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The Family Journal 2002; 10; 405

DOI: 10.1177/106648002236759

The online version of this article can be found at:
http://tfj.sagepub.com/cgi/content/abstract/10/4/405

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❖ **Literature Review—Theory**

We Are, Therefore I Am: A Multisystems Approach With Families in Poverty

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The U.S. Bureau of the Census recently indicated that there are 31 million individuals who are living below the poverty line. Although many of these individuals are referred for family counseling services via schools, court systems, and social service agencies, theories have failed to provide an adequate framework for treatment. This article addresses the common principles of the multisystems approach and feminist family therapies and how they can be applied in providing family therapy to this unique population.

The subject of social class remains taboo even in these progressive times. Society would rather discuss coital obscenities such as incest or pedophilia than debate the constructs of the social caste system. People who are poor have been given the irreversible stigma of being lazy and unwilling to work diligently to attain society's definition of wealth. They also are stereotyped as being improperly clothed, malnourished, and dwellers in inadequate housing. Although they are limited in material possessions, they take pride and solace in their "we orientation." This collective orientation is a support system consisting of family, extended family, nonblood kin, and religious and community resources, and it is the cornerstone of their existence.

To gain insight into families in poverty, one must first understand their plight. Charles Booth (as cited in Popple & Leighninger, 1993) defined poor people as those who "live under a struggle to obtain the necessaries of life and make both ends meet, while the very poor live in a state of chronic want" (p. 171). The U.S. Bureau of the Census (2000) reported that there are 31 million people who are living below the poverty line. The majority of poor children in the United States are of European ancestry. However, rates of childhood poverty among minority children typically are 2 to 3 times higher than that of non-Latino White children (McLoyd, 1998; Reddy, 1993). In addition, ethnic minority families are more likely than non-Latino White families to encounter persistent poverty and to dwell in areas of concentrated poverty (Jargowsky, 1994).

Many of these families receive some form of government assistance. According to the U.S. Department of Health and Human Services (2000), more than 2 million adults and 5 million children received government assistance. Ninety percent of these families were single-parent households, with the majority (61%) of recipients being people of color. Wilson (2001) postulated that welfare reform was created under the premise that underserved populations must behave in a socially appropriate manner to receive government assistance. They should be required to actively participate in job search activities and to accept any employment opportunity offered. Consequently, welfare reform places onus on the moral fabric of the individual or family as opposed to the social and economic structure of society. This "welfare ethos" also fosters society's silent disdain for disadvantaged populations.

Families who are poor constantly face the struggle to make ends meet, and there is an ever-present fear that they won't. They aren't able to spend sufficient amounts of quality time with their children or simply enjoy life because of this struggle and lack of financial resources (Nichols & Schwartz, 2001). They are disadvantaged by limited employment opportunities and high-quality public and private services such as child care and schools (McLoyd, 1998). Low-income families laugh at what middle-class families consider nuances that could ruin a perfect day. According to disadvantaged populations, a car breaking down (at least there is a car to break) or a child getting sick is nothing compared to not knowing whether you'll come home to find that your electricity has been shut off or wondering whether you and your family will have a place to lay your heads at night. Even though many families living in poverty experience a sense of distress, it is viewed as an expected norm (Walsh, 1998). Daily they are faced with increased exposure to pestiferous environmental

THE FAMILY JOURNAL: COUNSELING AND THERAPY FOR COUPLES AND FAMILIES, Vol. 10 No. 4, October 2002 405-409
DOI: 10.1177/106648002236759
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stressors such as violent communities, homelessness, dehumanizing jobs, or welfare's malicious cycle, and some people may respond to these feelings of hopelessness with the abuse of illegal drugs (Jargowsky, 1994; Nichols & Schwartz, 2001; Zigler, 1994). The insecurity and shame of being poor also burden them, and the contrast to the prosperous America they see on television fosters a negative self-image. Due to the subjection to oppression that manifests into hopelessness, I have labeled families in poverty as having a minority status. Wirth (as cited in Atkinson, Morten, & Sue, 1993) has offered a definition based on the concept of oppression that posits that a minority is "a group of people, who, because of physical and/or cultural characteristics, are singled out from the others in society in which they live for differential and unequal treatment and who therefore regard themselves as objects to collective discrimination" (p. 347).

