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Emily Erchick
Strategy and Power in
Contemporary Clinical
Practice: A Theoretical
Examination of Family
Preservation Philosophy and
Strategic Family Therapy in
the Context of Poverty

ABSTRACT

This theoretical study reviewed family therapy and child welfare literature in the context of poverty. Clinical practice with low-income families was investigated historically. The literature brought to life issues of clinical power and aspects of social control and social reform inherent in direct practice. A consideration of family preservation philosophy and strategic family therapy was proposed. In describing these two schemas separately, their synthesis was eventually formulated and supported.

The larger history of ideas that emerged yielded an epistemological discrepancy between models of practice in the field of family therapy. These discrepancies were further exaggerated by issues of policy, funding, and social service legalities pertinent to our work with the poor. These practical tensions continue to suggest the need for further synthesis and model integration on a theoretical level.

This theoretical study supports the need for a both/and epistemological approach to contemporary clinical practice with families experiencing poverty. Postmodern trends in clinical practice, favoring “stories” over “systems” must not be adopted or discounted, but rather, incorporated into more concrete aid and ways of knowing. Clinically we must continue to utilize and respect our social influence and our social power as providers of treatment.

STRATEGY AND POWER IN CONTEMPORARY CLINICAL PRACTICE: A
THEORETICAL EXAMINATION OF FAMILY PRESERVATION PHILOSOPHY
AND STRATEGIC FAMILY THERAPY IN THE CONTEXT OF POVERTY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2009

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For my paternal grandparents, Joseph Paul Erchick and Teresa Elaine Corbisella. See you soon and we will have a long and slow breakfast! We will talk about our childhoods and the weather, about Hungarian brothers, Italian sisters, and everything before and since. It will be nurturing, enriching, and safe. I will know that I am home.

Special thanks to Joan Laird.

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“Power is not necessarily a dirty word” (Shweder, 1996, p. 41).

CHAPTER I

INTRODUCTION

Social class is a significant demographic variable affecting every family's life and welfare. It has been theorized that socioeconomic standing is a social construct with ramifications for personality, humanity, and clinical intervention (Altman, 1995; Becker & Liddle, 2001; Bensen, 2007; Bos, Park, & Pietikainen, 2005; Brymer & Phillips, 2006; Dickerson, 2007; Doherty & Carroll, 2002; Eanon & Venkataraman, 2003; Ehrenreich, 1985; Gwyn & Kilpatrick, 1981; Hernandez, Almeida & Delvecchio, 2005; Liu, Soleck, Hopps, Dunston, & Pickett, 2004; McCarthy, 2001; Rojano, 2004; Tubbs, Roy, & Burton, 2005; Waldegrave, 2005). Many questions have been proposed considering how social class is subjectively understood and experienced (Altman, 1995; Bensen, 2007; Liu et al., 2004; McCarthy, 2001; Tubbs et al., 2005), as well as the general implications of poverty for development and well-being (Becker & Liddle, 2001; Davies, 2004; Doherty & Carroll, 2002; Duncan & Gunn, 2000; Eanon & Venkataraman, 2003; Rojano, 2004).

Despite the 7.6 million families roughly identified as living in poverty in the United States today (DeNavas-Walt, Proctor, & Smith, 2007) and its predominance in the lives of African American and Latina women most notably (Becker & Liddle, 2001; Eanon & Venkataraman, 2003; Gwyn & Kilpatrick, 1981; McCarthy, 2001; Osmond & Grigg, 1978; Rojano, 2004; Waldegrave, 2005), questions remain regarding how to successfully engage poor families clinically (Altman, 1995; Becker & Liddle, 2001; Bos

et al., 2005; Brymer & Phillips, 2006; Danto, 2005; Doherty & Carroll, 2002; Eanon & Venkataraman, 2003; Hernandez et al., 2005; Gwyn & Kilpatrick, 1981; Liu et al., 2004; Madsen, 1999; McCarthy, 2001; Minuchin, Montalvo, Guerney, Jr., Rosman, & Schumer, 1967; Minuchin, 1974; Minuchin, Colapinto, & Minuchin, 1998; Rojano, 2004; Tubbs et al., 2005; Waldegrave, 2005; Walls, 2004).

