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A Case for Family Therapy for Low-Income Families

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A CASE FOR FAMILY THERAPY FOR LOW-INCOME FAMILIES

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Table of Contents

INTRODUCTION

Professionals working with the poor either in research or in treatment, report that for nearly three decades the mental health needs of the disadvantaged have focused more on describing problems then on proposing and evaluating solutions (Lorion, 1970). When programs have been initiated, such as Ira Gordon's (1969) lengthy study with indigent teenage mothers, financial cutbacks occur and either significantly decrease or render the service impossible to provide. As in the past and at present, the mental health delivery system's attitude toward socioeconomic needs of the low-income and minority groups has been negative and pessimistic (Riessman, 1964; Clark, 1965, & Rainwater, 1966). Socioeconomic level and race appear to be barriers for gaining access to psychotherapeutic services. These same barriers seem, paradoxically, inversely related to the prevalence of psychopathology among the poor (Hollingshead & Redlich, 1958). Those most in need appear to be the least served (Lorion, 1970).

This project will focus on three points: I will review the literature about the life style and family patterns of the disadvantaged, as well as the psychosocial resources currently open to them. Next I will present a survey of pretreatment and treatment approaches that can be effective in caring for their mental health needs. Finally, I will suggest modes of family therapy which I believe to be effective in treating lower income families.

Blacks have been disproportionately represented among the poor. The literature reviewed will reflect this. Also included in references to the poor will be disadvantaged whites as well as the working class because of their historic problems in obtaining therapy and, once obtained, of seldom remaining long enough for effective adjustment to occur (Riessman, 1964; Giordano, 1973).

Serving the mental health needs of the poor is a complex issue that deserves attention by all, especially mental health professionals directly involved. Research will clearly indicate the crucial role of the therapist. The fact that most practitioners are raised with middle class standards and values can bias their viewpoints. They are trained in college and universities by middle and upper class professors whose perspective of theory and treatment is most often not empirical but based on second-hand information, hearsay and stereotypes. Beginners in the field of psychiatry, psychology and social work are assigned to clinics and agencies to work with the poor and minorities, yet they lack the experience and training for this specialty. I propose that it is essential for mental health workers to understand three basic principles. First, the poor and the minorities are heterogenous, not homogenous. Second, lower social class stresses like the perpetual lack of economic resources cause greater incidence of mental illness. Finally, behavior that stems from a culture of poverty and the influence of ethnicity on behavior has been sometimes falsely described as pathological.

The final focus of the project will describe what therapeutic approaches with the poor have been effective or ineffective and why. Family therapy will be the model that I propose.

Social Class and Mental Illness

Research

There appears to be a complex relationship between social class and mental illness. While we are becoming increasingly aware of the mental health problems of the lower socioeconomic segments of our society, we have also recognized and documented the inadequacy of the mental health services available to them (Reissman, Cohen, and Pearl, 1964). Added to this is the perplexing problems facing therapists of not having adequate knowledge and skills to engage and treat the poor. To complicate the problem further, the low-income person makes the decision to come into treatment only to find difficulties with paying regular transportation costs, clinical hours not suited to his work schedule, problems securing babysitting, requirements of the agency that he doesn't understand or can't fulfill and with aspects of treatment for which he's unprepared.

Traditional approaches do not seem advantageous to meet the problem of care for great numbers of people, especially the poor. Freud recognized that psychoanalytic therapy was inappropriate and needed to be altered or other approaches devised for the poor to be helped...

> One may reasonably expect that at some time or other the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has for the surgeon's means for saving his life;...The task will then arise for us to adapt our techniques to new conditions. I have no doubt that the validity of our psychological assumptions will

> impress the uneducated too, but we shall need to find the simplest and most natural expressions for our theoretical doctrines. We shall probably discover that the poor are even less ready to part with their neuroses than the rich, because the hard life that awaits them when they recover has no attraction and illness in them gives them more claim to help of others. Possibly, we may be able to achieve something if we combine aid to the mind with material support. (Freud, 1958)

Since our mental health system has been at an impasse to serve a significant portion of the population, there has been the need to assess salient aspects of the disadvantaged lifestyle to provide appropriate services (Riessman, et.al, 1964). Riessman goes on to say that we have lacked understanding of racial and socioeconomic parameters that prevented successful therapeutic interventions. According to traditional standards for diagnosis, we have found a high incidence of psychopathology in this same population. Yet we have not closed the gap between study and description of the problems and development of resolutions (Lorion, 1972; Riessman, et.al, 1964). The lower class should not be considered in a global fashion as a homogeneous group. There is the need to generalize at times, but it is important not to stereotype. Hollingshead and Redlich (1958) conducted a study in the New Haven community and developed an Index that has been used as an instrument for determining socioeconomic status (SES) for psychotherapy. Their Index was later revised to define class status according to occupation and educational level (1959). Table 22-1 summarizes the given levels and their defining characteristics. The members of Class IV and V make up the disadvantaged subgroups. They are characterized by manual occupations, little formal education, little upward mobility, and few material possessions (Gans, 1962; Miller, and Riessman, 1969).

TABLE 22-1 Occupational, Educational, and Familial Characteristics of Five Socioeconomic Status Levels

Class	Occupational Level	Educational Level	Family Structure
I	Salaried positions in policymaking executive level; private-practice professionals	Professional degrees A.B. level and beyond	Modal nuclear family of parents and children, with stability encouraged
II	Salaried positions in business and professions; minor professionals included	A.B. level or partial college	Modal nuclear family of parents and children, with stability encouraged
III	Middle-class administrative, clerical, sales, technical, and semiprofessional positions	High School diploma	Modal nuclear family of parents and children, with stability encouraged
IV	"Working-class" skilled and semiskilled manual occupations in unionized trades and industries	High School or technical school diploma with some below tenth grade	Modal nuclear family often three generations, instability more common than I to III
V	"Poor" semiskilled and unskilled manual occupations nonunionized with irregular employment	High School diploma infrequent with many not completing 8th grade	Modal nuclear family extended to three to four generations; divorce, separation, and instability common

Note: The socioeconomic status levels are referenced in Hollingshead and Redlich (1958). Table from Lorion (1973).

Mental health practitioners have used this Index to categorize group similarities and overlooked their differences. Hollingshead and Redlich's conclusion that "the lower the socioeconomic class the higher the rate of mental illness" was challanged by other researchers (Miller and Mishler, 1959; Langner, 1963). Miller and Mishler (1959) in their review of the problem and after significant reevaluation of the previous findings, concluded that there was not a clear-cut continuum between mental illness and social class according to the Hollingshead and Redlich report. Miller and Mishler criticized the use of prevalence. Data reported in such a way purports by implications to answer questions beyond its scope (1959). The distinction between "prevalence" and "incidence" is extremely important. "Prevalence" refers to the total number of active cases in the population during some specified time; "incidence" refers to the occurrence of new cases during a specified time. Prevalence rates are affected by a number of factors that can be misleading in understanding the relationship between social class and mental disorders. Miller and Mishler believe that a higher rate of mental disorder among one segment of the population being studied might mean that this group had less access to treatment resources available. One aspect documented by Miller and Mishler in the New Haven study was that, because of their social class position, differential treatment was accorded those suffering from mental illness. Langner (1963) related from his study of Midtown Manhattan that there is a definite inverse relationship between social class and mental illness. (That is, the lower the social class, the greater likelihood of mental illness.) The study focuses on a large untreated population, the poor. Researchers believe we need more longitudinal studies to improve upon the cross-sectional investigations,

such as the New Haven and Midtown studies, in order to prevent future erroneous studies from being read as final conclusions and in order not to be satisfied with correlations as a basis for cause and effect relationships (Riessman et.al., 1964; Gans, 1962; Langner, 1963; Miller and Mishler, 1959). The greatest danger is to assume that poor people are completely homogeneous and require only one particular kind of treatment. Instead, help must be based upon understanding specific needs of the poor. Lorion (1978) writes that it is important to recognize that poverty is primarily an economic problem instead of a psychological state. Nearly 10% of the population, more than twenty million people, fell below the Poverty Line. Economic limits cause psychological consequences that are multiple and negative. Kleiner and Parker (1967) provided a review of the literature in the '60's, and Lorion in the '70's reviewed the relationship between status and mental disorder. The data is complicated by definitions of "mental disorder" by different methods of casefinding and by the nature of the class system in the community being studied. In their review, however, they found one consistent relationship: where social striving existed, there was a larger discrepancy between achievement and aspiration in populations with known psychopathology. Kornhauser (1962) investigated another aspect relevant to mental illness of the poor. Mental health hazards were inherent in occupational tasks of lower socioeconomic groups. He reflected on the noxious influence of monotonous, frustrating, and hated dead-end jobs faced by the unskilled worker. Being poor also defines economic and educational opportunities and limits one's existence and patterns of daily behavior. Life becomes characterized by an endless

series of crises (Riessman, 1964; Rainwater, 1966). Upon reflection, mental health professionals came to realize that they knew little about the life styles, family patterns and psychosocial resources except by stereotype (1964, 1966). It is essential to have empirical information of the disadvantaged life style to provide appropriate services since social status, race and socioeconomic parameters prevent the poor from finding effective therapeutic treatment alternatives and we from providing them (Lorion, 1976).

Implications

It seems imperative for professionals, as well as the public, to understand where services for the poor break down in their effectiveness. It also seems ironic for therapists to work with a population that they are ignorant about. Instead of Hollingshead and Redlich's Index (1957) clarifying our understanding of the relationship between mental illness and poverty, it has added to our prejudices and allowed us a further stereotype, "people who live like that are crazy". We judge them crazy by their standards of living. Later research attempted to clarify the difference between prevalence and incidence in relation to the 1957 study, but I'm not sure that it changed the minds of the general public. Further research has documented that services for the poor aren't as plentiful and are different than services for the middle and upper classes. I believe that there is a correlation between the lifestyle of the poor, their sense of hopelessness because of lack of opportunity and the continual crises that affect their mental health.

The Culture of Poverty and Low Income Behavior Research

Previous global considerations of the "lower class" have ignored and underemphasized their extensive heterogeneity (Hollingshead and Redlich, 1958; Lorion, 1973). Significant heterogeneity exists both across and within each of the disadvantaged cultures (Lorion, 1973). There are two explanations for the definition of culture that will clarify an understanding for the developmental behavior, the lifestyle and the family patterns of the poor. The word "culture" involves two different meanings applicable to this study.

(a) The customary beliefs, social forms and material traits of racial, religious or social groups.

(b) The integrated pattern of human behavior that includes thought, speech, action and artifacts and depends on man's capacity for learning and transmitting knowledge to succeeding generations. (Webster's New Collegiate Dictionary, 1976)

Definition (a) will apply to the first section of this chapter and definition (b) to the second.

Cohen (1964) has described the mistake often made by social workers and other health-care practitioners after reading and taking literally some descriptions of lower class behavior. When confronting a real-life situation with a family or individual, a great deal more diversity is found than anticipated and the worker is surprised, disenchanted and perhaps confused or upset. The family or individual does not fit their

stereotypic views. There can be unfortunate consequences to follow when information from the SES client is not used in discreet and humane ways by the therapist. A thoughtless phrase as "I didn't expect much from him since most Blacks aren't as motivated". Cohen believes there will always be a great deal of behavioral variety within any subculture. "Subcultures", he states, "are not nice, clean, distinct entities; but there is much intermingling with the larger culture (1964)".

Linton (1956), an anthropologist in the 1940's, recognized that members of a social class are shaped by their own subculture. Although there are considerable variations within the subcultures, personality norms are learned from the subculture. Further, he found that while a high frequency of certain traits may be found within a subculture, their combination will vary from individual to individual, producing a somewhat different total picture. Anthropologists like Linton (1956) believes that several important benefits are gained from studying a particular culture. These benefits include being able to understand the manner in which adaptation, adjustments and problem-solving are handled. There are, however, many variations for doing this in each subculture. Before focusing on these variations, I'd like to present certain psychological limits that researchers have noted.

First, the general population sees the poor negatively and the poor also see themselves as unsatisfactory. The terms "poor", "disadvantaged", "lower socioeconomic status", "lower-income", "indigent", and "high risk" refer to those persons having the fewest economic, educational and cultural resources. Miller (1964), believes it is absolutely essential to demarcate

types of poor people. The label "lower class" distorts an already complicated situation. A clearly defined "lower class" doesn't exist. Understanding a group of people means understanding the cause and consequence of happenings. It means understanding that limited education affects potential for change. Second, he goes on to say that we must also believe that the lower class is willing to make positive change and is capable of it.

Researchers found that public opinion believed generally the opposite. The poor were regarded by the larger society as despicable (Gladwin, 1967). They were discussed and debated by most middle class whites as to their merits of being "deserving" or "undeserving", "respectable" or "degraded" (Sarbin, 1970); Lewis, 1966; Gladwin, 1967). Rainwater (1970) states, "the poor are perceived and see themselves as disinherited and not included in the collectivity that makes up the real people". Feagin (1975) and Gladwin (1967) report that the poor are described as "lazy", "shiftless", and "impulse-ridden" and somehow responsible for their poverty. Their daily existence contradicts the basic American ideal that success is achieved through self-effort. The poor are not oblivious to the attitudes and perceptions of the larger society (McKinney, Lorion & Zax, 1976). Becuase they have not overcome their state of poverty, they are perceived as incompetent (Gladwin, 1976). Until recently, many of the poor and especially Blacks, have shared these same attitudes about themselves. Because of this, the feeling of hopelessness has pervaded their life (Alinsky, 1967; Haggstrom, 1964; Gladwin, 1967). Unfortunately, some regard their predicament as a consequence of personal disability, either inherent or imposed (Clark, 1965). How can

the poor live up to the demands and expectations of the larger society? Clark believed that for them to prove themselves adequate and deserving, we must allow them the essential human rights of frailty and imperfection. This culture of poverty didn't originate in the ghetto (Comer, 1980). Comer has noted that low self-esteem, lack of belonging in a society and insecurity came as a result of a lifestyle predicated on difficult physical survival, lived under degrading conditions. He goes on to state that at the same time, they experience rejection and abuse as inferior or less than deserving persons in a controlling and powerful white society. Comer writes:

> Respect and dignity came primarily from acceptance or approval by the white master. This came from being a good slave or accepting an inferior life status. Individuals and families within this psychological and social organization framework developed copying skills and adjusted to the slave role, but could not develop a healthy sense of themselves as Blacks - they learned to ignore the absence of dignity and respect (1980).

Comer continues that until the 1940's more than ninety percent of the black population worked as share-croppers, tenant farmers, low-paid laborers and domestics - the lowest level in the job market. In America there has occured a three-generational movement from unskilled to moderately-skilled to highly-skilled and educated people. Many minorities in recent years unfortunately have not been able in any large numbers to alter their lifestyles (1980). Growing up in the slums involves an ever-increasing appreciation of one's short-comings and of the impossibility of finding a self-sufficient and gratifying way of living (Clark, 1965).

Ghetto living originated in Venice during the 16th century. It was the living quarters for Jews who were confined not only physically but emotionally and mentally by clear prohibitions denying other freedoms in life (Clark, 1965). Clark has described ghettos in America as economic colonies that perpetuate themselves through cumulative ugliness, deterioration and isolation. He believes they serve to strengthen the individual's sense of worthlessness and impotence. Clark also writes that the poor are relegated to live in these urban areas by a larger white-dominated society (1965).

Rainwater (1966) examined ghetto life and came to the conclusion that Blacks have created within the slum a structure of roles and group life that will aid them in their task of surviving a victimized life and will minimize the pain it produces. The ghetto operates according to social networks - the extended "kinship system" and the "street system" of buddies and broads. Although tenuous and unpredictable, it ties members to each other. Other institutions such as the church, provide escape from being a victim of society by focusing on the life hereafter, while the Civil Rights Movement (because of leadership programs such as Jesse Jackson's Operation Push) deal with concern for changing life now.

In the 1940's when Blacks rapidly moved from rural communities to urban areas looking for jobs, a very high proportion of the households became headed by women. During the years of slavery, the man was first separated from his family as a permanent prevention of family bonding (Comer, 1980). A disproportionate number of black male adults were unable to earn a living wage, take care of themselves and their families and control their own environment. They lacked a sense of adequacy,

control and belonging which related directly to their being able to do these things when slavery no longer existed (Comer, 1980). Sometimes females could earn wages more easily than males which was one factor leading males not to remain in the household (Rainwater, 1966). Elliot Liebrow points out in Tally's Corner, that even the father's decision to leave is an adaptive effort because the black male could meet the affectual and relationship needs of the family but had to rely on public aid to meet the economic needs (1966). Some black men arranged to leave their families to make them eligible for support (Comer, 1980; Liebrow, 1966; Rainwater, 1966).