A FEMINIST LENS WITH THE MULTISYSTEMS MODEL

There is a paucity of research and literature regarding therapy with this unique population. Although many theories have been developed to effectively provide mental health services to families, they do not specifically address the special needs of families below the poverty line. Feminist family therapies and the multisystems approach (Boyd-Franklin, 1989) hold promise for addressing the uniqueness and complexity of families in therapy who are poor. Feminist family therapies do not purport to be new models or theories for working with families but rather a lens or worldview that can be applied to many theoretical models, provided no interventions are gender-based or oppressive (May, 2001). The multisystems approach (Boyd-Franklin, 1989) is a specific model that is founded on Minuchin's (1974) structural family systems theory. Boyd-Franklin's (1989) multisystems approach recognizes the importance of examining the multiple levels and systems of families. In this article, I discuss the common principles of feminist family therapies and multisystems family therapy and how they can be applied in providing effective family therapy to families who are poor. Furthermore, I note the special considerations for family therapists when families are referred by or are working with outside agencies.

When working with poor families, therapists must be able to "distinguish unconscious depression from conscious despair, paranoia from adaptive wariness, and a sick (family) from a sick nation" (Grier & Cobbs, 1992, p. 158). Feminist family therapies have attempted to address this notion through their countering of society's ideology of the "normal" family with special emphasis on gender and power issues in family relationships and society (Ault-Riche, 1986; Goodrich, Rampage, Ellman, & Halstead, 1988; Horne, 2000; May, 2001). Feminist family therapists challenge society to put an end to the stigmatization of this culture and to acknowledge and recognize impoverished families for who and what they are.

Feminist family theory postulates the importance of acknowledging the larger context of the family and asserts that therapy without the exploration of the family's "larger system" is for naught (Horne, 2000). The multisystems approach also stresses the need to address the larger systems in the lives of disadvantaged populations for family therapy to be effective. Family therapy is based on the idea that to help individuals change their behavior, it is important that the therapist understands and acknowledges the historical context from which the family developed. Moreover, when working with underserved populations, as well as people of color, it is beneficial to "both conceptualize and intervene at multiple levels and in multiple systems" (Boyd-Franklin, 1989, p. 134). These systems might include the individual, the family of origin, the extended family, nonblood kin, and others. In addition, when working with some disadvantaged families, therapists must also consider the social services system.

The multisystems approach consists of two axes that are based on a concept of circularity suggesting that problems are sustained by a repetitious series of actions and reactions. The first axis includes the general variables of the "therapeutic process," which are joining, engaging, assessing, problem solving, and interventions to facilitate change in the family system (Boyd-Franklin, 1989).

The second axis provides a framework that allows the therapist to provide treatment effectively at any level (individual, family, extended family, or other systems) that is relevant to the issue being addressed. The multisystems model allows the expansion of the therapeutic frame of reference and therefore the capacity to provide effective services to poor families. The second axis encompasses the following multisystems levels: (a) individual, (b) subsystems, (c) family household, (d) extended family, (e) nonblood kin and friends, (f) church and community resources, and (g) social service agencies and other outside systems. Lower-class families, struggling to meet the priorities of subsistence, generally seek therapy when it is their last option or when they are coerced by external systems. Many families enter treatment with a vague sense of what counseling entails as well as a concern that their expectations will clash with those of the therapist. It is common that they will feel apprehensive about the therapeutic process and will not attend, consequently resulting in one family member attending therapy (Boyd-Franklin, 1989). Nevertheless, the individual family member can assist in the therapist gaining credence with other members of the family.

Like many minority families, the underserved populations' support system supersedes the family of origin. Their support network may consist of family, extended family, and neighborhood friends with whom they share the responsibility of child care, transportation, and so forth. Although there is no blood relation, these additional individuals are considered "family" and they receive the rights and status of blood

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relatives. On establishing trust with the family, the therapist will have the ability to gain more knowledge regarding the extended family system. Questions that ask about current living arrangements and assistance with child care will assist in the exploration of the extended network. A helpful way to organize and explore the extended family network is through the use of the genogram.

