‘JUST THERAPY’ IN POOR COMMUNITIES

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When we speak of families and therapy, we tend to think in mental health or relationship categories. A family in need of therapy may require help because of the unpredictable behaviour of one or a number of household members, or because relationships between members have become disrupted in some way. If instead of referring simply to families, we refer to ‘poor families’, we are triggered into issues of context.

Addressing the context
What is good therapy when families are poor? How are relationships addressed when parents who struggle to feed their families are not able to access decent housing? Do current clinical and therapeutic courses adequately prepare students to address the therapeutic issues of poor families? The words ‘families’ and ‘therapy’ tend conjure a reasonably predictable set of expectations, but if the adjective ‘poor’ is inserted to describe a set of particular families, those expectations become challenged.

Consider for example, how a group of therapists are likely to answer the question, “what is absolutely basic to a family or family life?” They would probably answer along the following lines. There must be at least a minimal commitment to relationship among members. There must be some evidence of emotional warmth among members. There must be some cooperative patterns of behaviour that order at least some of their life together and it would be hoped that there would be some evidence of, what is referred to in the non-social science world as, love.

Consider now how a group of community workers may answer the same question concerning “what is absolutely basic to a family or family life”. They would probably answer along the following lines. Families require adequate and safe housing. They require sufficient income to live out of poverty. They need to be able to access affordable healthcare and they need to be able to live free from fear and harassment.

Both views of course are correct in as far as they go, but their emphases are quite different. One is focussed primarily on family dynamics, while the other is focussed primarily on social and economic context. The same divergence of views would probably occur if therapists and community workers were asked a further question, “what causes the problems for poorer families who visit therapists for help?”

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Many therapists when referring to particular stresses poor families face, would probably still announce a list that would be characterised by the following sorts of problems: inadequacies in communication; the loss of emotional warmth; tensions in relationships; an inability to make decisions; and difficulties resolving conflict. Community workers on the other hand, would be more likely to refer to an alternative list of problems, like: poverty; bad housing; inadequate financial resources; ongoing racist experiences; ongoing sexist experiences; and ongoing hetero-sexist experiences, for example.

For many therapists, the problems of all families relate primarily to individual or family dynamics. Such a view provides a contained space to work effectively in, and that which is beyond those boundaries is the work of other professionals. While this view limits and defines the work of therapists, it unfortunately also ensures it will be ineffective, and possibly detrimental to poor families, because it treats the symptoms of larger scale social problems as though they are the result of internal family dysfunction. The context named by the community workers is largely dismissed.

Many families who come to therapists arrive with problems that include psychosomatic illnesses, violence, depression, addiction, delinquency, marital and partnership stress, psychotic illnesses, parenting problems, relationship stress and the like. If the therapists are sufficiently patient and persistent, they will discover after some questioning, that the onset of many, though certainly not all, family problems are located in events that are external to the family. These could be events like unemployment, bad housing, homelessness, racist, sexist or heterosexist experiences, and the like. The same problems, in fact, that were identified by the community workers. They can be extremely depressing ongoing experiences that eventually lead parents and children into a state of stress that open them up to physical and mental illnesses.

When people come to therapists depressed and in bad housing, and their clinical or social problems are treated within the conventional clinical boundaries, they are simply made to feel a little better in poverty. Quite often competent therapists are able to quite effectively help move people out of depression, but then simply send them back to the conditions that created the problems in the first place. Unintentionally, but nevertheless very effectively, they simply adjust people to poverty.

Furthermore, by implication they encourage families in the belief that they, rather than the unjust social, economic and political structures, were the authors of their problems and failures. They do this despite the knowledge we have today of structured and cyclical unemployment in most post industrial countries, despite our knowledge of the physical and psychological pathologies associated with inadequate housing, despite our knowledge of the same pathologies associated with ongoing racist experience and despite our knowledge of the patriarchal determinants of physical and sexual abuse.
Further still, such therapists can be guilty of silencing the voices of poor people. Low income families often share their vulnerability and pain with therapists, who then, because of their professional commitment to confidentiality never pass it on to the forums that could do something about it. The therapist is often one of the only persons in mainstream middle class society who poor people outline their difficulties to. If they feel no compulsion to address the causal factors by bringing the repeating themes of poor families (not the individual confidential stories) into the public debate or to the institutions that can change them, then the cry of help has been silenced.

**Inequalities and health**

There is certainly a substantial body of literature that associates low income households and inequality with physical and mental illhealth. One of the most significant early research projects on the subject was carried out by Harvey Brenner in the early 1970s at Harvard University (Brenner 1973). His research focussed on unemployment and societal health. He led a large scale study on the effects of economic recession in the USA and his results indicated that a 1% rise in unemployment is followed by 6% more admissions into psychiatric hospitals, a 4% rise in suicides, a 4% rise in state prison admissions and 6% more homicides.