In the ghetto, having the first child held the same importance as the first marriage. This first pregnancy was indicative of a girl's becoming a woman. Parents sometimes tried to hold children to stable family norms while the ghetto culture affected the spouse relationship. The mores of the slums allowed each partner the freedom for sexual relationship with a boyfriend or girlfriend with no questions asked. Marital bonds were held tentatively. The initial steps toward mating and family formation developed in highly-structured peer groups as early as twelve and thirteen years of age and involvement continued until after the first pregnancy and first marriage. Commitment to the same-sex peer group meant a life for social activities and sharing of personal matters.

The slum community provided experiences for young people from which delinquent behavior emerged almost imperceptibly (Rainwater, 1966). Lewis (1964) described the behavior for delinquency emerging as a manner of mastery over this environment. The adolescent interacts with the

adult in "high-life" activities that represents an identification with adult behavior. The "street system" for young men enhances their status as significant persons by their ability to win women by giving sexual favors or material benefits. Women are not expected to remain virgins except for reasons of lack of opportunity or immaturity. Males are forced toward testing their strength as seducers and are mercilessly rated by their peers and the opposite sex if they are unable to "talk" to girls or if they have a "weak line" (being able to convince girls to respond to them). Girls have extremely strong ties with their peers. Although they may engage in sex with a number of young men, they are careful about not getting pregnant. Because fewer restrictions are placed on their behavior, there is not the same desire for these girls to get away from home, as in middle class homes. Pregnancies among young poor black girls is not a disgrace as it is with girls in Class I, II & III SES. In marriage, the male doesn't necessarily give up all gratifications involving the street system, but he is to become a provider. His premarital sexual relationships do not carry the responsibility of fatherhood. The arrangement is fragile and based on affectional ties. It doesn't provide stabilization and a gratifying experience because many times it was arranged impulsively.

Male and female roles remain segregated in family functions of responsibility, recreation and outside interests. If the father is responsible and brings home the check, he is free to indulge himself. If the mother makes the home comfortable and clean and cares for the children, she often goes her own way at leisure moments and not with her husband.

When there are two incomes, the wife is to support herself and the children, and the husband keeps his own income for himself. White lower-class wives are often intimidated by their spouses, whereas black women usually are not. If the husband does not provide financial income, the black wife often refuses to perform her duties. Money coming in is what counts - not whether the male works to bring it in. Gambling on the street is a common way for men to earn an income. Women make most family decisions and they also carry the greatest responsibility. For day-to-day problems, women seek support and counsel, not from their husbands, but from other women.

When the husband is not working, alcohol becomes the wife's enemy. Then, mother's control of the household is often superficial. Their children come home at any hour and do not contribute to the maintenance of the home.

When women beyond the age of child-bearing may take on a boyfriend or paramour, this relationship revolves around food, money, sexual favors or companionship. It can either be a steady relationship as the male becomes a pseudo-member of the family or an otherwise less-than-regular relationship. The female role emphasizes self-sufficiency. She is most secure when she can manage her family affairs and dominate her men. The male world emphasizes expressive, affectional techniques for making one's way in the world. He tries to avoid exposing himself to risk of failure by not assuming the roles of husband and father but counts on his ability to court women and ingratiate himself to them. Such a listing of characteristics for any population must be thought of as "generalizations". Any grouping of characteristics are clearly not descriptive of everyone and every ghetto situation.

The lower class needs to be distinguished from the working class. There are similarities but there are also differences. Cohen (1964) cites some of these similarities and differences in his article "Social Work and the Culture of Poverty". According to Cohen's analysis:

DIFFERENCES: THE LOWER CLASS

1. Lives under more difficult and deprived conditions.
2. Has less access to middle class goals and goods.
3. Has less access to the working class means of organization (e.g. unions).
4. Has less stability in terms of jobs, neighborhood and family.
5. Has fewer working-class traditions and fewer urban experiences.
6. Has a different ethnic composition, a larger proportion of Blacks and Spanish-speaking people.

SIMILARITIES: BOTH GROUPS

1. Perform manual work for their livelihood.
2. Are essentially removed from the middle class mobility.
3. Live a "realistic" concrete-centered, physical life; and the mental styles of both are quite similar.
4. Have a family and community life that constrains them toward some degree of interdependence and cooperation (although there is a greater strain in the lower class).

Walter Miller's (1959) study describes qualities of lower class culture as "tough", "daring", "exciting" and "rejecting authority". Gana (1962) expands this further in his description of family life.

The segregation of family roles and the separate lives of husbands and wives have been reported in studies among Puerto Ricans both in Puerto Rico and in the United States. In Mexican families and as already described in Black families, the marriage relationship does not develop into an intensive bond. There seems to be no rigid set of

expectations to which the other must conform. The same study notes the male's need to display his masculinity. The peer group instead provides for supportive relationships. The family tends to be adult-centered and children are not focused upon as in middle-income families. Often relatives are the only friends of the adults and if spouses do have friends, they see them not as a couple but on a single-sex basis. Anthropologists have labeled lower-class Black, Puerto Rican and Carribean families as "matrifocal". The man is often marginal. These families live what writers describe as "serial monogamy" - a pattern in which a woman lives with a series of men and has children with them. They either desert her one by one or she asks each to leave (Miller, 1959). During slavery, the formation of a normal family was discouraged and the Blacks' economic position has maintained a similar pattern. The man who has difficulty in finding a steady job and is laid off frequently finds it difficult to perform the functions of male breadwinner and household head (Gans, 1962). He goes on to say that women treat the men with disdain when they secure work or make it on welfare payments and he complicates life by getting her pregnant. The incentive for the man to stay in the family isn't there. As the male grows up in a female household, he is a powerless and scorned figure. The pattern of male inferiority is perpetuated (1963).

This section of Chapter Three presents what researchers describe as the developmental characteristics of the poor. Cohen (1964) believes it is important to view social structure as shaping the behavior of the poor as a natural consequence of the conditions it imposed. Social structure, he continues, is also responsible for affecting the conditions

under which personality is developed. The socialization process for any individual growing up in the slums is a complicated process of thinking, feeling, behaving and communicating that are closely tied to the structure and processes of their family system (Minuchin, 1967). Minuchin looked at the culture of the slums from the position of a psychiatrist involved with minority families (Italian, Puerto Rican, Black and Jewish). He claims the home is the place where the major experiences of life are learned. He described a cluster of impermanent and unpredictable features as directly related to the slum family system.

In the socialization of the child, Minuchin observed two family characteristics. First, the parent's responses to their children's behavior was random and deficient in conveying rules which could be internalized. Second, the parent emphasis was on short-range control and inhibition of behavior rather than long-range guidance. Parental unpredictability in giving control signals prevented internalization of the family rules so a child was unclear about what behaviors were inappropriate. The child, instead of following established rules, defined his limits according to momentary parental mood and presence. "Don'ts" were learned in relation to pain or power of the mother or other powerful figures present. Because established norms were lacking to control behavior, the child depended on continuous parental supervision to regulate the norms of family life and to control interpersonal experiences. Parental control of this type develops into ineffective transactions with the child and perpetually overtaxes the mother. The mother responds erratically to the children's behavior and they obey only when an outside controlling figure is present. The child grows up looking for solutions

to problems in relation to the reactions of others. He doesn't develop introspectively to examine situations and examine himself for his own solutions to conflict.

Minuchin goes on to describe the home environment. The living arrangements are transient and internal arrangements, like who sleeps where are often uncertain. The care of the young is divided among many (mother, aunts, grandmother and siblings). Attention from parents fluctuates from profuse stimulation sometimes to none at all for other extended periods of time. Being cared for by mother, aunts and grandmothers and by sisters seems to make it difficult for a child to develop a sense of self. Development of self is hindered by randomness, much or little interpersonal contact, controls that shift with adult moods, lack of guidance and lack of orientation to norms. Theorists believe that lack of consistency leads to cognitive and emotional styles that are reactive and impulsive (Bernstein, 1962; Deutsch, 1963; Minuchin, 1967). They also see two tendencies developing in the low SES children's conceptual styles. These children think in global and non-analytic terms and react in motoric impulsive manners associated with poor focal attention (Berstein, 1963; Deutsch, 1963; Minuchin, 1965).

The following discussion on "Object Relations" was presented by Steve Phlaum at Family Psychological Services and was based on the written works of Hartmann (1958), Kernberg (1972), and Klein (1957). Object relation theorists believe that, in the development of the human personality, certain factors are essential and life becomes problematic when they are deficient or absent. The term "object constancy" refers to the psychological

and biological equilibrium that is dependent on the early social intereactions of the mother and infant. The infant needs repetitive encounters with the mother and, later on, other important persons and things in their environment. As the early months pass, the child grows to understand that the significant persons and things that are not visibly present or touchable have continued existence and retain their basic characteristics. This constancy of person permanence is affected by the mother primarily in the beginning but also by the father in later months and years.

When the mother does not provide the infant with sufficient emotional nourishment, or severely disappoints the child by lack of empathy for his needs, she can inhibit the child's early development. Mother is needed to reduce tension for her infant, to provide soothing and calming, to give sufficient physical and emotional warmth, to mirror feelings of self-worth by reflecting pleasure, consistency and competence and to confirm the infant's bodily existence by touching, holding, caressing and being attentive. These affects given by the mother and internalized by the child develop a foundation for basic trust, self-esteem and feeling worthwhile.

The father reinforces the negative aspects of Mom's behavior when he lacks understanding toward the infant and is disinterested and emotionally unavailable when baby is crying and father won't pick up the child even though the mother is tired. He needs to provide the child with the experience of learning the concept of what a father is to provide for the child's needs when the mother is emotionally unavailable. He needs to be a source of warmth and comfort and not reinforce mother's deficient interaction with the child (when mother is impatient about changing the baby's diapers, father does the job easily and playfully

with the infant). Father may reject the child's admiration, depreciate him, or allow Mom to be overprotective or rejecting. Either way the child is receiving messages from the most significant persons around as to his value and desirability. Mixed messages will be frustrating for the child.

Erikson (1959) believed that the infant learned early to distinguish between himself and those who satisfy his biological needs. The early interactions between the infant and his parents give him his ego identity or early self-concept. When interactions are pleasant, the child begins an attachment and learns to trust his parents. Sullivan (1953) believed the infant needs primarily a sense of security and satisfaction. Accordingly, the infant derives his sense of self from his parents' approval and disapproval of his behavior. Security or insecurity are gotten through the child's perception of his parents' positive or negative attitudes toward him.

Margaret Mead (1953), spoke of the vicious cycle of insecure parents creating insecure children, who grow up to create an insecure society which, in turn, creates more insecure parents. With this description, it is easy to understand the vital importance for positive interpersonal relationships between parents and child. It would not be difficult to imagine the negative repercussions coming from an environment that deprives infants of these necessary attachments in their early social development (Minuchin, 1967). The issue of sex role development was addressed by Sullivan (1953) and Erikson (1959). Sullivan regarded the important persons in shaping the child's personality and self-concept to be his peers and parents (1953). Erikson concurred with Sullivan and went further to say that appropriate sex role behavior resulted from

the child's identification with his same sex parent and assimilation of his parents' behavior into his own personal identity. Erikson (1959) described identity as, "the sense of continuity and social sameness that bridges what the individual was as a child and what he is about to become. He also needs to reconcile his concept of himself with his community's recognition of him".

Minuchin (1967) saw self-observation and communication as essentials coming from object constancy and consistency. For this to develop normally, there needs to be a certain order to the child's life involving significant people and things, plus the internal experience that he is affecting his environment. Self-esteem seems to be related to the discovery of self through one's effect on his environment. Mastery is achieved in a child's world of people and things where the sense of competence is developing. Minuchin believed the idea of ego development and the self-observing ego for the young child begins when he can focus attention on himself as an agent of change (1967). As ego development occurs in the child, the processes of separation and individuation happen. These processes can be blocked or hindered by the lack of privacy due to overcrowded conditions, lack of cohesiveness necessary for survival and a sense of success is prevented by a lack of varied experiences (Bernstein, 1962; Minuchin, 1967). Members of the lower economic class have little opportunity for mastery and its anxiety - reducing function (Cohen, 1964).

The early socialization process of the child affects his future developments for learning and adaption (Bernstein, 1962; Deutsch, 1963). The relationship of poverty-stricken parents to the conditions and consequences of their children's ability to learn is pertinent. Factors

such as a child's verbal skills, memory development, auditory-discrimination, organization and motivation are adversely affected in the slum community (Minuchin, 1967; Bernstein, 1962). The disadvantaged child approaches a more precarious situation upon entering school than entering therapy, although teacher and therapist must deal with similar differences and difficulties (Minuchin, 1967). Children coming from impoverished circumstances generally leave their educational experiences poorly equipped academically and also unsocialized by the institution. Deutsch and Bernstein propose that the lower-class child enters so poorly prepared to produce what the school demands that initial failures are almost inevitable and the school experience becomes negative. The culture of their home environment is different from the school environment and they come unprepared behaviorally and academically.

Deutsch (1963) and Bernstein (1960) have attempted to define aspects of the slum background that are most influential in producing certain deficits in skills. The slum child looks upon the larger society as an outsider and an observer. The public and the educational system does not recognize that there is a gap between the training of the teacher and needs, limitations and unique strengths of the child from a marginal situation. In the first grade, there are only slight differences between socioeconomic or racial groups, intellectual, language and conceptual measures. As the children progress into the later grades, the differences become more obvious. Social adaptation seems to be a problem to which teachers and the educational structure remain insensitive to. There lacks continuity for the child moving from one value system in the home to another in an educational institution. There needs to be continuity for sharing and participation in each other's value system.

The lower class Black child entering school has seldom, if ever, had a "successful" male model or a psychological framework from which to expect that effort will bring achievement. In the young child's experience, there is a dearth of objects as books, toys, puzzles, pencils and scribbling paper. For effective utilization of these tools, the children need continual use of the tools as well as guidance and explanations from adults that are aware. This is not usually true in a marginal situation and the commodity of time given by an adult to a child is limited. Periodically, many parents express high aspirations for their children. They are, however, unaware of the operational steps to prepare their child for optimum learning opportunities or feel unable to go through the steps or indeed are incapable. Hunt (1961) discusses the need for variety of experiences in the child's environment as expressed by Piaget:

> The rate of development is in substantial part, but certainly not wholly, a function of environmental circumstances. Change in circumstances is required to force the accommodative modifications of schemata that constitute development. Thus, the greater the variety of situations to which the child must accommodate his behavioral structures, the more differentiated and mobile they become. Thus, the more new things a child has seen and the more he has heard, the more things he is interested in seeing and hearing. Moreover, the more variation in reality with which he has coped, the greater is his capacity for coping (2. pp. 258-259).

The stimulation available to slum children is less useful to growth and activation of cognitive potential (Deutsch, 1963). Deutsch goes on to say, this deprivation affects both form and content of thought. Formal refers to operations or behavior by which stimuli are perceived, encouraged and responded to. Content refers to the actual context of the child's knowledge and comprehension. The child's environment affects

both formal and contentual cognition. Social poverty may be the major factor in deterring the development of individual skills and ability. Minimal range of stimuli in overcrowded apartments and lack of useful household objects and artifacts hampers the development of visual perception, spatial organization and form discrimination.

Growing up in a society created for those with highly differentiated skills and use of intellect can cause disadvantaged children to despair (Bernstein, 1960). Lack of conversation affects contentual learning. The environment is noisy. The noise generally is not meaningful to the child and becomes background noise. Conversations are often undirected and the situation provides an atmosphere for learning inattention. There is lack of feedback from adults on the information and skills he ought to be learning in his experiences. Auditory discrimination is important to reading. When the child is also learning to be inattentive to incoming stimulation becuase of a high, continuous noise level, his learning experiences for discrimination are affected (Minuchin, 1965). The child also needs reinforcement from the parents. Learning specialists believe it will provide motivation for further learning (Bernstein, 1960). Memory is related to being attentive. Memory linked with adult and child interaction where prior experiences are recalled reinforces this aspect of learning.

These children seem more present-oriented and less aware of past sequences. Unawareness of time is also caused by lack of predictibility by one's home structure. Psychologists have noticed that American Indian children, mountain children and children from other non-industrial

groups have difficulty in responding to time limitations. Slum children have this same difficulty. These children also lack expectation of reward for successful task completion. This often reduces motivation for beginning tasks and gaining the feeling of competence. In impoverished homes, there is little child-adult interaction around a parent setting a task for the child, observing the task performance and completion and giving rewards for completion (Minuchin, 1967).