Family therapists must be sensitive to the role that the spiritual belief system plays in the lives of impoverished families, especially African Americans. Clinicians are encouraged to explore it as though it is a natural part of the interviewing process, and failure to do so may cause irreparable damage to the therapeutic alliance. Spirituality is used as a coping mechanism and should be integrated into the counseling process. "Jesus will fix it by and by" is a popular "spiritual reframe" used by believers, which conveys that a belief in a higher being will sustain the family through adverse circumstances. It would be advantageous for therapists to integrate spiritual themes into the counseling process through the use of reframes when families are experiencing quandaries. Through the use of religion and social service, the church plays a principal role in the revitalization of hope in underserved communities. Some churches provide child care, after-school and mentoring programs, free meals and clothing, psychospiritual classes, and a social network for likeminded individuals. When families experience emergencies (familial and physical losses), they rely on the church for assistance and support. Although some families are not members of the church, they are welcomed with open arms. Therapists should have an awareness of the church's level of intervention when attempting to mobilize impoverished families (Boyd-Franklin, 1989; Hines & Boyd-Franklin, 1982; Ho, 1987; Saba, Karrer, & Hardy, 1990).

SPECIAL CONSIDERATIONS

Social services and public institutions constitute the final level and are external structures that could possibly be salient to the treatment outcome of families in poverty. Many families are dependent on these systems for survival. A missed welfare check means having insufficient funds to pay the rent for housing or feed the family. Boyd-Franklin (1989) noted special considerations when working with low-income families.

1. It is important to be aware of the families' relationships with external organizations such as social services, the school system, the court system, and many other agencies. Many poor families receive government benefits and are mandated to participate in activities (e.g., mental health services, adult basic education classes, workforce development exercises) that will assist them with their transition from welfare to work. Due to their involvement with social services, there is a lack of privacy regarding personal and financial issues. There is also a concern that therapists will report their disclosures, their progress, or lack thereof to government officials (e.g., a male partner restricted from residing in the home), which could result in the termination of financial benefits. Boyd-Franklin (1989) suggested that therapists candidly address this issue with the family during the beginning phase of treatment as well as explain the terms of confidentiality.
2. Like many African Americans, underserved populations suffer from hypervigilance. Consequently, therapists, like intrusive referral sources, are viewed as the enemy. The therapist should make a distinction between his or her role and that of the outside referring agency. For further clarification, therapists are encouraged to contact the referral source to determine the expected outcome of the therapeutic interventions, which might conflict with the families' goals. Therapists are warned to avoid triangulation between the referring agency and the family (Boyd-Franklin, 1989). By allowing the family to enact and role-play their roles and relationships with outside agencies, therapists are empowering the families to strategize and create solutions to their problems.
3. On joining and establishing trust with the family, it is suggested that the therapist construct an "eco map" (Holman as cited in Boyd-Franklin, 1989) to further assess the roles of social and community organizations. The eco map is a drawing that depicts the relationships that the family has with other agencies. This map can assist with determining which agencies are contributing to the family's problems in a positive or negative fashion. The eco map could also determine resources that the family has not been privy to.
4. As noted above, poor families are generally dealing with many other pressing issues at once. If a family is referred by social services because there is concern that the parents are neglecting the children, the family may be too overwhelmed by environmental stressors to fathom a discussion on appropriate parenting. Therapists must remember to meet the families where they are and on their terms. Boyd-Franklin (1989) suggested that therapists assume the role of facilitator of change and use the initial sessions to assist the family with addressing emergency needs such as assistance with shelter, utilities, transportation, and so forth. This is accomplished through locating and referring families to community resources. Many poor families feel powerless and helpless, and it is important that they know their therapist is genuinely concerned about their welfare. When working with underserved populations, action is stronger than words. Therapists are encouraged to "roll up their sleeves and get to work" (Boyd-Franklin, 1989, p. 162).