Further research by Brenner (1979) confirmed the same findings in England and Wales. The relationship between unemployment and suicide was tested in eight different developed countries and again the close link between annual variations in unemployment and suicide rates was demonstrated (Boor 1980). In another study, the same relationship was again found in New Zealand (Macdonald et al 1982).

Since the 1980s many local and national studies have followed (Acheson 1998, Benzeval et al 1995, Crampton et al 2000, Dunn et al 2003, Kawachi & Kennedy 2002, Kawachi & Berkman 2003, National Health Committee 1998 and Waldegrave et al 2004). They each show a distinct relationship between inequalities in society and physical and mental illhealth. Poorer people die earlier, consistently have the poorest health and the highest hospitalisation rates. Furthermore, when there is an overall improvement in a country’s population health status, the health inequalities do not decrease.

The evidence is so overwhelming that a number of major government enquiries have been set up to study the evidence and recommend new directions for national health services to address health status from the perspective of inequalities. The famous Acheson Independent Inquiry into Inequalities in Health Report in the United Kingdom (1998) and the Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health (1998) are two such examples.
Given the substantive evidence of the relationship between inequality and physical and mental illhealth, it is reasonable to suggest that many of the problems that families present in therapy result from poverty, inadequate housing, unjust economic planning, unemployment, racism and so on. As such, where this is the case, they can be conceived as the symptoms of inequality.

From this perspective, these symptoms that are usually construed in mental health or social categories, should not be considered as simply personal, intra-psychic or intra-family disorders if they arise in association with broader structural problems in society. They can be more accurately viewed primarily as the symptoms of those structural social problems. The tighter clinical categories are secondary, and only useful if viewed in relation to the primary focus.

This suggests a notion that many, though obviously not all, of the mental health and relationship problems people have are the consequences of power difference and injustice. Such a notion seldom features in clinical literature or as major themes in therapeutic conferences. If it did however, there would be considerably more exploration and analysis around ethics and social justice themes as they relate to family context and less exclusive focus on the boundaried space of individuals, couples or families.

**Therapists as thermometers of pain**

Therapists have a critical role in post industrial and largely secular states. They are the predominant professional group who listen to the pain of individuals and families. They work in the institutions that address pain in these societies, like the health, welfare and justice services. They work in the non-Government (NGOs) and community organisations that provide family support and services around abuse, poverty, housing, general counselling, mental and physical illhealth and so on. They also work privately, but are often contracted into the work of these larger organisations.

Therapists, as a professional group, are the most informed ‘experts’ of the grounded levels of hurt, sadness and pain in modern countries. As such they carry a substantial responsibility to identify, quantify and describe the severity and causes of it. This is ethically essential if they are committed to honouring their client group. They have a responsibility to publish and publicise the causes and outcomes of people’s pain in order that they may be addressed in the public debate and impact on policy. Good policy in this sense can address issues of wellbeing and inclusion in informed and effective ways.

Therapists in this view, can be healthily seen as the ‘thermometers of pain’ in modern countries. Instead of withholding their knowledge in clinical vacuums, they can quantify, describe and identify causality for all to see. Where issues around housing, poverty or race become dominant in caseloads for example,
they can register the rise in the mercury. Their voice in the public debate will add reality and depth. A good example of this can be seen in the public work many fine therapists have carried out highlighting the levels of abuse occurring in many countries, the causes of that abuse and the policies and laws required to stop it. A parallel level of action and commitment is required in a range of other pain causing factors therapists identify.

There are a number of critical questions along these lines that therapists could usefully ponder at professional conferences, within professional organisations and at staff meetings that may be more useful than the endless string of case study presentations and focus on therapeutic techniques. They could include:

*Wouldn’t it be useful for therapists to keep track of the numbers of individuals and families they meet in therapy who are below the poverty income threshold in their country for example (or in inadequate housing, or being subject to ongoing racist experiences, etc), and encouraging their colleagues to as well, and sending those statistics out into the public arena?*

*Wouldn’t it be useful for therapists to be telling the sorts of stories they see and hear in therapy through popular media outlets and advocate for social changes that will address the sorts of therapeutic problems they identify?*

*Wouldn’t it be useful for therapists to identify the failure of certain social and economic policies as the prime cause of pain and illhealth to many low income families, rather than the failure of individuals and families as many in society often view the situation?*

*If therapists know that certain social and economic conditions prolong illhealth, wouldn’t it be useful to be creating public awareness concerning that, out of respect for the needs of their clients not to have their sicknesses prolonged?*

Positive answers to these types of questions require a fundamental institutional shift in the profession. Keeping the statistics would simply involve a few more columns in case-note sheets after some sensitive questioning. However, reflective and careful analysis would be required to address the social critique, based on those statistics, through academic and popular media outlets. Success in achieving these goals though, would go a long way to rid the profession of the fair and current accusation that practitioners so often silence the voice of poor people as they unintentionally help make them happy in poverty.