For a child to formulate concepts, he must develop the ability to ask questions, using the adult as a source of information, correction and reality testing. This is essential to problem solving and absorption of new information. In a recent survey of verbal skills, verbal fluency was strongly related to reading skills and to other highly organized, integrated and conceptual verbal activity (Deutsch, 1962). If the child has no language facility and fluency nor auditory discrimination nor the ability to sustain attention, his problems are multiple and seem irreversible. Where language is concerned, lower class homes use speech sequences that seem very limited and poorly structured syntactically. Bernstein (1960) found that lower-class adults tend to use informal language mainly to convey physical needs of immediate consequence.

According to Piaget, later problem solving and logical ability are built on the earlier and orderly progression through a series of developmental ages involving the active interaction between the child and his environment. Young Black, indigent child lack this experience from adult conversation. This is a maturation process thought strongly related to experience and practice (Deutsch, 1963). The discontinuity between the home and the school need briding. Socialization and personality development

are primarily affected by the home. It therefore behooves the educational system to provide an experience that considers all of these important elements of the home environment and provides a mutually productive and satisfying experience (Deutsch, 1962; Bernstein, 1960).

Implications

It would be naive for any therapist to expect to be effective while working with the poor and not appreciate how these people have learned to adapt, adjust and solve their problems. Just as important is our understanding of their reality, "what makes a man", "the role of the male child", "the spouse relationship", "the importance of the same-sex peer group", "the importance of pregnancy to a young girl", etc. Professionals cannot effectively intervene in people's lives with whom we lack resonable expertise. The insights of anthropologists and sociologists are the key to our understanding the disadvantaged culture and behavior. We must understand how a culture of poverty has shaped their behavior and we need to accept our role in shaping their culture.

Stereotyping people prevents the therapist from being aware of individual differences. Ghetto life because of its limitations can cause mental health practitioners to think in narrow, superficial and negative ways. The therapist must accept the cognitive and affective limits of some clients and understand the ramifications of these limits. This should be done, however, to aid us in devising useful interventions not to create a pessimistic attitude that would add to their already numerous dilemmas.

Research Implications Affecting Services to the Poor

There have been major obstacles that have hampered effective mental health treatment of the disadvantaged. The findings presented focus on four major topics.

1. The existence of an imbalance between the mental health needs of the disadvantaged and the availability of appropriate services.
2. The inconsistency among treatment acceptance, attrition and outcome data.
3. The relevance of patient attitudes and expectations to the design and evaluation of treatment approaches.
4. The relevance of therapist attitudes and expectations to the design and evaluation of treatment approaches (Lorion, 1976).

The availability of psychotherapy for the disadvantaged is not proportionate to those needing services (Lorion, 1973). Lorion also found that SES level correlated significantly to the location and duration of treatment. Patients from the low-income groups were either not accepted into treatment or when accepted, were referred to medication clinics (D'Angelo & Walsh, 1967; Jackson, Berkowitz, & Farley, 1974; Krebs, 1971; Kurtz, Weech & Dizenhuz, 1970; Lee, Gianturco & Eisdorfer, 1974; Rosenblatt & mayer, 1972). Veterans' Administration and New York Psychiatric Institute (Budner, Esecover & Malitz, 1964) report that SES variables appear to be the more crucial determinant to treatment availability than the presenting symptom. The availability of treatment was further impeded by unemployment (Yamamoto & Goin, 1966) and minority group membership

(Yamamoto, James, Bloombaum & Hattem, 1967). Senior staff members at treatment centers generally treated middle and upper income patients (Lorion, 1973, 1974a). It is ironic that the individuals of this population seemed to have the most severe psychiatric disorders are treated by the least experienced (Fried, 1969; Sanua, 1966; Hollingshead & Redlich, 1958; Sue, McKinney, Allen, & Hall, 1974). Minuchin, a family therapist and psychiatrist asked why are the middle class treated by the trained, while the poor are seen by the untrained (1969)?

There appears to be inconsistent data regarding the correlation of acceptance rates and attrition rates for lower income clients as compared with middle income clients involved in psychotherapy (Fried, 1969). There have been studies demonstrating the responsiveness of low income applicants to traditional psychotherapy. Neither have there been many studies to indicate that such psychotherapy has been offered to the poor (1969). According to the reports of Brill and Storrow (1969) and Coles, Branch and Allison (1962) significant numbers of low SES clients do complete treatment. Other studies indicate that if the low income patient remains in treatment longer than three months they may be more highly motivated for and responsive to therapy than middle and upper income clients (Frank, 1961; Aloronda, Dean, & Starkweather, 1964).

Lerner reports that minority patients involved in traditional psychotherapy have responded positively as measured by patient, therapist, and behavioral ratings with ghetto residents (1972). Segments of the disadvantaged population of profit from traditional procedures and others do not (Lorion, 1973). Riessman and Scribner believe that the argument

most often used when low SES clients are eliminated from consideration for traditional psychotherapy is the ability to be insightful. They believe there is a disregard for qualities which indicate a positive potential for this method of therapy, such as the tendency not to isolate or intellectualize (1965).

There are perhaps other reasons than the person's personality make-up that affect which treatment is offered. Jones (1974) found that a person's social class figured importantly into whether or not he was offered and accepted for treatment and also for determining his therapist's level of training and experience. Unfortunately social class has been used as an index for health, pathology and personality development (Scaffer & Meyers, 1954; Hollingshead & Redlich, 1958; Cole, 1962, Rosenthal & Frank, 1958; and Bailey, 1958). Therapists prefer clients that communicate more easily, are introspective, and hold their same middle-class values (Riessman, 1964; Lorion, 1973). Research also indicates that lower class persons tend to be diagnosed as more severely ill than they are because psychological evaluations are subject to the biased influence of the examiner (Jones, 1974). Since low SES clients haven't assimilated middle-class values and behavior, they are described by some as being untreatable (1974). Lorion believes that accepting and understanding another subgroup's cultural values and behavior are crucial for diagnosis and the treatment of mental illness (1973).

When therapy was aimed at reducing attrition and clients were trained to participate more productively in the therapeutic process,

therapeutic involvement lengthened, clients improved and attrition was found to be significantly reduced (Rice & Warren, 1972). The disadvantaged often came to treatment feeling more negative about therapy and appeared unsophisticated (1972). They did not value psychotherapy as an appropriate solution to their problems. Some felt insulted by the idea that their troubles were emotional and could be helped by discussion (Lorion 1973, 1974). They felt more comfortable with an active, supportive therapist. Bernstein (1963) discussed the predicament the disadvantaged person finds himself in upon entering therapy. "Part of the process is learning about what to communicate in therapy. The patient must unlearn what he thought he was supposed to talk about and become sensitive in expectational terms to the requirements of the situation in which he finds himself". It is important for therapists not to evaluate "appropriateness of expectations" as a criteria for treatment except to use the information as a key to open the client's mind to aid ourselves in client preparation (Lorion, 1970).

The crucial target for success with the disadvantaged may clearly be the therapist. When the therapist pretends to care, respect or understand, he is fooling only himself. The patient may not know why the therapist is "phony" but he can easily detect true warmth from insincere prefessional warmth (Truax & Carkhuff, 1967). The therapist must be skillful and sensitive to be able to involve the reluctant client (Rogers, 1967). Carkhuff believes that if the therapist is remote or superficial he will dampen the client's enthusiasm (1969). Therapists need to perceive the poor as potentially responsive to their efforts. Rather than ask for "less" than the client is offered, the therapist may not realize that the client is asking for "more". The

client may want a fuller, more extensive and more permanent relationship than is normally entered into (Jones, 1974). Therapists have their own prejudices, misperceptions and resistances that they must resolve (Carkhuff, 1969). Baum (1966) found that therapists who were personally secure, clinically experienced and task oriented and had undergone personal therapy were able to establish better relationships with lower class clients and had lower drop-out rates.

Three interesting studies were conducted between the years 1966 and 1974 to indicate the need for a change in attitude among therapists when working with low SES clients. Aronson and Overall (1966) conducted a study comparing lower and middle-class expectations upon entering therapy. They investigated the patient's anticipation as the basic determinant of their therapeutic behavior. The two populations were compared by means of a questionnaire given each patient before his first interview. The categories were those previously suggested by Hollingshead and Redlich (1958). There were some major differences as Table 2 indicates.

While both groups expected the therapist to focus on psychological interests, the middle class expected less emphasis on physical matters (medication, chronic illness, etc.). The lower class expected therapy to be supportive, direct and active whereas the middle-class clients expected the therapist to be more passive and the client to be more responsive. Even though they found differences in the expected techniques to be used by the therapist, there were not differences regarding the content to be discussed in the sessions.

There were several reasons hypothesized for these differences. First, a discrepancy in the social status between the client and the

Table 2. Questionnaire Items that Obtained Significant Differences Between Classes

Category Number-a	Do you think the doctor will....?	Lower Class-b (percent)	Middle Class-b (percent)
Medical (11 items in all)			
1.	give you medicine.	56	18
18.	be interested in your digestion.	72	42
24.	be particularly interested in your aches and pains.	67	40
32.	take your pulse and blood pressure.	54	25
34.	tell you what kinds of food you should eat	46	10
Directive (12 items in all)			
3.	tell you what is wrong with you	59	22
7.	give you definite rules to follow.	67	28
12.	tell you what is causing your trouble	62	20
20.	tell you ways to solve your problems.	74	28
21.	have a list of things he will want to check over.	67	35
28.	tell you what is wrong with what you do.	69	32
Supportive (4 items in all)			
4.	try and cheer you up	77	48
8.	avoid subjects which might upset you.	53	15
14.	want you to look at the bright side of things.	87	65
25.	try to get your mind off your troubles.	79	35
Passive (3 items in all)			
6.	listen more than he talks.	77	100
23.	expect you to do most of the talking	67	92
Psychological (9 items in all)			
29.	not give you a physical exmination.	51	78

a-Only those items which reached a significant difference are listed here. The complete questionnaire can be found in Betty Overall and H. Aronson, "Expectations of Psychotherapy in Patients of Lower Socioeconomic Class" American Journal of Orthopsychiatry, Vol. 33, No. 3 (April 1963), pp. 421-430. Significance was determined by X^2 and Fisher's exact probability test. The number preceding each question indicates its position within the questionnaire.

b-Lower class N=38 for items 8 and 14, 39 for all others. Middle class N=40.

therapist may have caused the client to devalue his own judgment in preference to the therapist's judgment because he felt the therapist knew more. Second, the lower-class patient may be less able to answer "no" regardless of the questions being asked. Third, the middle-class were perhaps better informed by friends or by a more prudent use of mass media. Fourth, the lower-class patient may have based his expectations on past experiences with medical personnel or with authority figures in general and therefore behaved in a more dependent manner. For these reasons, researchers believed it would be prudent to prepare lower-class clients for therapy (1966).

Strupp and Bloxom (1973) developed a film, "Turning Point", as part of a study with low SES clients. They wanted to study the effects that preparation prior to therapy would have on the client. They wanted to form a better alignment between the patient's feelings, attitudes and expectations about psychotherapy and the therapist's. They also wanted to clarify for the patient the roles of both of them. They found that the patient's lack of information about therapy, poor motivation stemming from apathy or feelings of helplessness, threat of self-examination and misconceptions about problems (the threat of being crazy) and amelioration through psychotherapy were obstacles to treatment (1973).

Three other studies employed a role-induction interview as preparation for therapy. The interviews aided the therapeutic process by providing to have important significance for one or more of the following results: (1) To give accurate information about the process of therapy, (2) to dispel misconceptions and prejudices about therapy, (3) to enhance the patient's motivation for change and (4) to pave the way for a more realistic view for resolving emotional problems (Heitler, 1973, 1976; Baum & Felzer, 1964; and Orne & Winder, 1968).

Lorion (1974) reported contrary findings. He suggested that low income clients do not necessarily have move negative attitudes and expectations toward treatment than middle or upper SES applicants. He used 21 of the 29 categories from Aronson and Overall's (1966) expectation scale with clients grouped according to Hollingshead and Redlich's three socioeconomic levels, Classes III, IV and V (1958). He suggested that "help-seeking" attitudes and "treatment expectations" among these different status groups needs to be reevaluated. Lorion noted that the changes from 1966 to 1974 may reflect the difference between the use of biased observation verses questionnaire data or it may suggest that differences between classes have been reduced over the years (1974b). Either way Lorion believes it is necessary to access objectively the patient's view of therapy before they begin.

During the late 1960's and early 1970's, researchers focused on assessing therapists' attitudes and their effect on the parameters of client acceptance, client assignment and client continuation in therapy. Questions were asked of middle and upper-class therapists about their ability to emphathize with the needs and experiences of the poor, their knowledge of the patient's situational limits and resources and their basis for assessing the client's problem-solving potential and treatment response (Lerner, 1972; Schneiderman, 1965; and Lorion, 1974). Data from these studies has shown that negative attitudes from therapists critically affect treatment outcome and significantly relate to the quality of the therapeutic relationship (Parloff, 1961; Vander Veen, 1965). Therapists attitudes related significantly to the quality of direct and indirect mental health services provided to the disadvantaged

(Didato, 1971; Schoenfeld, Lyerly & Miller, 1971). A positive correlation was found between therapists' prognostic expectations and the duration of treatment (Affleck & Garfield, 1961).

Goldstein has contributed numerous studies since the 1960's on the role of therapists' expectation to the treatment process. He has found that the therapists' role is more important to the outcome of therapy than those of the patient (Goldstein, 1960, 1962, 1966, Heller & Goldstein, 1961). Goldstein (1971) found in an analog study that when a therapist responded negatively toward low-income clients on the intake interview it was perceived by the clients. Therapists, however, that were viewed as warm by their patients retained more clients from all SES levels as compared with therapists rated cold, distant or passive. Therapists' attitudes and expectations influenced the impact of treatment for the disadvantaged (1971). Jacob's found that therapists regardless of their economic or racial background could become affective service providers to the poor (1972). It would seem ironic for mental health practitioners to believe in the efficacy of change for their patients and not for themselves (1972).

After working with a staff of therapists of varied clinical experience at Family Resource Center, I was curious about their attitudes, ideas and responses when working with a disadvantaged population as compared with middle-income clients. I composed a questionnaire to compare their personal views with the information gathered from professional journals. The following collated material summarizes the feelings, ideas and experiences of five therapists with an accumulated experience of forty

years. Answer (a) corresponds throughout the questionnaire to one particular therapist's opinions.

(1) What poses the most difficulty when working with lower income families in therapy?

(a) Lack of transportation and other resources, as child care.
(b) Generally the multiplicity of their needs and their tendency to expect the therapist to fulfill too many roles for them. The therapist must reach accord with the family regarding the parameters of therapy to be done.
(c) Multiple problematic nature of the families. The families are in or on the verge of constant crisis - so doing therapy in an orderly fashion is very difficult.
(d) Issues like transportation and the family's preoccupation with survival issues. Most of us are trained with an insight oriented psychotherapy that explores relationship and self-actualization issues. Using Maslow's triangle, these families are not oriented to these issues. We must learn a new type of therapy.
(e) Often there is a forced-treatment aspect. They are "made to come" to fulfill some requirement for getting into trouble with society (e.g. as part of probation for a felony, to get their children back from foster care). Very few seek out help voluntarily.

(2) What problems exist in the early sessions when establishing a therapeutic relationship with the lower income family as compared with middle income family?

(a) Lower income are more likely to be less verbal. They may be less trusting, possibly as a result of having been shuffled around from agency to agency alot.
(b) Issues related to inappropriate expectations (see #1). Assuming a middle class therapist, it's frequently tough for the therapist to understand and/or accept their family's values and priorities. Many lower socioeconomic families prefer change to insight, events to talk.
(c) Lower income families are more suspicious of outside interference with their family. They tend to not form intense relationships and the problems they are experiencing are not as well defined.
(d) Families are not as verbal. You have to do something dramatic fairly early on.
(e) Same as one above - letting them know you really want to help and that you are not doing it "just for your job". Paying someone for services rendered is a big part of therapy. Lower income families often do not pay.

(3) What is your major assumption about the potential for change of lower income clients as compared with middle income clients?