PRINCIPLES OF THE MULTISYSTEMS APPROACH AND FEMINIST FAMILY THERAPIES

The multisystems approach intertwines with feminist family therapies. Both models seek to foster cultural sensitivity and competence of therapists and laypersons alike (Boyd-Franklin, 1989). This sensitivity is facilitated through acknowledging the diversity among impoverished families as well as the promotion of economic and social parity. Both approaches challenge therapists to be aware of how their val-

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ues and assumptions affect the therapeutic process (Aponte, 1991; Boyd-Franklin, 1989; Ziemba, 2001). Family therapy with poor families in particular is an "active therapy" requiring that clinicians examine and understand how their cultural and religious beliefs impact their therapeutic practices. Therapists must examine their own families and their own cultural identification as well as their own beliefs about poor families. Intimate knowledge of the family being treated is vital to assessment and treatment. Grier and Cobbs (1992) contended that some clinicians may instinctively withdraw from having an intimate knowledge of self and the poor family they treat because sometimes placing themselves in the position of the family, socially and mentally, can be extremely painful and taxing. Once the therapist has explored his or her own beliefs, biases, values, and so on about what it means to be poor, he or she is in a very different position to work with these families.

The multisystems approach and feminist family therapies also place great emphasis on empowerment. The goal of the therapeutic process is to provide families with a sense of personal control and to encourage the family members to take an active role when confronted by negative life events. Both models look for and build on strengths, which is essential to their work with poor families. Families often experience victimization, which leads to feelings of powerlessness and entrapment by society (Ziemba, 2001). Feminist family therapies place a greater emphasis on the gender socialization roles of women in personal, interpersonal, and institutional settings (Enns, 1997; Seem, 2001). A mother who feels oppressed by child welfare agencies is empowered when she is able to enter into a counseling session with both the therapist and social service agent and she is able to voice her concerns and make requests in a respectful and assertive manner. This setting epitomizes an effectual "restructure" and communicates the structural message to the children that their mother is in charge. It is through this kind of examination and the therapist's ability to convey respect for the families that empowerment can occur (Boyd-Franklin, 1989).

Both models also stress nonhierarchical therapeutic relationships (Boyd-Franklin, 1989, 1993; Enns, 1997; Horne, 2000; Ziemba, 2001) in the treatment of poor families. As stated earlier, poor families often depend on outside agencies for very basic needs and services. Often each agency is perceived as a mysterious maze of individuals who do not give clear answers or show respect. The therapist does not assume the role of expert but becomes an "agent of change." The therapeutic relationship is one that is filled with reciprocity and mutuality, deep respect, and appreciation of the family's strengths and resources (Enns, 1997; Goodrich et al., 1988; May, 2001). In addition, family therapists attempt to create an environment that is respectful of the expressions of each family member (Horne, 2000).

The feminist family therapy models emphasize individual and family well-being (Ziemba, 2001). From a feminist perspective, the subordination of personal needs to the needs of the family is avoided. Although therapists promote personal well-being, the needs of the family remain the central focus of the therapeutic process. It has been noted that many poor families have a collective focus and struggle with the concept of finding a balance between cultural and familial expectations and the ability to meet the needs of the individual (Atkinson et al., 1993; Boyd-Franklin, 1989; Denny, 1986). For many minority families in which the tradition of a collective identity can be delineated to their ancestral legacy, this struggle can be very overwhelming. Both feminist family models and the multisystems model deem individual therapy an option for a family member and provide the flexibility to allow this possibility.

CONCLUSION

Boyd-Franklin (1989) defined the multisystems approach as an expansion of the "road map" that therapists use when counseling underserved families. This approach allows the counselor to acknowledge problem resolution as a focal point and to examine how each system level sustains the problem that a family is struggling to resolve (Boyd-Franklin, 1989). Similarly, feminist family therapies challenge therapists to be more inclusive of diversity and to focus on societal transformation as well as individual family change. Gender and power arrangements are explored to determine whether they are contributing to the family's difficulties.