There are some further less comfortable and more personal questions the profession may also choose to address. They could include:

*Has the profession of therapy been captured by a group who believe in low taxes and minimal social policies?*
Are therapists paid off to be silent, given the profound knowledge many of them have about the lives of poor people?

Are therapists making money off people’s misery and thus have no interest in reducing their problems at root?

These are tough reflective questions, but they are the sort a profession who is entrusted with the vulnerability of people during some of their most fragile periods, should be asking. It is perhaps excusable to admit one’s naiveté and unintentional behaviour when first addressing these questions, but once admitted, it is surely unethical not to change. Societies need their reliable thermometers of pain, the mercury readings provided by the therapists.

‘Just Therapy’ in poor communities
For therapists to successfully work in poor communities, they have to take the critical context beyond the family into account. Those most in need of the health and welfare resources in most societies and communities are those who experience the most trauma, the greatest stress and as a consequence the most illhealth. They are usually those on low incomes, people in cultures that have been marginalised in the societies in which they live and most frequently women. Unfortunately therapeutic resources are spread rather thinly for this group because they are outside the mainstream and have less money.

‘Just Therapy’ (Waldegrave, Tamasese, Tuhaka and Campbell 2003) was created to help therapists address the critical socio-economic, cultural and gender contexts of therapy. This paper has focussed predominantly on the socio-economic aspect and therapists interactions with and responsibilities to their societies. Each of these contexts though, are very important.

It is equally important to address the context in the therapeutic process as well. A full development of this is not possible in a paper of this size. Some pointers however, may be helpful. It is beneficial when questioning low income household members to sensitively address their stories around accessing necessities. Unfortunately, this is seldom referred to in therapeutic discourse. The adequacy of household income, the quality of housing and access to good healthcare are critical contexts. Families in these situations struggle and are often highly motivated to share coping strategies and survival skills. These in turn offer genuine stories for the therapist to admire, honour and in a sense to be in awe of.

So many of these families are viewed by institutions in a pathological light. They are often referred to as ‘dysfunctional’ or ‘multi-problem’ families. This consistently negative view, combined with the sense of social failure and lower status conferred by mainstream society, can quickly become self-fulfilling. It is critical to this work to recognise where their strength lies and to honour it. It is usually found in their resilience under the sort of stress middle income households are seldom required to endure.
There is nothing more basic, for example, to a family than a house. Housing as such can usefully become a central context in the therapeutic process. Without adequate, safe and secure housing all families are at risk of mental and/or physical sickness. The meaning therapists assign to poor families’ housing problems determines whether or not the problem will be located internally or in its socio-economic context. If the former route is taken, then feelings of inadequacy and self-blame will be encouraged. If the latter contextual route is chosen, then the focus will move towards understanding the socio-economic context and developing smart survival strategies. It is so important to challenge the failure meanings that so many poor families take on board as a result of their constrained circumstances and the reactions of others to them.

In our work for example, we often congratulate families for surviving overcrowded living conditions with their families still intact. Their ability to survive a housing crisis not of their own making, but that of the housing planners, can be recognised as courageous, committed and extraordinarily competent. Having explored their stories of resilience, resistance and survival, we often indicate that we are not at all confident our families would have survived those circumstances as well as they have. In this positive context, we are able to address the symptomatic presenting problems in context, enabling families to identify the broader structural issues that have been imposed on them. We can then help them recognise their strengths as the stepping stones to either survive without self-blame or to develop smart strategies to move to a more secure social place.

**Focussing the problems of current practice**

Poor families have been badly served by the therapy community in three ways. Although such families are those most in need of therapeutic resources, they seldom receive such resources on their own terms. A combination of middle class capture and preference for therapists to work above the poverty line constrains the resources available to low income households.

Secondly, therapists working with poor families typically constrain themselves within narrow clinical boundaries that avoid the prime contextual factors that are so basic to their daily survival. This encourages the internalising of their problems and the consequent self-blame during therapy and subsequently if there is a relapse.

Finally, this paper strongly suggests that poor families would be better served if therapists took seriously their role in social and economic policy development. As the key profession most in touch with grounded pain in society, they would contribute substantially more to disadvantaged families if they were active in the public debates and policy discussions that impact on these families in modern democratic societies.
References
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