(a) They take longer to engage in therapy; may miss more sessions.
(b) Potential for change equals that of middle SES folks but only if the initial joining plus parameter setting is achieved.
(c) Potential is lower overall - change needs to be basic and related very practically to the problem they have.
(d) Potential is the same as for anyone.
(e) Potential is the same except that different approaches need to be used with the same basic underlying theory.

(4) Since you work as a therapist with white and black clients, evaluate your effectiveness with each population.

(a) Generally equal.
(b) I generally see the issue more in terms of SES than race, although race does sometimes hamper the joining process.
(c) Lower income blacks are more difficult for me to work with. Generally I feel that race does not determine effectivness.
(d) Not quite as effective with black when subcultural issues are relevant to the problem. This is true with any subcultural group.
(e) I've done research in this area and each time there has been no difference. If there ever is, I would suspect it is more of a problem with the therapist rather than the client.

(5) Have your middle class biases and values ever interferred with the therapeutic process when working with lower income clients?

(a) Probably so, especially when disengaging enmeshed families, getting fathers more involved in parenting.
(b) Of course! Trying to convince lower SES clients who might believe in physical discipline to use time out and ignore tantrums can be futile.
(c) Yes. At times, I do not understand the dynamics of the lower income families; especially boudaries between families and generations and how subsystems function.
(d) Of course. I cannot help but want them to do what I think is most functional, but how do I know - I've never been in their shoes.
(e) When I was a beginning therapist - Yes. The need for routine and upbringing by my family in general greatly influenced what I expected of clients. Now, after ten years experience, I am much more flexible and recognize other levels and cultures.

(6) How do the interventions used with lower income families differ from those used with middle income families on the issue of life cycle crises, parent-child relationships, and marital problems?

(a) May use more verbal techniques and more gestalt interventions with middle and not with lower income.
(b) The question is one of culture. Lower SES cultures are frequently more functional when the extended family joins together in the struggle to survive. This carries with it the risk of more role confusion, vague boundaries, etc. Therapists need to balance reality demands with theory.
(c) More concrete, less abstract; more emphasis on extended family less on nuclear family; life cycle crises are different - low income families are less active in life decisions and more reactive; parent-child relationships for lower income families have less emphasis on emotional components; work more with practical skills; marital problems - lower income families place less emphasis on equal fulfillment.
(d) More action, less talk.
(e) The key point is starting where the client is presently at and this greatly differs from case to case. The techniques are the same (behavorism, paradoxes, etc.) with the outline tailored tothe individual or family within their particular system.

(7) How do you deal with racial barriers in therapy between you and a black family? Have these barriers affected the family remaining in therapy or the outcome of therapy?

(a) Some clients have made race an issue. When they really didn't want to be in therapy at all! I acknowledge that there are differences and ask how we can work around them. I don't think it's really affected engagement or outcome.
(b) Generally helpful to address the racial differences fairly openly. It's not helpful to try to convince a low SES black family that you, a middle SES white therapist, really fully understand their position. Be real!
(c) I deal directly with the issue making an assumption that the barriers are natually present. The more that the issue is dealt with the greater likelihood that it will not affect treatment adversely.
(d) I deal with these very directly and openly attempting to openly acknowledge our differences. Usually it doesn't affect therapy except to better things.
(e) I have found that if it is not a problem with me, it is not with them. It is usually not race but why (i.e., forced treatment vs. voluntary) that can influence the length of therapy and the outcome.

(8) What differences have you observed in family structure when working with middle class clients as compared with lower income clients?

(a) Lower - more likely to be single parent and have more involvement from extended family, though it's likely to be conflicted; lack of supervision is frequent problem with children.

(b) Lower SES groups tend towards more extended family involvment, less clear roles and boundaries and more transient relationships (especially in adolescence and young adulthood).
Middle SES families tend more towards the stereotype dad is married to his job, mom to the kids and the kids to keeping them together scenario.

(c) In middle income there is more recognizable structure; more emphasis on nuclear family; more two parent families; more interaction positively between parents and children; adults have more of a sense of independence and individualization.

(d) None. Only a difference in style of expressing it, i.e., middle class clients use more verbal and sometimes more subtle methods of expression.

(e) Often times the lower income have a "disrupted" structure in that the make model is often transient and not permanent. This obviously affects the whole family structure. Also, the lack of knowledge in dealing with stress especially around the family (e.g., raising the children) is a problem, although when and if a grandmother exists with a lower income family there is a great dependency. If the grandmother is not around, this greatly exacerbates the problem and issues. Also, lower income families deal with more basic problems (housing, food, etc.) whereas middle class turn to the next level of concern (marital problems, children problems).

(9) When middle or lower income clients terminate therapy what type of inquiries do you make?

(a) Assuming I think therapy should not continue: What's changed in the presenting problem? What are you going to do now? Other questions may be more specific to family's situation.

(b) Generally a three to six month follow up. No difference between middle or lower SES folks.

(c) I attempt to discuss the issues that resulted in termination - if fact to fact session is not possible, I work by phone or letter.

(d) Same as anyone else.

(e) That varies with the case. Sometimes I purposely set up the situation to terminate because they are not ready to change. Later on I do contact (after two to four months) often times things are better. Again this really varies.

(10) What influenced you to work with lower income clients?

(a) Globally - probably a sense of social injustice. That I'd like to remediate. More specifically - I liked programs and people at FRC.
(b) That's where the job was. No particular noble reason.
(c) My religious training and family beliefs emphasized that a human beings' work is not dictated by amount of income. I also felt that our treatment of the poor was dehumanizing as a nation and I wanted to assist people to understand their humanness and worth.
(d) I don't seek them out particularly.
(e) That's a good question. I initially just wanted to help people. I didn't know to what extent that way. Initially it was in correctional work, now child neglect.

(11) What previous reading, experience and/or training have you had with regard to background and the subculture of the black population?

(a) I'd done extensive reading regarding black culture and taken some formal courses in minority culture. I've worked with blacks and other minorities since 1968.
(b) No readings or courses. Just experience of working with several black families plus discussing the black culture with black therapists.
(c) Mainly through experience - working in educational type programs with black youth (summer programs).
(d) Courses in college. I don't feel that it is as much a racial issue. I don't experience working with middle class blacks as different except to pay attention to how they experience being black. But lower class whites and blacks are very similar.
(e) Ten years experience, research comparing differences. Most has been strictly experience, with research.

Implications

The literature researched provides data regarding the importance of the therapist's role upon services provided. We therapists need to be aware of ourselves as possible obstacles to the provision of good treatment. Goldstein and others found the therapist to be the crucial target for affecting admittance, duration and outcome of treatment. The literature also indicates the subjectivity reflected in treatment for the poor: who would treat whom, whether they should be admitted and where services would be provided. Segregation seems to have crept into our services. SES level has become the crucial factor for determining treatment rather than symptoms. Mental health service providers may need to reassess whether we are people-oriented or not. The literature seems to indicate that even though traditional therapy certainly won't work for all - there are those who are poor and also introspective. They can profit from such treatment if it is offered. It appears that critical to good treatment is preparation in a prescribed way that would eliminate nervousness, embarrassment, and misunderstanding. The findings seem valid enough to be required information for anyone seeking professional help, especially the poor.

Ethnicity: Its Influence on Lifestyle and Pathology

Joseph Giordano (1973), commissioned by the National Institute for Mental Health, completed a lengthy study on Ethnicity and Mental Health. The major work of this chapter is based on Giordano's prestigious project. He believed that cultural and ethnic influences on mental health cannot be ignored in favor of preoccupation with socio-economic issues. Because of assumptions and rhetoric about the myth of the melting pot, the existence of ethnicity has been ignored, under-utilized and limited to observable differences (like accents, dress, taste in food or to the traditional "Ethnic Joke") (1973). Giordano writes that politicians and union leaders have always been aware of residential patterns, voting behavior, social characteristics and group conflict. Only recently have social scientists tackled the questions of why the myriad cultural groups haven't "melted", why there is inevitable competition, friction and conflict among these groups, and why most Americans choose to ignore the groups and their friction.

We assume that assimilation and acculturation of these different ethnic groups has occurred. They are so extremely different, and we expect them to blend so easily. Ethnic identification and ethnic organization are still important to many people. Security is tied to identity, as alluded to earlier in Erikson's writing (Erickson, 1959). A man's roots give him grounding and reinforce the strong need

to belong. "Identity", Erikson (1959) said, "is a process located in the core of the individual and also in the core of his communal culture - a process which establishes, in fact, the identity of these two identities. Many mental health practitioners and theorist have stressed the influence of social and cultural environment in normal and deviant behavior (Sullivan, Horney, Ferenczi, Mead and Benedict). Many more have come to see a relationship between culture and personality. Therefore, those involved with community mental health, community psychiatry and family therapy regard drugs, psychotherapy and psychoanalysis to be inadequate to answer questions relating to a particular population's mental health and mental illness (Jahoda, 1970).

Jahoda (1970) used the following characteristics to describe mental health: (1) active adjustments or attempts at mastery of environment, (2) unity of personality through internal integration with flexibility of behavior for active adjustment and (3) the ability to perceive correctly the world and oneself. Mastery of one's environment would surely include feeling comfortable with the group to which one belongs. Coping with inner stress calls for a supportive environment.

"Stress and support" can relate to cultural and ethnic factors like norms, customs, values and roles whether political, economic, religious, social or familial. The quality of treatment is likely to suffer when the clinician is unaware of the differences in emotional language, family symbolism and the variation of family roles. The therapist's own cultural background may differ radically from that of the patient, producing a variety of misunderstandings if the therapist is ignorant

and unfamiliar. The following illustrates ethnic differences which could be misinterpreted as characteristics labeled pathological (Giordano, 1973). The following differences in the mother-son relationship of Italian, Jewish, Irish and "Old American" families were found in families with "psychotic children".

ITALIAN

Sex-linked preferential treatment from both parents. Little affection and practically no overt display of it. Over-solicitous mother concerned about son's physical welfare (superior status of men).

Father's physical punishment of son with mother becoming a buffer between father and son.

Son dependent on mother as result and obeys her commands without hesitation.

Neither parent shows interest in personal problems.

Father's extreme strictness--child rejects father not as role model, but as a symbol of warmth.

Stressful--role expectations for son are not supported by emotional security.

JEWISH

Mother and son relationship highly emotional.

Overprotective and overly affectionate.

Withdrawal of love used as a means of control.

Father not very punishing, yet yields much control over his life and wife.

Son does not have strong negative feelings towards father, but does not accept him as a strong role model.

Son's reaction to inconsistency of maternal love, -- ambivalent, repressed hostility (deep-rooted), and an exaggerated dependency.

IRISH

Son preference for mother.

Lack of overt affection.

Strict discipline and failure to reward -- boy reacts with stress -- excessive dependency on mother punctuated by frequent verbal agression.

Father detached, but role of supervisor all-inclusive.

Belittles son about his looks.
Son does not develop strong emotional reactions toward father -- apt to accept his subordination to him with little conflict -- situation of subordination less than with mother.

"OLD AMERICAN" (YANKEE)

Element of positive emotion, but not displayed.

Overprotective and restrictive of son.

Son must compete with other siblings.

Son must reach constantly for signs (indirect) of approval in things his mother does for him, rather than communicate in direct fashion.

Father nonpunishing -- rejected by son as a role model -- relies on mother's emotional guidance.

Withdrawal of love used for control, but differs from Jewish mother in emphasizing moral implications rather than personal attitudes.

Son has strong sense of guilt and inadequacy -- vague, pervasiveness of moral implications.

It may be that life styles, family structure and family roles, as well as, mechanisms that are used to cope with aggression and anxiety display healthy patterns of adjustment and adaption for many ethnic subgroups (Giordano, 1973). It behooves the mental health profession to understand the distinguishing characteristics of each subgroup to effectively intervene with appropriate treatment.

Giordano believes that the need for new models of treatment is increasingly clear. He also believes that we need more serious research on the values and attitudes of ethnic groups and their implications for health and illness. Studies such as The Mental Health of the Poor (1964) and Black Rage (1976) have influenced the development of new models and treatment programs. The poor and the working class need for services to be continuous. The mental health of both groups are affected by feelings of powerlessness, alienation, lack of participation, and the belief that no one cares about their situation. The following six suggestions were made to the National Institute for Mental Health for lower-class ethnic communities by Giordano (1973) following his intense investigation and study.

1. There needs to be an intensive study of the cultural, ethnic and socioeconomic groups in each community where there is a mental health center. A strategy should then emerge to make services more accessible to the entire community.

2. The mental health facility or unit should be a function, not a place. The staff should cover strategic groups and institutions within the community. Each community group should report to a member of the staff for consultation.

3. Mental health information and education should involve representatives of various groups in the community in translating and distributing materials.

4. Institutes and workshops on the culture, ethnicity, and style of life of the community should be a regular part of the hospital or clinic's training program.

5. Experimental programs should use non-professionals, particularly housewives as lay persons involved in the life of the mental health center. Active recruitment should go on through community organizations for responsible lay persons.

6. Neighborhood multi-service centers should be set up in communities, their initial purpose being to provide information and referral services needed by individuals. Community residents would staff these centers under the guidance of a professional. Later, the centers could expand, offering counseling, social action, and integration of existing community services.

"Etnicity need not have the negative distinguishing marks that we so often associate with different nationalities. In order to live in a complex modern society as enlightened individuals, we in the mental health field need especially to rid ourselves of old and new stereotypes that diminish a person's uniqueness. The message needs to come from intelligent informed people who care and who can teach and influence the public to accept and understand as we set the example" (1973).

Implications

If the "core" of man as Erikson has said, is tied to his communal culture, we must attend seriously to understand what this means cognitively and also pragmatically. Social services and the policies directing how, when, with whom and where they will be carried out are crucial. An outsider to the community no matter how knowledgeable will not be accepted. If the outsider works hand-in-hand with someone familiar, respected and accepted by the neighborhood families, elderly, teens, etc. his chances of effectiveness are much greater. This is certainly not a new idea but why don't we use what we already know? Mental health practitioners will not be effective if they disregard ethnic family structure, rules and mechanisms for coping, and patterns of behavior determined by the ethnic group to be normal. Models of treatment must adapt to the style and needs of the ethnic group and not vice-versa.

Individuals from the community, Giordano asserts, must be an inherent and strategic part of the mental health structure for the services to be accepted and utilized. Observing uniqueness among people does not mean we are weakening to the demands of each different group. It means that professionals have understood the essential requirement for providing services, becoming adaptable ourselves.

Treatment Approaches: Goals and Procedures

Riessman's classic volume, "Mental Health of the Poor", speaks to the drastic need for more innovative approaches to provide services and to base these services on a clearer understanding of the background, resources and needs of the poor (1964). In the past decade, two trends have emerged in the field of psychiatry. These include, first, a physiological trend highlighted by a variety of new drugs; and second, an environmental-social trend reflected in community psychiatry, milieu therapy, family therapy and brief preventative programs. These two developments appear most congruent with treatment expectations and the desires of the low SES client (1964).

I have researched only the second of the two trends. Therapy's early training, cultural orientation, values and beliefs are primarily reflected in a therapist working with any population. However, I will try to show that even though past procedures and goals have failed us, the direction of the 60's, 70's and early 80's does indicate that adaptive and innovative methods are being tried by those committed to serving the poor. Each approach seems to reflect a particular theoretical commitment. As will be evident, being innovative and creative has caused an overlapping between the traditional approach and the behaviorist, between the behaviorist and the family therapist, and between the short-term treatment programs and preventative treatment programs. The term "overlapping" indicates that one particular modality may not be effective alone to meet the needs of the low SES client.

D'Angelo and Walsh (1967) evaluated extended services for children in poorer areas and found them sorely lacking. In central Harlem, they received permission to provide needed psychiatric services by working from one of five public schools in the area. The staff included two psychiatrist, four clinical psychologists, two psychiatric social workers and one secretary. Referrals were suggested by teachers, parents, the Courts and the police and other agencies. Being a preventative program, it attempted to make maximum use of school facilities, focused on other existing problems besides those referred, and capitalized on making conditions prime for the prevention of parental problems. Their physical location aided in getting families to therapy and feeling more comfortable than in a huge medical complex. Services were provided in the evening, preventing loss of time from work, and arrangements were provided for child care supervision. Without these services, the project personnel felt there might be a high cancellation rate. Indications from the study point to the effectiveness of a community-based operation. The process encouraged greater participation by parents and children, and broken appointments were kept to a minimum.

