allyn & Bacon.

Schwartz, W.C. 1969. "Private Troubles and Public Issues: One Job or Two?" In *Social Welfare Forum, 25* (pp. 87-92). New York: Columbia University Press.

Sen, A.K. 1983. "Poor, Relatively Speaking." *Oxford Economic Papers*, 35, no. 2, 153-169.

Skinner, H.A., Steinhauer, P.D., & Santa-Barbara, J. 1983. "The Family Assessment Measure." *Canadian Journal of Community Mental Health*, 2, no. 2, 91-105.

Sluski, C.E. 1996. *La red social: Frontera de la practica sistemica* (The social network: Frontier of systemic practice). Barcelona: Gedisa.

Specht, H. & Courtney, M.E. 1994. *Unfaithful angels: How social work has abandoned its mission.* New York: Free Press.

Sprenkle, D.H., Blow, A.J., & Dickey, M.H. 1999. "Common Factors and Other Nontechnique Variables in Marital and Family Therapy." In M.A. Hubble, B.L. Duncan, & S.D. Miller, eds. *The heart and soul of change: What works in therapy*, pp. 329-359. Washington, DC: American Psychological Association.

Statistics Canada Health Statistics Division. 1999. National Health Survey. http://www.statcan.ca/english/concepts/nphs/index.htm

Sullivan, H.S. 1953. *The interpersonal theory of psychiatry.* New York: W. W. Norton.

Tamasese, K. & Waldegrave, C. 1993. "Cultural and Gender Accountability in the Just Therapy Approach." *Journal of Feminist Family Therapy*, 5, no. 2, 29-45.

Totton, N. 2000. *Psychotherapy and politics.* London: Sage.

Townsend, P. 1993. *The international analysis of poverty.* New York: Harvester Wheatsheaf.

Townsend, P. 1985. "A Sociological Approach to the Measurement of Poverty: A Rejoinder to Professor Amartya Sen." *Oxford Economic Papers*, 37, no. 4, 659-668.

Ungar, M.. 2004. "Surviving as a Postmodern Social Worker: Two Ps and Three Rs of Direct Practice." *Social Work*, 49, no. 3, 488-496.

Vosler, N.R. 1996. *New approaches to family practice.* Thousand Oaks, CA: Sage.

Vosler, N.R. & Nair, S. 1993. "Families, Children, Poverty: Education for Social Work Practice at Multiple System Levels." *International Social Work*, 36, no. 2, 159-172.

Waldegrave, C. 2005. "Just Therapy with Families on Low Incomes." *Child Welfare* LXXXIV, no. 2, 265-276.

Waldegrave, C. 2000. "Just Therapy with Families and Communities." In G. Burford & J. Hudson, eds. *Family group conferencing: New directions in community centred child and family practice*, pp. 153-163. New York: Aldine de Gruyter.

Waldegrave, C.T. 1990. "Just Therapy." *Dulwich Centre Newsletter*, 1, 5-46.

Waldegrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. 2003. *Just therapy: A journey.* Adelaide: Dulwich Centre.

Walsh, F. 2003. "Clinical Views of Family Normality, Health, and Dysfunction." In F. Walsh, ed. *Normal family processes*, 3rd edition, pp. 27-57. New York: Guilford.

Walters, M., Carter, B., Papp, P., & Silverstein, O. 1988. *The invisible web: Gender patterns in family relationships.* New York: Guilford.

Westbrooks, K.L. 1995. *Functional low-income families: Activating strengths.* New York: Vantage Press.

White, M. & Epston, D. 1990. *Narrative means to therapeutic ends.* New York: W.W. Norton.

Wise, J.B. 2005. *Empowerment practice with families in distress.* New York: Columbia University Press.

Ziemba, S.J. 2001. "Therapy with Families in Poverty: Application of Feminist Family Therapy Principles." *Journal of Feminist Family Therapy*, 12, no. 4, 205-223.

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