According to both of these approaches, to become more effective family therapists, clinicians will need to acclimate themselves to the "cultural exigencies" and belief systems of their underserved clients. Furthermore, it is important to remember that poor families, like many families, simply want to feel understood and validated. Underserved families are in quest for an implicit message that can only be supplied by the therapist, which is, as follows:

> Here is a second chance to organize your inner life and (familial structure) . . . you have a listener and companion who wants you to make it. If you must weep, I'll wipe your tears. If you must hit someone, hit me. I can take it. I will, in fact, do anything to help you be (the family) . . . you can be—my love for you is of such an order. (Grier & Cobbs, 1992, p. 180)

REFERENCES

Aponte, H. J. (1991). Training on the person of the therapist for work with the poor and minorities. *Journal of Independent Social Work*, *5*, 23-39.

Atkinson, D. R., Morten, G., & Sue, D. W. (1993). *Counseling American minorities: A cross-cultural perspective* (4th ed.). Madison, WI: W. C. Brown & Benchmark.

Ault-Riche, M. (1986). *Women and family therapy.* Rockville, MD: Aspen Systems.

Boyd-Franklin, N. (1989). *Black family in therapy: A multisystems approach*. New York: Guilford.

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Boyd-Franklin, N. (1993). Race, class, and poverty. In F. Walsh (Ed.), *Normal family processes* (pp. 361-376). New York: Guilford.

Denny, P. A. (1986). Women and poverty: A challenge to the intellectual and therapeutic integrity of feminist therapy. *Women & Therapy*, *5*, 51-63.

Enns, C. Z. (1997). *Feminist theories and feminist psychotherapies: Origins, themes, and variations*. Binghamton, NY: Harrington Park Press.

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1988). *Feminist family therapy: A casebook*. New York: Norton.

Grier, W., & Cobbs, P. (1992). *Black rage*. New York: Basic Books.

Hines, P. M., & Boyd-Franklin, N. (1982). Black families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 84-107). New York: Guilford.

Ho, M. K. (1987). *Family therapy with ethnic minorities*. Newbury Park, CA: Sage.

Horne, A. M. (2000). *Family counseling and therapy* (3rd ed.). Itasca, IL: F. E. Peacock.

Jargowsky, P. (1994). Ghetto poverty among Blacks in the 1980s. *Journal of Policy Analysis and Management*, *13*, 288-310.

May, K. (2001). Feminist family therapy defined. In K. May (Ed.), *Feminist family therapy.* Alexandria, VA: American Counseling Association.

McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, *53*, 185-204.

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

Nichols, M., & Schwartz, R. (2001). *Family therapy: Concepts and methods* (5th ed.). Boston: Allyn & Bacon.

Popple, P. R., & Leighninger, L. (1993). *Social work, social welfare, and American society* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Reddy, M. A. (1993). *Statistical record of Hispanic Americans*. Detroit, MI: Gale Research.

Saba, G. W., Karrer, B. M., & Hardy, K. V. (1990). *Minorities and family therapy.* Binghamton, NY: Haworth.

Seem, S. R. (2001). Feminist family therapy: For heterosexual couples and families only? In K. May (Ed.), *Feminist family therapy* (pp. 29-52). Alexandria, VA: American Counseling Association.

U. S. Bureau of the Census. (2000). *Statistical abstract of the United States: 2000*. Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services. (2000). *Temporary assistance for needy families program*. Retrieved July 2, 2002, from the World Wide Web: http://www.acf.hhs.gov/programs/opre/characteristics/fy2000/analysis.htm

Walsh, F. (1998). Beliefs, spirituality, and transcendence: Keys to family resilience. In M. McGoldrick (Ed.), *Revisioning family therapy: Race, culture, and gender in clinical practice* (pp. 62-77). New York: Guilford.

Wilson, W. (2001). The truly disadvantaged: The hidden agenda. In S. Fainstein & S. Campbell (Eds.), *Readings in urban theory* (pp. 191-215). Cambridge, MA: Blackwell.

Ziemba, S. (2001). Therapy with families in poverty: Application of feminist family therapy principles. *Journal of Feminist Family Therapy*, *12*, 205-237.

Zigler, E. (1994). Reshaping early childhood intervention to be a more effective weapon against poverty. *American Journal of Community Psychology*, *22*, 37-47.

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