Attention was directed to the parents with environmental stresses. This resulted in improved mental health in the child, and seemed to be a more effective procedure than giving direct clinical attention to the child alone. Teachers at the five schools participated by giving information to the practitioners. In turn, the practitioners supported the teachers by giving clarification and understanding of the home situation and what would be helpful in the classroom. The greatest drawback seemed to be that improvements in the child and in the parents were not solidified by the time the brief therapy sessions came to an end.

The study ended because funding for the project ceased. The approach seemed highly useful to parents, children and clinicians. Resource persons were close at hand and parents sensed the practicality of handling their children's problems while the problems were still small and hadn't developed into being unmanageable as was true with their older children. All parents wanted some kind of success in their children's education. They saw education as the stepping-stone from their life of impoverishment. The parents became the key to working with their own children rather than the clinician working directly with the children without the parents. The five community educational systems were boosted by their identification with the mental health study. The consideration of parental needs and problems was an effective intervention rather than regarding the situations as hopeless and the parents as uncaring.

The National Institute for Mental Health statistics reports that 30 percent to 60 percent of the disadvantaged terminate within the first six sessions of therapy, with or without consent of the therapist. The median treatment duration ranged from 3-12 sessions. Often the reasons for terminating were known only to the client. The "crisis concept" involved relatively short periods of psychological disequilibrium which occurs in everyone's life in response to developing transitions or to situational hazards and challenges that could be either potential training experiences or which could lead to a mental disorder. During the upset of a crisis, a person usually has an increased desire to be helped and is more susceptible to influence than during periods of relatively stable functioning (La Vietes, 1974). The poor, however, live a life of crises - for them it is not an occational happening.

Crisis intervention can be a tool of expediency and not optimum patient care, due to using the modality (crisis intervention) as a means of reducing the cost per capita of patient care when the use of third party payment (welfare) procedures are available (1974). The group of patients to whom these directives will most often apply are the very patients who have received the least and the briefest services - the poor, the minorities, the people of the ghetto (1974).

Treatment for immediate crisis intervention was considered from several different angles as to its efficacy. One important criticism of this type of therapy is that treatment becomes a series of responses to immediate crises (example, handling the symptom alone) with little time generally directed to more central issues. This is an argument frequently made against behavioral therapy. There needs to be a definition or diagnosis of the structural problem from which multiple problems are coming (Butehorn, 1978).

Time-limited approaches have been thought to be more appropriate for the disadvantaged and consistent with economic and occupational realities (Lorion, 1973). Stress with finances and occupation hindered therapeutic work because the present crisis led to other interpersonal and individual problems being overlooked. Emphasis of treatment needed to be problem-oriented and realistic (Strupp and Bergin, 1969; Urban and Ford, 1970). Time-limited therapeutic approaches focused directly on present symptoms and problems. This sometimes led clients later to decide to work on more complex intrapsychic difficulties (Barton, 1971). Wolberg (1967) fears that if brief treatment becomes more pervasive, such a form of care will substitute for more effective long-term treatment.

Those with long-standing problems are less likely to respond well to crisis intervention than are individuals and families with genuinely short-term crisis (La Vietes, 1974). Some clinicians believe that the ability to establish basic trust and develop a positive rapport or transference are essentials for brief treatment. Although the disadvantaged client has been accepted for brief treatment, there have been years of chronic malfunctioning. The event that causes referral, said La Vietes, is often a crisis such as a mother's death, a new father in the family, change in school administration, etc. The event, she believes, precipitates an exacerbation of an existing problem instead of producing motivation and receptivity toward adjustment. The resources of the person's ego are already strained, so the patient may use customary defenses such as denial or projection. The person's solutions can then become the problem (La Vietes, 1974).

There are limitations to the benefits of crisis intervention (1974). (1) Often with treatment there is a symptomatic improvement which relapses when therapeutic support is withdrawn. (2) When there is widespread dysfunctioning which extends beyond the presenting problem, brief interventions are not effective enough. (3) Sometimes diagnosis of a child reflects his developmental stage and not his dysfunction or pathology. Therefore, caution must be taken because a shift in symptoms may be interpreted as a resolution of the difficulty (La Vietes, 1974).

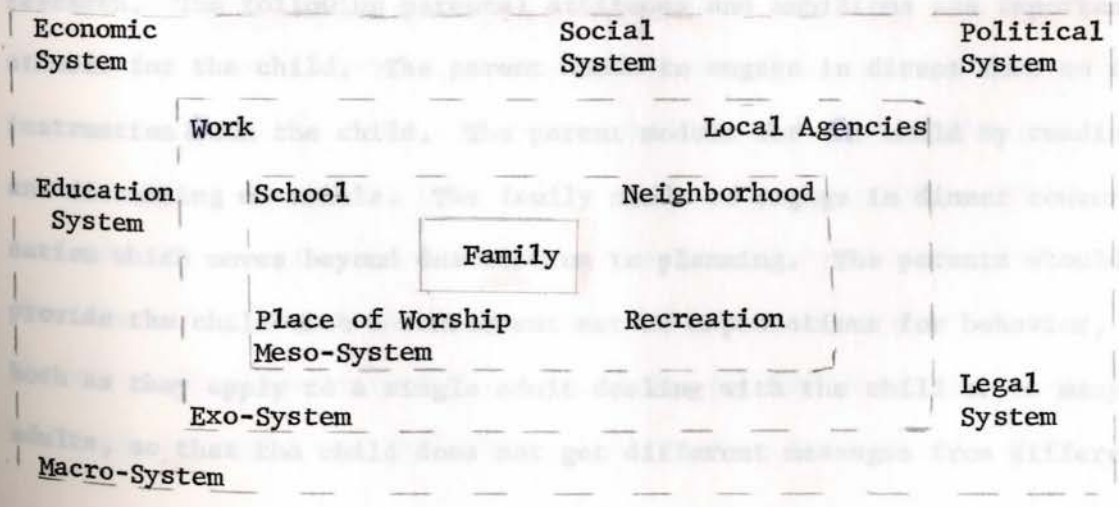
La Vietes, goes on to say that the hallmark of crisis intervention is the selection of one major area of focus (like misbehavior in school). A difficulty with the disadvantaged is that this usually is not possible. High-risk families have multiple problems: medical socioeconomic, psychiatric and cultural. Numerous difficulties militate against short-

lived interventions. Crisis intervention La Vietes believes depends heavily on the family (especially the parents) taking an active role and assuming some responsibility in the therapy process to provide structure and to have reserve emotional strengths. There needs to be relatively good inter-family relationships, few adverse environmental circumstances, and stabilized motivation (1974). Poor prognosis in these areas, according to La Vietes, requires a different method of treatment. This mode of therapy depends on extended support systems outside the home (such as special school attention, hospitalization, the "big brother" program, social services, etc.). La Vietes recommended a cross-section of professional services appropriate for crisis intervention that are suitable to initiate and continue optimum stabilizing care. La Vietes believes that many times neither short-term nor long-term individual therapy is required but she recommends the following practices.

1. A spectrum of interventions that will vary from time to time, ranging from the concrete to the insightful.
2. A long-term association with a helping agent (therapist) which will at times be intensive and at other times minimal.
3. An advocate for the child's and family's right to emotional and physical well-being.
4. Access to highly-skilled specialists as needed.
5. An executive agent to help the person negotiate with what appears to be a hostile or mysterious system: the welfare department, the school, the hospital, the Court, etc.
6. A flexible approach to type, location, and timing of service (1974).

La Vietes description of short-term psychotherapy differs from Sifneos' version for the middle-class client. He requires the patient have above-average intelligence, have at least one meaningful relationship with another during his lifetime, voice a specific chief complaint, be able to maintain a job and recognize that his symptoms are psychological in nature. Sifneos' techniques require that the client have a strong ego because the techniques are anxiety-provoking through confrontation and clarification. He expects the patient to use content discussed during the sessions, to rehearse reactions at home and to utilize problem-solving techniques (1972).

Another treatment approach involved teaching parenting skills. Ira Gordon was a forerunner and a most prolific writer in this area. Gordon perceived the goal of good parenting not only for physical survival but for psychological survival -- instilling a sense of belonging, cohesion and roots (1978). Effective parenting is related to societal goals and to the family's goals and makeup. Brim (1975) and Bronfenbrenner (1976) conceptualized a diagram of a network of systems that influences the family as described in Figure 1.



The important emphasis is the complex flow from the center outward and the reactions and reverberations that affect the family members as their roles and activities change. In our society, great importance is placed on the individual's decision to change the behavior of others in his cultural group. Gordon described the disparity that comes between the lower and middle and upper classes. The low SES individual's effect is minimal, and the economic, educational and cultural system is a far cry from the opportunities possible for the other two classes. Instead, the poor man's system can be described by one impoverished mechanism affecting another impoverished mechanism.

Head Start was a program that had the potential to affect other systems influencing the child's development. It was a program to prepare young children with an advantage or at least an equal opportunity in their educational years. The program focused on parents' involvement with their young to affect their children, their neighborhood and their school (Gordon, 1978). Gordon describes some studies that relate to parenting along the lines of academic achievement. The studies were conducted in several countries and show a common thread among societal research. The following parental attitudes and ambitions are important stimuli for the child. The parent needs to engage in direct face to face instruction with the child. The parent models for the child by reading and discussing materials. The family needs to engage in dinner conversation which moves beyond description to planning. The parents should provide the child with a consistent set of expectations for behavior, both as they apply to a single adult dealing with the child or to many adults, so that the child does not get different messages from different

people. The family needs to utilize not only the home but the neighborhood and the community as a resource. The parents must spend time with the child. The parents need to provide a secure and orderly home. The parents should provide opportunities for independence for the child (1969).

Piaget (1979) has described three activities at a very early age which are essential for infant-adult interactions affecting a child's development. Gordon labeled the first "the ping-pong effect" because it has a game-like quality and doesn't last long. It involves a rapid interchange of the parent doing something followed by the child doing something, followed by the parent doing something, etc. around a particular task (i.e. peek-a-boo game). A second pattern was mutual gaze, and the third pattern was persistence. "Persistence" refers to an activity with a child where the parent begins with the child and engages the child and then backs off and allows the child to carry on and explore further by himself. Responsiveness to the individuality of the child seems to be the most important parenting pattern (1978). How does this spread out into the larger system and affect the child's greater environmental influences? In a project funded by the National Institute for Mental Health, Gordon incorporated these very concepts. A group of lay women (many black) were enlisted, and he taught and trained them to be instructors called Parent Educators (PE). These trained PE's were to work with young teenage mothers. Gordon believed that the infant became maladjusted and an under achiever due to his chaotic world where he needed order, continuity and security. He has believed, as did Piaget, that the parent (mother in particular and

father later), are the most stimulating and interesting objects in the young child's life. For this reason, Gordon and his associates trained the PE to train the young mothers to give the children love, to show daily interest and to raise the child's expectations. Over a three-year period, the PE's taught the mothers to recognize the influences of their homelife that were shaping the child. They wanted the mothers to grasp the idea that a role-caring adult could aid the emotional strength and mental health of the child. They practiced talking with the child rather than at the child, giving their child interesting things to do and encouraging them to stay with an activity. The PE's were trained to instruct the mothers about attending to a child's physical care and psychological development simultaneously. For instance, while changing a diaper, a mother should look at the child's face and smile; while dressing the child, she should rub his tummy; while feeding the child, she should talk to him. The bonds between the young child and his mother paid off in consequences that benefited both of their futures. Later test scores demonstrated the children's ability to learn and retain information as they progressed further in their education. The parents were surprised to realize their children scored better on tests in the longitudinal study when they were in the intermediate grades in school. The mothers themselves increased in their own self-esteem; many married, some completed high school, some went on for further education and became involved in their communities. The effects rippled from the immediate family into the other systems (the school, the neighborhood, and work). Gordon had believed for many years that the parent was the key to intervention and prevention of problems with the child.

Behaviorists working with lower-income persons have primarily concentrated their efforts with school age children and delinquent youths. The word "behavioral" is a generic term for an assortment of therapeutic procedures that differ from traditional expressive psychotherapy like modeling, desensitization, aversive psychotherapy, positive reinforcement, etc. (Lorion, 1970). Krasner (1971) reports that over 4,000 studies of this treatment modality have been published. Unfortunately, few data exists that demonstrates effectiveness of the behavioral approach with the working class and the poor. Some behavioral techniques have seemed appropriate for the disadvantaged. Therapists using them operate from the perspective that psychopathology requires a more direct, problem-oriented focus. This is accomplished by attending to symptom removal rather than resolving intrapsychic conflicts. Graziano felt that the disadvantaged wanted exactly that, direct resolution of the symptoms (1969). However, there has been little data to substantiate this idea with the poor (Lorion, 1970). Behaviorists emphasize resolution of such symptoms as phobias, tics, sex perversion, etc. which they now have generalized to their work with depression, anxiety reactions, alcoholism, and drug addiction (Eysenck, 1972; Krasner, 1971; Lazarus, 1972, 1976).

Work with the poor has been predicated on the two ideas that behavior therapy can be at least as effective as expressive psychotherapy, and it can serve a more heterogeneous population than traditional therapy (Sloane, 1975).

The therapist's relationship skills had been previously overlooked in behavioral literature. These skills were found crucial for supportive communication to be effective (Truax, Mitchell, 1971). Therapists were

were trained to modify family communication patterns and interaction sequences by modeling, prompting, reinforcing by verbal demands and by expressing their feelings as well as by offering alternative solutions (Parsons & Alexander, 1973). The training emphasized verbal activity, directness and clarity to interrupt repetitive sequences from the past ("like he's always doing that") attention to present and future behaviors, and to adopt a style of positive reinforcement through acceptance rather than punishing by blaming, restricting, etc. (Barton, 1976; Alexander, 1974; Parsons & Alexander, 1973).

The goal of Barton's (1976) study was to teach the technique of contingency contracting. At first, contracting was done with the help of the therapist. Later it was done by the adolescent and parents without the therapis's assistance. The emphasis was to get away from "delinquent behaviors" like truancy and defiance that maintained parent and adolescent distance whereby the parent felt compelled to control the family functioning through force. Instead, the goal was to share the parental role and to balance the relationship by the parent taking charge through making contracts that would satisfy all involved.

Another study focused on teaching parents empathy skills to ease the transition with their young adolescent from childhood into adulthood (Guzzella, 1976). Goldstein (1973) reiterates the necessity of teaching specific skills like empathy through modeling, role playing, social reinforcement, etc. He found the central problem was that it was hard to make situations similar for the greatest amount of learning transfer to occur. Empathy involved not only being sensitive but communicating

this to the adolescent. The study indicated positive results when the therapist was empathic toward the parents (Guzella, 1976).

Other studies with aggressive and delinquent boys have shown positive results when therapists were trained for the interventions, when the setting of learning corresponded closely with the school and family setting and when parents were trained to handle the work that the therapist began (Patterson, 1974, 1973). Patterson related that when children were diagnosed as having more severly disordered behavior, they didn't outgrow or change their problem behaviors. Interventions focusing on the parents were more effective in improving their children's behavior than time-limited psychotherapy for the child (Love, Kaswan, Bugetal, 1972). This was true in Ira Gordon's work and in Guzella (1976) and Goldstein (1973) studies discussed earlier. SES level was important in the different types of treatment presented (1973). Lower income parents wanted more direct information and advice from an expert source while middle and upper income responded to autonomy and problem solving on their own (Patterson, 1974).

Only one study that I read did not claim that their interventions were effective. Wealther (1975) used a combination of short-term family therapy and behavioral techniques when working with adolescents and parents decimated by divorce, crime and drug abuse. He attempted to teach them communication skills, contingency contracting, and positive reinforcement. The work seemed ineffective because the clients did not respond and many dropped out of treatment. He felt treatment needed to be long-term and consist of a wider range of interventions.

Implications

Riessman's call for more innovative approaches when working with the poor is possible. The problem is not the lack of ideas but having the money to try an approach with this population and for a long enough period of time to substantiate its effectiveness.

I anticipate that the second trend of the last twenty years, the environmental-social trend, to be highly useful. Working with the poor where they live, in their circumstances and assisting them with resources and personnel as D'Angelo and Walsh did can be more comforting and helpful than forcing the poor into the complicated and unfamiliar system of the larger society. The personal threat of feeling inadequate can be a barrier to seeking therapeutic work or remaining in therapy. I'm afrad that what we do learn from D'Angelo and Walsh, La Vietes, Butehorn, and Gordon, etc. is written in professional journals and discussed in workshops but not duplicated often enough in real life where it needs to be.

Gordon's work with impoverished parents as well as Patterson's and other behaviorists seems to reiterate the importance of teaching effectiveness in school. I personally wonder the extent to which any of these findings have been demonstrated to work in the ghetto community today. The need is not necessarily for more research in new ideas but to research the effectiveness of implementing these already learned and tested ideas.

I don't believe the impasse is with what we already know but with the need to generate funds to implement what we know and to develop evaluative components for these intervention programs.

Family Therapy Proposed For The Poor

Only within the past few decades has family therapy emerged as a psychotherapeutic specialty. This approach considers the individual as inseparable from the social context in which he lives. An emotional problem is viewed not as an individual's problem, but a problem within the family system. The term "family system" refers to the interactional unit wherein family members relate to each other through structures (as parents, siblings, rules and regulations) and by communication styles (as assertive and nonassertive).

Most clinicians since Freud had been trained in the traditional analytic methods of treatment. Bell (1963) concluded that it was frightening to realize and draw the conclusion that "the family was the problem" and not the individual. This meant moving from a clinical orientation to a social psychological orientation. Another analyst, Nathan Ackerman (1966) viewed his treatment of patients as needing to focus on emotional and social development in the relationship between family members rather than on the removal of an individual's symptoms. Looking at clients in the context of their families was foreign to those psychoanalytically trained. In fact, anyone interfering in the transference between patient and analyst was thought to "contaminate" the transference and ruin the effectiveness of the analysis. Rieff (1963) notes that Freud never examined in any serious way the cultural conditions in which his therapy

would have to operate. Freud himself recognized some serious limitations with the effectiveness of psychoanalysis when used outside specific parameters of clientele, age and certain emotional disorders. Freud thought persons of lower income, over fifty years of age and severely psychotic could not benefit from psychoanalysis.

Family therapy was a radical move away from traditional psychodynamic therapy. Those trained in Freudian ideology and the practice of individual therapy focused on how to change a person. When family therapy was introduced, a new focus emerged: how to change a family. This was a crucial theoretical shift. Formerly, individual treatment concentrated on issues of repression, fantasy, dreams, transference, diagnosis, and other concepts. In family therapy, the clinician emphasizes interpersonal relationships of the family (in terms of dyads, triads, and larger social networks); communication homeostasis, power balances, and conflict resolutions. The differences of these two theories cannot be expressed too strongly when the focus is upon what motivates people and what causes change. The idea behind psychodynamic change is based on the notion that a therapist acts as an objective influence to restore health to an individual who has suffered harmful influences in his past which are currently determining his behavior. For instance, a person is thought to have undergone unfortunate past childhood experiences with his family and therefore, as an adult is responding to harmful parental introjects. By the therapist dealing with him permissively and kindly, through transference, the therapist substitutes himself, relieves the repressive forces and transforms the inner nature of the "child" in the adult.

Family therapists, however, operate from a different point of view where change is concerned. Usually, the presenting problem involves a child's inappropriate behavior. The family comes for help on the initiative of a parent or at the insistence of some outside social agency involved with the child. Family therapists believe the child's behavior is adaptive and responsive to his current family situation. They believe that the family situation must change if the child is to change. Rather than accepting the idea of parental repression, they think that often the parents are too benign and permissive already. Therefore, if the therapist behaves in a permissive way, it can be anti-therapeutic. Instead of seeing the parents as a harmful influence, family therapists may see the parents caught up in a power struggle with the child which is maintained by how the family functions. Family therapy concentrates on causing change by reorganizing the current family. They may increase the power balance with the parents over the child by supporting the parents; they may teach conflict-resolution skills; they may instruct in listening and communication skills; or they may use any number of other techniques.

The individually-oriented therapist wants to explore past causes, perhaps discuss Piaget and interpret the unconscious. The family therapist wants to explore the current situation, discuss the family's stage of development and change the ways family members are behaving toward each other. Instead of seeing the child as responding to an introject (I am not going to succeed in school because Mom says I'm stupid) or being fixed at a developmental phase, trust vs. mistrust (I'm scared that when I come home by parents will have moved.), the family therapist sees him in a

struggle with other people and expressing behavior adaptive to that struggle (Haley, 1967).

Anthropologists and sociologists for years have studied man in his social milieu and have stressed the importance of role structure and cultural and ethnic systems as they affect individual behavior and development. Haley (1975) writes that there is an increasing awareness that psychiatric problems are social problems which involve the total ecological system. He believes that fragmenting the individual or the family into parts should be abandoned. Family therapy sees a person in this familial-social framework for defining problems as well as for developing new methods of therapy.

Theoretical interpretations and therapeutic styles of family therapists differ according to the practitioner. There are, however, certain concepts agreed upon by all the schools of family therapy. Important to the family approach is the concept of the family as a system and the use of "rules" to regulate the system. The family as a system is open and interactional. Family behavior and activity are regulated by the family members as well as by the other forces outside the system such as school, work, love affairs, drugs, therapy, etc. The family system is self-regulated, and this allows for either adaptive or dysfunctional behavior over time. Family members act constantly on each other, modifying each other's behavior in complex ways. The system's model conceptualizes families in terms of subsystems made up by the parents, siblings, and grandparents. The marital dyad is the subsystem critical to family functioning. Terms such as "norms", "should" or "rules" are used interchangeably to describe how a family is run. Members of the family system

behave among themselves in an organized repetitive manner according to specific or abstract rules (Jackson, 1965). Rules are necessary whether the situation involves daily chores or survival of the family. Systems theorists believe that behind the theory of communication and interpersonal relations lies the necessary hypothesis of family rules.

Throughout this paper emphasis has been on the disadvantaged and the need to identify salient aspects of their lifestyles and needs in order to provide treatment approaches for good mental health. Although family life among the poor, the working class and minority groups may differ somewhat from the other segments of society, the family is an important parameter of emotional functioning (Rainwater 1966; Miller and Riessman, 1968; Gans, 1962; Giordano, 1973; Riessman, 1964; Miller and Mishler, 1959). In the last decade, the disadvantaged family has been perceived as a viable target for mental health services (Chaiklin and Frank, 1973; La Vietes, 1974; Mannio and Shore, 1972). One such program, "ecologically oriented family intervention", attempts to assist low-income families in their interaction with other social systems like the schools, welfare, medical facilities, etc. They believe the major goal is to increase the family's effectiveness as a unit and its capacity to relate to relevant social systems and deal effectively with them (Mannino and Shore, 1972).

Rosenblatt and Mayer (1972) reported on the hesitancy of low-income families to use and respond to family services. Data collected from 6,200 parents participating in project ENABLE, a national demonstration program to help socially and economically deprived persons solve family

and neighborhood problems, found that black and white women showed a marked difference in their willingness to approach professionals for family services. Sixty-one percent of the white women used professional services as compared to 45 percent of the black women. At the same time, the report suggests that those black women who participated, though most unwillingly, were ultimately the most satisfied with the help. Rosenblatt and Mayer (1972) felt the availability and attractiveness of such services could have positive effects for the poor.

The major difference reported in a study by Speer, Fossum, Lippman, Schwartz and Slocum (1968) of family services for mid- and low-income families differed in the number of unkept appointments. Class V individuals had significantly more difficulty in attending sessions regularly than Class III members. They didn't differ, however, in terms of continuing with treatment. Love, Kawan, and Bugental (1972) conducted a well-designed study for comparative analysis of child psychotherapy, parent counseling and informational feedback demonstrating that family-oriented approaches were effective in serving the needs of the disadvantaged. Ninety-one referred families with children experiencing serious school-related difficulties were assigned to one of three treatment conditions. A nonreferred control group also was used as a "normal" comparison group to provide baseline data on family and school measures. Researchers used dependent measures such as school grades, behavior ratings by objective observers, and ratings of family interaction and communication patterns derived from videotape recordings. The results clearly indicated that parental interventions were significantly more effective in improving their children's performance than child psychotherapy was. Low-income

parents responded best to direct information and advice (Love, Kaswan, & Bugental, 1972). Heinicke (1975) also evaluated the effects of family treatment on the parents of 112 children who were experiencing developmental lags. Her study indicated a positive response to family approaches on measured ratings of effectiveness and on specific measures of adjustment.

Marital therapy is often considered the companion of family therapy. Rainwater (1966) suggests that low-income family life is characterized by unstructured marital roles, so strategies focused on improving the marital relationship should be of primary importance for the disadvantaged. Gurman (1974) examined and analyzed 15 studies and concluded that across a variety of marital therapy approaches and outcome criteria, sixty-six percent of treated low SES clients improved. The average treatment consisted of fewer than twenty sessions, and the studies used clinic populations. In only two percent of the cases treated, the referral problem was worse after treatment (Gurman & Kniskern, 1974). Beck and Jones (1973) also summarized follow-up data by interview or mailed questionnaires to 2,000 low SES marital cases served by Family Service Association of America.

Their study included global ratings of patient improvement, change in presenting problem, skills, family relationship and measures of improvement in specific family members. Sixty to seventy percent of the clients returned the questionnaire. They found that patients attending 2-20 sessions had significantly higher improvement rates. Beck later (1976) considered eight studies of 500 low SES couples and concluded that improving communication patterns between spouses was the reason

for significant positive improvement in the marriage. Olson (1976) developed a behaviorally structured, communication-oriented treatment for the disadvantaged but final results have yet to be proven effective with the disadvantaged. Stuart (1976) described a study still underway for improving communication skills between marriage partners. The study involved 750 low SES couples for a ten-year span. The effectiveness of Stuart's operant approach cannot be decided until it ends in 1986. However, one year after treatment, of 200 couples reporting in the study, 174 reported "reasonable satisfaction" with the relationship. Lorion (1976) believes that the trend of available findings is consistently positive and suggests that marital and family procedures seem worthwhile for the disadvantaged.

Some clinicians prefer an eclectic approach of different treatment modalities when working with the poor. Barnhill, Bloomgarten, Siracusa, Squires, and Bergham (1980) combined group and family therapy. Their procedures were also meant to expedite the coordination of community resources and agency procedures for the neighborhood families. They aligned the family's environment and the context in which treatment would occur. They proceeded to intervene with several social agencies, to understand the family's dynamics and to coordinate resources for meeting family needs. Beginning procedures involved four stages of assessment. They wanted to determine whether this meant the problem was physiological. Determining if there was minimum brain dysfunction, hypoglycemia, substance use and abuse (like alcohol, stimulants, and depressants) because any one of these could impede impulse control and judgment. They next assessed the psychological level, whether an acute

sense of helplessness or desperation existed on the part of the violent individual or the victim. They assessed the interpersonal functioning level according to the patient's sense of adequcy, self esteem, or helplessness. They described two obvious symptoms being rigid and perfectionistic; or being socially isolated because outsiders threaten their symbiotic relationship at home. The fourth level of assessment involved family and cultural background for deciding type and level of violence as (a) violence to achieve a goal, (b) expressiveness for emotional catharsis, and (c) cultural values such as sexism or acceptance and passivity. The fifth level of assessment focused on stress that might predispose and precipitate violence, as well as finances, work, school pressures, legal difficulties, disasters, life-cycle transitions and interpersonal conflicts like separation or divorce.

The (Barnhill, et. al., 1980) study indicated that when the poor encountered service agencies they felt withdrawn, socially unskilled, suspicious and threatened. Therapy was low on their priority of needs because major life stresses meant doing something about themselves now. With few resources they tended to feel helpless and become passive and pessimistic. Therapists needed good basic skills and to look for something positive to like about the family, since most clinicians found working with the poor difficult and unpleasant. The clinicians worked in teams, and early visits were made to the home. They tried to teach the clients that the community was to be source of help for their basic needs. Barnhill et al. also tried to coordinate the services of the multiagencies and to evaluate this collaboration of agencies to facilitate goals. The group-experience method of therapy provided a cost-effective

alternative model and a follow-up to crisis and family treatment. The interaction between families strengthened other families. Crisis intervention focused on abuse, legal services, hospital emergencies and support groups connecting individuals with others having similar problems (1980).

Sager, Brayboy and Waxemberg (1970) conducted an interesting laboratory exercise. Five black staff members from participating agencies assumed the roles of members of a ghetto family and four distinguished family therapists (Nathan Ackerman, Thomas Brayboy, Robert MacGregor, and Carl Whitaker) individually and separately conducted an initial "family" interview. The book, Black Ghetto Family in Therapy, a laboratory study, was valued because of the questions it raised, the patient and therapist variables that must be controlled if it were a sophisticated study, and the self-educating techniques displayed by four therapists at work before a live audience.

Each therapist worked to engage the family around four concepts. First, the problem presented is psychological in nature or has major psychiatric components. Second, the emotional problems of an individual are bound up with his life in the family. Third, when one family member is experiencing psychic pain, the others are in some way affected. Finally, family therapy offers some possibility of alleviating the difficulties. The demonstration involved a typical clinic family around the issues: the family was compelled to come; they were split in family matters along gender and generational lines; the family was impoverished and confused about the reason for being in therapy. Whitaker didn't take responsibility for the family accepting treatment, whereas Ackerman felt strong obligations to do so. Ackerman considered the issue of "blackness" important to

address openly with the family as did Brayboy. Whitaker felt the opposite. He accused the family of using "blackness" as an excuse for not looking at more important matters. Sager's et. al. (1970) position states that prejudicial feelings are apt to surface at crucial and unexpected times. They may diminish the likelihood of effective treatment if not handled honestly with all. They believe that whatever the racial background, the therapist must respond to the client's subjective responses based on racial concepts. Sager et. al (1970) believes that it is important for the therapist to have personal black friends to have a deeper understanding of the black client's feelings in therapy.

Ackerman & Brayboy offered the family critical assistance (helping Dad to get a job) in order to strengthen the ties to therapy and to get into more critical hidden family issues (mom's resentment toward dad, dad and son aligned because of black man's concept of manliness, etc.). Whitaker became anxiety provoking to the family and forced unity among family members in opposition to himself. MacGregor conducted a slow-paced interviewed gaining a sense of family history and relationships. They were angered at his pace and lack of interest in solving immediate problems.

Brayboy, Sager and Waxenberg (1970) posed the following conclusions as a synopsis of their study in response to five questions:

I. Can a white therapist operating against the background of a three-hundred-year history of discrimination and deprivation, and within the context of today's tense racial situation, engage such a family in treatment?

II. Is a black middle-class therapist, by virtue of his color bond, better able to engage the black family in treatment than his white colleagues, or do social and economic class barriers render him equally ineffective?

III. What is the role of the therapist in treating families whose prime concerns are subsistence and survival rather than exploration and change?

IV. Are there specific techniques of engagement that are more likely than others to be successful, and where do traditional approaches fail?

V. Are models of psychopathology still relevant? (1970)

I. Can a white therapist operating against the background of a three-hundred-year history of discrimination and deprivation, and within the context of today's tense racial situation, engage such a family in treatment? The question should not be answered by "can". The process of "how can" will answer the question with the following facts in mind. A certain amount of resistance is normal, but the therapist must bear in mind that the family is black and the therapist must deal with overt or hidden prejudices as they arise. The therapist must earn the family's confidence and trust. The therapist must accept that the family's perception of him may be distorted. The therapist must not deny or feel guilty about suspicion and hostility from a black client; otherwise the therapist will interfere with the client's reality testing. The therapist must not label issues of black and white as necessarily "resistance". If the therapist appeases misguided demands, the clients will perceive this as condescending and paternalistic. The therapist must want to know the living conditions, cultural patterns and value system of the clients and not base his understanding on prevailing stereotypes. The therapist needs to understand that overt job discrimination is far more rigid for men than women; police brutality for blacks is a fact of life; and when the family comes as a court referral, they come with the same suspicion and resentment as shown to other authorities. The burden is on the therapist to prove he can be trusted and useful.

II. Is a black middle-class therapist, by virtue of his color bond, better able to engage the black family in treatment than his white colleagues, or do social and economic class barriers render him equally ineffective? Class, as well as racial differences, may affect the patient's felt need to defend himself. Blacks have come to respect blacks more and so today they may generally prefer a black therapist to a white one. However, a black therapist must earn the trust and respect of his black patients and at times they may check, test and force him down into a defensive position. Class distinction can cause the most problems despite the same skin color.

III. What is the role of the therapist in treating families whose prime concerns are subsistence and survival rather than exploration and change? The authors agree that if change is to occur, the interventions should be aimed at stresses coming from the patient's social conditions as well as from interpersonal problems. Ghetto residents understand that others in the larger society live in a more stable and functional manner. Poor people cannot deal with psychological issues until they first learn to handle the hard facts of social or economic problems that dominate their thinking. Treatment and resources need to go hand in hand to deal with life's stresses. "Assistance with matters related to their daily lives cannot be regarded as merely the sugar frosting that seduces a family into treatment." "Doing" for the client frequently has to do with encouraging and supporting the patient's autonomous activities (i.e., referring a client to a vocational counselor because of employment needs). A therapist's professional involvement in the ghetto

community's social and political realm provides support against helplessness and futility.

IV. Are there specific techniques of engagement that are more likely than others to be successful, and where do traditional approaches fail? In the treatment of blacks, the therapy is common to that used in all good family therapy. The difference lies more in the therapist's understanding and attitude than it does with specific techniques of treatment. Blacks have a style of communication that is alien to most middle class professionals. The authors contend that years of humiliating contact with whites have taught the black person not to share his personal feelings with them. Blacks sometimes feel that whites will mock them and be judgmental. Since therapy is based on openness, it is absolutely necessary to establish a relationship of basic trust. Many impoverished families profit most from short-term therapy geared toward dealing with crisis situations of fifteen sessions or less. The crisis can provide immediate motivation which can perhaps be later expanded to more interpersonal issues. Meeting the family at the level of their priorities better enables them to increase their self esteem as well as handle the crisis situation. Families may return later with less resistance and more motivation toward achieving other interpersonal changes. In the therapist's mind, the term "family" needs to be redefined when dealing with ghetto residents. It perhaps should mean, "two or more interconnected or related persons who may or may not share a common residence". The location for therapy may move from clinic to home to include someone important who won't come otherwise. Using titles as "Mr." and "Mrs."

is significant for status that black adults are commonly denied. Being understood and appreciated is the key to good therapy. The therapist must resolve his own fears and hostility toward blacks or the sessions will be a farce.

V. Are our models of psychopathology still relevant? We cannot simply label an attitude or behavior "pathological" because it may reflect the client's family situation or his cultural milieu. Many symptoms can be social in origin and not psychological. We may view wife beating, hustling, and continuous unemployment as "neurotic" and the person who indulges in them as "ill". Viewed against the culture of ghetto life, these may become appropriate, adaptive measures, acceptable to standards for manhood. Conditions under which a client lives must be considered when a treatment program is developed. Today the therapist must learn methods of engagement rooted in the patient's world, and which reflect the patient's priorities rather than the therapist's or that of the agency. The authors also believe that blacks are in the midst of a period of concentrated change between white and black relations, and understanding the change is crucial for effective therapeutic work (Sager, Brayboy, Waxemberg, 1970).

Dennis Bagarazzi (1980) researched the black middle-class family involved in family therapy. The study provides an interesting contrast for interventions and concepts when compared with lower-income blacks. The term "middle-class" referred to a family being economically secure, conjugally stable and upwardly mobile. In such families, either one or both spouses is steadily employed and economically they fall substantially above the poverty level. Little has been researched so there are few insights into the internal dynamics of middle-class black families. Most

sources draw from personal accounts and anecdotal reports. Bagarazzi (1980) feels the systems approach transcends ethnic, racial and social-economic boundaries and offers guidelines for how the family functions.

The black middle-class family Bagarazzi (1980) believes is still affected by prejudice and discrimination inherent in many social, cultural and economic institutions, and therefore, families are reluctant to seek out white clinicians. He thinks that this may be the reason why they drop out of therapy earlier and more frequently than whites do. Scangoni (1971) found that black children of these families experience adequate preparation for marriage and family life, experience encouragement for educational attainment to achieve upward mobility, and are aided in achieving these goals through financial and emotional support and modeling. There were several differences between white and black middle-class families. Stages of the black family life cycle are perhaps not defined in form, timing and process as in most white families. A twenty-year old, unwed black daughter or nonworking black son may still be in the household. Conversely, in white families at this stage, children depart and spouses readjust to each other. Black family boundaries may be more open to outside influences from kinship and community ties. Black spouses experience more egalitarian power structure that affects husband and wife roles. Middle-class blacks living in a white society have several choices to teach their children for personal development and for changing organizational structure and interactional patterns. They may meet crises as they come (changed their phone number when insulting calls keep happening); or physically remove themselves from stresses caused by majority groups (moved from the suburbs back into the black community); or willfully maintain segregation imposed by themselves, (not allow their children to

play with any of the neighborhood children); attempt to combat segregation by forcing change in the white society, (call the police when the neighborhood kids burn a cross on their lawn and sue the parents of the vandalizing youths for damages).

Sattler (1977) found that blacks prefer a same-race therapist, but if the therapist's style and technique are the more important choice factors, then race is secondary. Clinically, black middle-class families are still considered an ethnic subsociety (Billingsley, 1968). Halpern (1970) found that if anger resulted from the black middle-class feeling of being "put down" the therapist needed to deal with this early in therapy as an essential part of treatment. Anger refocused could be used in more constructive and self-actualizing ways. Sattler (1977) suggests a dual role for the therapist: to help the clients recognize the external sources of their difficulties and to encourage them to restructure white society by combating those forces which perpetuate discrimination and limit individual achievement. Sattler recommends that the therapist help family members to be aware that they are displacing their anger against white society and are acting it out within the family context. Another area of importance is establishing firm boundaries when kinship and community groups interfere with marital relations. Extended family members' support systems need not interfere with marital boundaries. Kinship groups can provide parental surrogates who can nurture and accept an abused child or scapegoated child. Bagarazzi (1980) believes that behavioral contracting is useful with blacks because of their egalitarian family structure. He did not describe in any detail the process of variations of contingency contracting recommended for spouses.

Minuchin is a psychiatrist and family therapist belonging more to the structural point of view among family therapists than either of the other two groups, communications or the objection relations. Structural theorists prefer to view the family system as a "dynamic order and structure" where systems, subsystems and rules are more important than the breakdown of communication. Minuchin's unique contribution has been his emphasis on sociocultural stresses that affect family members (unemployment, chronic illness, ghetto life, etc.). His goals as a therapist are to join the family as its leader, to unearth and evaluate family structure and create situations of tension to change family structure (forcing nontalkers to talk, forcing talkers to remain silent, etc.).

Minuchin has been a forerunner in working with low-income families. He has contributed numerous articles to the professional journals dealing with delinquent adolescents and acting-out families; most of which have been compiled in the volume, "Families of the Slums" (1967). For that reason, I shall not refer to most of the articles but rather to the book. Minuchin collaborated with four others, Montalvo, Guerney, Rosman and Schumer, during the clinic work and in the research. In the volume, "Families of the Slums" (1967), the subject is twelve ghetto families who each have at least one delinquent child. These twelve families were matched with a group of ten control families not having a delinquent child. All the families were paid for participating. This served as motivation for the length of the study. Only one of the twelve family's remained unmotivated and missed numerous sessions. The book provides a subjective review of their sessions with the families, on a variety of objective-type family interaction tasks recorded during the sessions. The book also serves as an instructor for those of us interested in

family therapy for the disadvantaged. Its chapters on therapeutic interventions are the clearest and best on the subject, to my way of thinking. Minuchin's approach embraces the family model according to the systems concepts. The research of him and his collaborators represents continuous discussion of cases, peer observation, and supervision of treatment sessions. Each therapist, however, developed his own therapeutic style. The material in the book presents the phases actually used in therapy: a communicational system, a system of family structure, and the affective system. His discussion concludes with the therapist's role, its stresses and strains, planning interventions and resolving problems.

Minuchin et. al. (1967) believed it to be essential for the therapist to be aware of the communication style prevalent among low SES families. Communication can be coded in messages that are symbolic, verbal or active. The therapist can <u>say</u> something or <u>do</u> something that expresses the same meaning and preferably both. "Movement" language is more attended to by the poor. For example, instead of asking a family member, "How come your mother doesn't talk with you?" the therapist challenges, "could you make your mother talk to you?" Enactment of problems is a more stimulating goal than having to abstract thoughts. This technique was especially important during initial periods of therapy. Interpretations of a member's behavior in the family easily registers as criticism and the response can easily be resistance. Instead, comments on behavior that either imply physical or territorial language and are based on more primitive cognitive responses, are more in keeping with these families' communicative style. For instance, a grandmother was continually dominating

mom in the sessions. The therapist had the grandmother go behind the one-way mirror and observe mom and the son in discussion. Grandmother was anxious to return to the session and instruct mom what she should be saying and doing. The therapist commented on grandmother's behavior, "You are always two minutes ahead of your daughter." The therapist's comment was close to the actual occurrence and offered the minimum of abstraction.

In the beginning phases, there are three procedures important to therapy: reducing "noise", focusing on rules of talking, and disengaging content from relationship messages. The first phase, reducing noise is usually pointed out by the therapist. He comments that because of the verbal and paraverbal noise it is difficult to hear the speaker, plus it seems that the person speaking doesn't expect to be heard or be responded to. The therapist insists that the member speaking must single out the person to whom he is speaking and demand that he respond. The therapist also decodes any unclear messages and keeps the individual centered on the communication itself. He stops interruptions, keeps the conversation relevant to the theme, and helps the members carry the theme of the conversation to a conclusion.

The therapist wants to intervene in a systems manner to allow for interactional negotiations. Usually, these people interact with jumbled messages and with the result of not understanding each other. The therapist can fall into a pitfall in this phase. He communicates most with family members most inclined to use logical language. Those most disruptive who aren't as verbal find their only recourse for establishing themselves to continue their disruptive interactions (whistling, singing, looking out the window). If the therapist doesn't succeed in the early

stage of communication operations, he will get caught in the family's system of communicating in a field of noise. The therapist needs to keep the rules of communication to a minimum and he needs to establish a verbal means of problem-solving. Separating content from relationship messages is a difficult process. There is often a lack of response to the content of the message and instead the need to establish contact by reacting to the person. The researchers of the project surmised that reacting only to the person was caused by a desire for closeness. The therapist wants the family members to grow in their observational awareness. For example, a daughter responded to her mother, "I cannot hear you because you always holler at me, so I stop listening." The daughter is responding to her mother's loud behavior toward her and not to what her mother is saying to her.

The beginning sessions also hinge on providing family members with new and various differentiated labels for thinking of their experiences. In the systems approach, it is called "reframing". It is a form of feedback centered on positives, and they are given in the context of present situations. For instance, a mother answered the therapist, "This no good so-and-so; I told him yesterday that he would have to do his homework at four o'clock". The therapist listened, ignored the insult, and selected from the statement something positive for the mother and son. To the child, the therapist stressed mom's concern for his improving in school and for mom he reinforced her interest in his competence in school. Often reframes focus on a person's successful coping attempts. Minuchin et. al. feels that cognitive and affective impoverishment doesn't allow for more effective search for other coping devices, and the therapist needs to supply this.

Communication in most of these families usually relates to a few central issues. These issues can be enlarged by relabeling specific affects (sarcasm, insult) or transactions (arguments). This becomes an ego-enlarging experience for the people involved because it encourages them to solve old problems that have become burdensome. An example involved a controlling mother and several rebellious young children who were out of control when away at school. The therapist rephrased the issue, "Look how the childrens' inability for self control is making you overburdened and helpless. Let's try to help the children increase their self-control." The mother was relabled "overburdened" instead of "controlling", and the children were labeled "lacking in self-control" instead of "rebellious". Interpersonal learning occured as the mother later expressed the wish for her children to help her by assuming self-control, and positive expectations from the therapist followed.

In the study conducted by Minuchin and the others, the strategy followed a three-stage pattern. The stages allowed the parents to vary their roles between being strictly in the spouse role or in the parent role. The goal was to help the family members function within the context of the total family in multiple roles. When spouses were put in the stage to relate only as spouses, the therapist might block any of their communications as parents. When the spouses joined the other family members, the roles assumed might be entirely different. Different subgroups emerged between parents and siblings. According to a systems concept, there may be any number of alliances and splits among family members according to whatever the central issue is (mom and son against dad when son wants more money for fun; dad and son against mom when son wants to gamble on the street, etc.). In rigid families, roles and issues are not

as changeable. The role of the therapist is to operate along lines different from the family's accustomed way and help behavioral roles to become more flexible rather than allow the family to continue in set roles (ex. if mom and dad cannot make a decision without mom consulting son, then Minuchin might set parents apart from son and have them discuss the topic of money for the son without the son interferring.)

Minuchin et. al. (1967) found that families coming for therapy often have their own view of the problems that affect them and the ways in which the family or a particular member needs to be helped. Family members often want change to occur without disrupting their old familiar patterns of communicating or getting along. The family seems determined to make change impossible. The therapist has to be alert not to be pulled into the family's system of fortifying itself against change. Increasing the family's resistance can serve to teach the therapist where the hidden dynamics of the family are. The therapist has the following four choices when working toward new ways of transacting.

First, the therapist can obey the interaction pathways between family members, yet attempt to change the nature of the interaction channeled through them. When the situation is limited to interventions (as, for instance, a brain-injured, extremely limited father and "strong" mother with many small children), the therapist's only choice may be to change interactions but keep the existing pathways (mother relating to children). In order not to challenge her style of mothering, he would only go to the children through their mother's control. "Could we find someone like you to babysit when you're at work - you keep them behaving

good all the time?" The therapist reinforces mom's role. Mom could teach them to listen, to question, to express their ideas - always, of course, keeping "the good control she had over them."

Second, disobey the pathways without explicitly pressing for or pointing to the possibilities or differences for change. In the second choice, the therapist needs to disobey the familiar pathways through simple, nonverbal and nonthematic manuevers. He might ignore a dominating woman and give specific verbal and nonverbal attention to the peripheral, displaced husband and engage him with the children. If tensions are aroused between the husband and wife - find and good. The therapist wants to focus on this issue of the spouse relationship instead of other less important ones (dad what do you think about the trouble John has been in at school. Mom wants to explain but the therapist doesn't look at her and again approaches dad verbally while looking at him and the son and not recognizing mom at all).

The third choice, disobey the pathways while explicitly requesting the use of new counteracting pathways. This choice forces the therapist to go beyond being nonverbal and subtle. Instead, he may need to frontally silence the wife and urge the husband to assume an unfamiliar role of speaking to the child for himself ("Dad, tell John what you think about all this trouble in school", and with his hand raised against mom, he causes her to hesitate when she feels the urge to talk to John in the place of dad).

Fourth, the therapist must eliminate the pathways. The fourth choice calls for more drastic steps. If the system quickly reorganizes itself when the therapist attempts to modify any pathway and the family

cannot wait long enough or allow for new interaction, the situation may then call for removal of particular family member or members to the observation room with another therapist (Dad cannot speak to John directly and so mom begins to correct John's behavior for how he is sitting and why did he wear his dirty clothes to the session. John jumps back at mom verbally and the argument begins. The therapist interrupts and suggests that mom be in the observation room while John and dad are talking).

Assigning interpersonal tasks is an important intervention for creating change. The therapist uses this technique to allow for new or better interaction. He selects one area of conflict between some family members and suggests the interaction occur within a different emotional context. For example, if members are already competitive over an issue, he may suggest cooperation or he may suggest different directions of response (if the child goes through mom to get to dad then he may want them to reverse the pattern by the child going to dad to get to mom or he may want the child to go directly to dad for everything). The rest of the family may be taken behind the one-way mirror to help them in their perceptual discrimination of the family interactions.

Tasks are usually formed along gender (mom and the girls and dad and son) or generational (dad and mom, siblings, etc.) lines. Designing a task means the therapist must clearly understand the family's dynamics and intra-interactions. The important features of communication and affect are such that if the therapist doesn't pay attention to their effectiveness in the task - the interpersonal problems will be unresolved. Minuchin describes the rationale behind these tasks as a therapeutic

intervention. There is the need to limit a person's participation in order to help them become observing and evaluating which helps to develop the ability to be introspective. Becoming introspective is encouraged when family members are behind the one-way mirror because a barrier prevents their habitual reaction of a general, impulsive nature (yelling out, disrupting someone speaking). The impulse to be reactive is delayed and channeled into verbal communication instead. Parents often gain from observing with another therapist because from a position of participation they shift onto the behavior of the therapist in the room with the family and identify with him. Other values from the observation method are: increased self-esteem, greater attention focused among all the children instead of on one, expression of emotions other than anger alone, and a supportive experience of a peer relationship with the therapist. The therapist needs to reward or support changes such as conflict-resolution or new patterns of interaction.

The role of the therapist is complex. The underlying need is to have a deep understanding of the family's dynamics manifested in communication and family transactions. Conflict-resolution skills are strategies such as the task assignment. All assignments must be flexible and responsive to any family changes. Tasks require the therapist to be aware of hidden patterns and underlying motivations. The therapist needs to have tasks well timed and based on clinical ideas that convey the ability to intensify conflict. "When we ask for an interaction in an unfamiliar way, we are not attempting to break a habit by the simple formula of creating another; we are hoping to incuse a vivid awareness of hidden patterns and underlying motivations while at the same time providing

an opportunity for experiencing new ways of attacking a problem". The therapist wants to affect a cooperative outcome in an ordinary situation of antagonists and friction. For instance, mother and son have always ganged up against dad's opinions and ideas. The therapist suggests that mom who was in the observation room come back into the session and in a cooperative capacity help her husband to support their son. The significance of conflict-resolution therapy for the disadvantaged is contained in the following ideas:

1. Typical ways of talking are framed as interpersonal problems and these problems are presented as having solutions by learning how to interact.

2. Tasks are clearly structured, deal with familiar situations, are focused on the here and now, and compel family members to search for solutions through interactions between themselves.

3. When working with large families, dividing the family into subgroups helps to become observers and participants to allow for different types of transactions. It also prevents the usual erratic and multiple patterns of conversation they are used to.

4. The one-way mirror observation helps with distancing feelings, keeps the family in contact although it isn't immediate and habitual, but impulses are channeled into verbal forms.

5. Because these families have difficulty with numerous stimuli and resisting the urge to respond to it all with little sustaining attention, the use of the subgroups prevents this from happening and provides enough stimuli that the experience is productive.

6. Subgroups prevents their impulsive natures from responding without hesitation and reflection because the stimuli is limited.

7. The variations in subgroups helps in the variations of affects expressed in the groups and helps with observing self and others in more individual terms rather than in global terms.

8. Manipulating the subgroup composition helps to prevent the most prominent characteristic of these family members - the reliance on the behavior of others as a target or cue for reaction. Instead they must find alternative responses to whomever is present.

An important responsibility of the therapist is to modify the mood and affect of the family. Any of the previously described techniques can be used toward accomplishing this. There are other techniques which can be helpful such as joining the family by adopting the pace of a crucial family member and by modifying, accelerating or decelerating the affect that most characterizes that person. For instance, if the person in the crucial role is a joker than it is important to be more light; if more argumentative, than the therapist should be more of a fighter; if the mood is excitement, than it would not be good to be reserved or cool). This gives the therapist an "edge" as a most powerful person in effecting transactions. Another technique might be for the therapist to introduce a new affect by modeling it himself. The therapist must also be aware and sensitive to a wide-spread gambit of moods in the family. Emotional disorders in the family can be reflected by a lack of an appropriate affective mood. The therapist may need to directly communicate his feelings as to what is significant or pertinent. Mood of the family can be affected by session length, and by the therapist's own personal mood and language.

The therapist working with this population faces great stress. When planned interventions, meaning accommodations to the family system, turns into an unplanned induction or "suction" into the family system - the therapist is compelled to behave in ways he wouldn't choose and his role becomes restricted. Strain is expected when the therapist enters the family system to challenge it and he resists the power of the system to suck him into reinforce family pathology and resist change. The process of suction is only avoided the more experienced the therapist becomes. While working at Family Resource Center, the "W" family, mother,

son and daughter came to be one of my first clients. The family was volatile and constantly facing interpersonal crises. The mood of the family changed from week to week and whenever I tried to match their mood, they wanted to know why I was acting the way I was. I didn't try to explain except to say that was just me. Being inexperienced, I did face great frustration and did experience the meaning of being "suctioned" into the family's pathological system. I found myself competing with them for a turn to talk, yelling and responding to their various outcries and challenges. Only once did I do in a more outlandish fashion what I had wanted to do for a long time. When their old system of transacting was occuring, I got up and left the room. No one seemed to notice for almost fifteen minutes. Troy came out of the room and asked what I was doing to earn my $5. I told them they didn't need me because they wanted to carry on as they do at home. They could do that without me. Mom was the most upset. She accused me of not caring. I said she was right. I didn't care to be a part of what they were doing. They were angry that I wanted them to pay for the session. And angry that I wouldn't get back into their discussion with them. I told them to only come back if they wanted to work. They didn't come for two weeks but when they did, they wanted to know what it was I wanted of them. My experience with the "W" family was difficult. Many of Minuchin's ideas were tried and found to be useful. When I was suctioned into their system, I became another family member. I adapted to their negative family patterns. Having a second or third therapist working with the family did help to serve as a prevention to suctioning because the third therapist could serve as a true outsider. The following suggestions were a useful reminder of the difficulties that trap a therapist:

1. The therapist can be pressured into accepting unfocused discussion. This entrapment occurs when the therapist tries to maintain a theme while the family continues their usual patterns of loud talk and overactive behavior. The therapist allows the family's manner of conversing to continue without strong enough interventions and rules to prevent these patterns. The therapist will be bombarded with multiple stimulation and will be unable to direct the manner of discussion.

2. The therapist may lower his expectations for communication with the family. Because the therapist is continually thwarted by the random transactions of family members and tries unsuccessfully to link unity into what transactions occur, he raises the intensity of his voice and his tempo of communication for impact. Even if he moves physically closer with his chair to the family, he fails to get the family's attention on his communication. In trying to join the family, he instead is becoming another family member by their prevention of his interventions.

3. The therapist loses his belief in the family members ability to communicate between themselves. The therapist may feel ill-at-ease when the family engages in repeated instances of teasing and aggressive behavior. The family makes affective contact through these operations with each other because they do not directly express ideas between themselves. The therapists must intervene by reframing, modeling, making engagement and disengagements quickly with family members to instruct and continue reconstructive episodes with them. If these difficulties so perplex the therapist, he will find himself conversing with one family member who is more verbal, usually the mother, or he may use their patterns of conversing or he may do the work of other family members by inter-

acting for them and not allowing for moments of silence and waiting for their responses.

4. The therapist may act as if contact alone is sufficient. The Rogerian approach of being an empathic listener has its place when one is first learning and observing the family system and subsystems. However, being a supportive listener in a volatile family puts one on a collision course because each member wants the therapist to be his ally. Contact alone allows the same patterns of transacting to be left untouched and unchanged. Contact is meant to active and not passive. The contact must also be planned and have a goal in mind to be effective.

5. The therapist may find himself replacing orientation to content with active but unexamined relatedness. This means the therapist when joining the family may get caught in the family's patterns of transacting and have difficulty in producing and sustaining rational coherent dialogue. The therapist will begin to "read" behavior rather than verbal content. The therapist's relatedness will be on the family's disruptive activities between members instead of developing a specific and concrete focus on the the content of interactions. This style of unexamined relatedness occurs when the family and the therapist are talking in parallel monologues.

6. The therapist may be anxious to see evidence of impact. When we are impatient and frustrated this intensifies our own need not to feel ineffective and unnecessary. This occurs when a therapist is unsure whether his interventions are registering in the family because he does not have a sense of potency.

7. The therapist may multiply interventions without regard for therapeutic value. The therapist may lose his sense of direction in

understanding the family system, between whom the most potent conflicts reside and how to teach skills of communication and conflict resolution. When this happens and the therapist finds himself either in a field of loud noise and disruptive behavior or with members who are distant and uninvolved, he will feel that he's lost his impact and to resolve this he may feel the need to do something and may go so far as to overdo. This can come from a repeated sense of futility. The therapist is trying in vain to have some impact. The interventions may not fit the highest priority at the time or the person and their value may lie in whether they ought to be paradoxical rather than direct.

8. The family may challenge the therapist's endurance - "why should we talk?" Action is often valued over talking. This concept of devaluation of talking may be threatening to a therapist whose main clinical methods of involvement are "his ability to talk in a special way".

9. The therapist may encourage enormous dependence on himself as therapist. This can develop because all else tried seems ineffective and material aid can become the answer to being useful to a family. Therapy may then be seen by the family as depending on whether they receive material supplies instead of altering their communicational styles that may be blocking a move toward more autonomous behavior. Minuchin and his coworkers have found "that helping the family by giving them money for babysitting or car fare or even loans to buy a coat or install a heater had been used frequently and successfully" (1967).

The therapist must watch the family system, identify areas of stress, note the ways members negotiate, increase tension to test the limits of the system, unbalance and loosen family patterns and force them to organize around conflicts in new ways. The therapist must

learn to observe interpersonal events (who talks to whom and about what) and plan interventions around the family's present situation. Talking about conflict won't help but achieving tenseness can allow for searching out new coping mechanisms by the family members. The therapist must use the family's immediate experience as a vehicle for change. Valuing what they value is essential and understanding what the family's limits are, is essential.

Implications

In the mid to late 1960's when a social psychological orientation was developing, family therapy was a significant part of this ecological trend. Its status, however, was not on the level of community psychiatry and milieu therapy. Those interested in the development of the family approach according to a system concept were not primarily psychiatrists but two anthropologists, a linguist and one psychiatrist. Questions were being asked about the schizophrenic and the interrelatedness of his problems to the family's lifestyle, their manner of functioning and their model of communication. Several groups of psychiatrists and psychologists with similar questions were doing their own research at the same time. One of these psychiatrist, Murray Bowen, became best known for his achievement of expanding research information on schizophrenia to a more general population.

In the 1960's, Salvadore Minuchin, with various collaborators, was particularly interested in family therapy for the poor. Minuchin's background included work among the poor in Argentina and Israel before working in the United States. Rather than having stereotyped the characteristics of the poor, Minuchin has generalized these characteristics. I base this on the premise that to stereotype means to hold a fixed mental picture of a group of people that represents an oversimplified opinion, attitude or uncritical judgment. First, Minuchin's experiences were

broader than most researchers and spanned a working relationship with poor populations elsewhere in the world. Second, Minuchin's conclusions weren't based entirely on his own work but on the findings of Berstein, Deutsch, Riessman and others who worked and researched poor populations in the United States and abroad. Third, Minuchin recognized heterogeneity among the poor and the complications of lifestyles and individuality among the family members with whom he worked. He adjusted his style and techniques to fit the particular family. Fourth, the generalizations he proposed concerning cognitive and affective styles of living and communicating were based on experience and research. Without such basic information, I doubt whether the interventions he and his colleagues clinically researched would have ever been developed.

Although Minuchin's research was subjective, it was later that Minuchin expanded the same data learned from working with poor families to apply to middle and upper-income families. This indicates that some of the same problems affecting poor families were also hindering other SES levels from optimum family functioning.

Research indicates that "good family therapy" can transcend socio-economic levels and racial and ethnic boundaries. Family therapy can work with the rich or the poor and with the black or the white. To engage in "good family therapy" means not only understanding basic systems concepts and interventions but also having a basic understanding of the client's background, present life situation and cultural viewpoints. When working with the poor, a therapist raised with middle-class values and standards and trained by those with the same values and standards must be able to philosophically and behaviorally shift to accept alien values and unfamiliar behavior. It is far too easy to label behavior of another

socioeconomic level or ethnic group as pathological or resistant rather than adaptive and constructive. Every mental health practitioner must reckon with his biases and prejudices. Early in therapy, it may be necessary to confront issues of SES level and race with clients.

There needs to be a variety of personal styles when working with any population. If we are to learn anything from past research, however, we must accept that therapy prior to crisis intervention or assistance with other social systems (like school, work, welfare agencies or other needs, etc.) may prove useless. The therapist cannot remain distant and uninvolved with the practical needs of the poor. Although group therapy is cost-effective and has other merits, I would not invision this mode of therapy replacing family therapy. The difficulty of working with the disorganized family and teaching communication skills, conflict-resolution skills, contingency contracting, etc. will strengthen the viability of group therapy. Cost-effectiveness is perhaps the biggest problem. As professionals, we are capable of learning and being creative but working with the poor will not make us wealthy.

Conclusion

Jesus once said, "the poor you will always have with you". I'm not sure if that was a prophecy or a conclusion. The point is, however, that in any society there will be a portion of the population that will be poor. I had to ask myself: "Shall I blame them for their state of poverty or shall I try to alleviate the frustration and problems they face because of their poverty?"

Research indicates that many responsible individuals have tried to find solutions to this complicated issue of poverty. No one has proposed the elimination of poverty from our Western society, but many are concerned in alleviating the situations the poor must face through understanding, further research, greater funding and better services.

It behooves mental health practitioners to understand the complex relationship between social class and mental illness, to understand the behavior of the poor, to understand the lifestyle learned from a tradition of poverty and to understand the parameters effecting the role of the client. The fact that we know the lower the social class, the greater their likelihood of having mental illness, has not drastically altered choices or availability of services and resources for the poor. There seems to be little research and discussion on practical matters affecting the decision for treatment (as transportation, fees, clinical hours, or babysitting services). The general public believes if you want these

services, you can provide for them yourself. Only recently has this viewpoint changed. Single, middle-class, white parents that are divorced and must support their children are now facing some of these same problems.

Disadvantaged persons have a support system that is minimal, or they live isolated with their problems. Their relatives and neighbors often live with the same difficulties or more, therefore, it is nearly impossible for them to give creative, helpful emotional support to the one in serious need. Sometimes the support system or peer group can obstruct possible solutions. I saw a sixteen year old mother of a two year old son once a week for several months. Her family had abandoned her when she became pregnant. Cynthia lived on welfare in a shabby apartment. After two years of living alone with a young child, circumstances and desperation forced her to ask for assistance. She came because she wanted to finish her high school education, provide better care for Dennis, her son, and be able to qualify after further education as a computer programmer. Through inquiries, phone calls, and visits to agencies in metropolitan St. Louis, some good opportunities developed. When Cynthia went back to the neighborhood and consulted with her friends, they influenced her not to accept agency help but to work it out herself. It was a difficult decision for her to make. Mental health practitioners must understand the extent to which the environment of the poor and their economic and educational opportunities have a stronger influence on them than the services we can provide. Her support system had stronger ties on her and was more influential than I could be.

Personal development of the poor is negatively affected by the severity of their daily circumstances. The early mother-child relationship

and lack of the father in the family has affected the personal development of this population. Self-esteem, role identification, security, and mental development have been stymied. When a slum child's early education and social experiences are not positive and adaptive, their future as an adult becomes more difficult and precarious. The mental health worker must understand the ramifications of the ghetto life on cognition and affective development. Impermanence and unpredictability also describes the life to the poor white. Their life appears more affected by their pride, than has been true for blacks. Since the 1960's this, however, has been changing for the black man and woman.

Understanding the influences of ethnicity on the individual and the family is essential during the initial and subsequent interviews because the therpist is mentally evaluating the client's behavior and conversation. The therapist's personal lack of information about the client's cultural background can affect diagnosis, treatment recommendation, attrition, and the outcome of therapy. This is also true for low SES clients. Negative assessment by stereotyping does not demonstrate personal regard for the individual. Whenever a therapist finds himself in such a mental rut, he must face himself and resolve the question of "why" and "how can I change my way of thinking?" Research clearly indicates the role of the therapist is crucial to treatment. Perhaps the pretreatment process for low-income and working-class clients also needs to include help for the therapist. Bias, prejudice, expectations and disappointments all need to be addressed. Our system of therapist training also needs improvement. If we are going to place the least experienced therapist

with the smallest amount of training into such a difficult position of responsibility, we had better readjust the college and graduate school curriculum to prepare these students for the duties and strains awaiting them.

Riessman, Minuchin and Giordano all believe we must evaluate the salient aspects of the disadvantaged and the ethnic working class life-style to develop appropriate models for treatment. I believe family therapy and a community model for treatment will best serve the needs of these two populations. The orientation for both groups would be more natural, although difficult. Deprivation has kept both groups from becoming a part of the larger society. Family and kinship ties are important. I believe that Minuchin's "slum family therapy" is as comprehensive and practical a means of therapy as we have today. It affects not only the person in trouble but also the environment around him because it works within his family and within the other social networks of which he is a part. The community approach provides for identification with a larger society. This approach would also make it easier for the poor to have access to services. Because of their multiple needs, limited resources and numerous crises; these people require the assistance of those whom they can trust. A community program with lay personnel from their neighborhoods would provide the disadvantaged with the security for relationship and friendship that they need. The community approach also provides for a social networking (with various agencies) that can be somewhat free of judgment from the larger society. Many of the poor want to be free from the suffocating circumstances of poverty.

Contingency contracting as used by behaviorists has also been successful in bringing about change in some families with adolescents and younger children. Working with the parents has been demonstrated to be crucial in effecting change in children. No therapeutic style is complete in itself. The poor are heterogeneous and their needs are diverse. We must be innovative and creative. We must also care. When one of these qualities is lacking, we will be ineffective.

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