This study will build on this discussion. In examining the efficacy and success to date of various ways of working with poor families, my objective is to survey and synthesize the literature on clinical work with families experiencing poverty. To study the relationship between models of family treatment is the project's main intent. This review will serve as the basis for my discussion. My hypothesis is that poverty in general and family poverty in particular is both complex and inadequately understood, which is why I have selected a theoretical approach as my research design. An examination of the major themes in the literature will serve as a foundation for a critical discussion and, hopefully, some suggestions for both further research and clinical practice in working with families in poverty.

The project will begin with a historical literature review in Chapter II. My aim is to situate family therapy and intervention in relationship to family poverty. Family therapy and the many theories, concepts, and interventions associated with various models has a long and often times confused history within the larger scope of mental health (Beels, 2002). Some credit family therapy as a set of radically new ideas (Dickerson, 2007; Hernandez et al., 2005; Kaslow, 2000), which commenced with systems theory and the communications research of the Bateson Project in the early 1950s (Guerin & Chabot, 2007; Hoffman, 1981, 2002).

In addition to this groundbreaking and interdisciplinary work, which led to the development of various family models, others highlight the strong tradition of attention to the family unit in social work's professional beginnings (Beels, 2002; Ehrenreich, 1985; Hartman & Laird, 1983; Laird, 1995; Woolston, Adnopolz, & Berkowitz, 2007). Charity workers and organizations led by middle-class and affluent women targeted poor families with their interventions and home-based visits focused on health and sanitation at the turn of the 20th century (Beels, 2002; Ehrenreich, 1985; Hartman & Laird, 1983; Halpern, 1999; Richmond, 1919). Many received a welcome as well as an introduction and general socialization to life in the neighborhood by these women working towards a communal goal (Beels, 2002; Ehrenreich, 1985; Halpern, 1999).

The work of child psychiatrist Nathan Ackerman must also be considered an important milestone in the development of the field of family therapy (Beels, 2002; Guerin & Chabot, 2007; Hoffman, 1981, 2002; Rojano, 2004). Ackerman, in the 1930s, began working with both the child and the family as he believed the health and well-being of the child was dependent on the health and well-being of the family (Ackerman, 1937, 1967; Beels, 2002; Guerin & Chabot, 2007; Hoffman, 1981, 2002; Rojano, 2004). Today, in many agencies, therapists work with both the child and the child's caretakers (Altman, Briggs Frankel, Gensler, & Pantone, 2002).

My goal for this project is to balance carefully the history of family treatment with the special consideration of poverty in a family's life. Chapter II will lay the groundwork for the remaining paper. I will focus the project thereafter by exploring two theoretical stances that I believe hold significant promise for continued work with

families experiencing poverty. Family preservation philosophy and strategic family therapy are the two organizational schemata I will explore and describe.

Chapter III will elaborate on family preservation philosophy. It will highlight the nuances, strengths, and basic values of this broadly conceptualized approach. Family preservation, which commenced as a movement within the field of child welfare specifically, has since grown to encompass policy, funding, and a general philosophy for family intervention (Berry, 1997; Cole, 1995; Kelly & Blythe, 2000; Kim Berg, 1994; Ronnan & Marlow, 1993). A strengths-based approach to traditionally pathologized relationships and family systems lies at the heart of this clinical model (Berry, 1997; Cole, 1995; Kelly & Blythe, 2000; Kim Berg, 1994; Ronnan & Marlow, 1993).

In Chapter IV, I describe strategic family therapy and its potential as a field therapy in working with families experiencing poverty (Bobrow & Ray, 2004). This model may seem to be an inappropriate choice for those familiar with the activity of the therapist and the paradoxical directives central to strategic intervention. My intent is to re-consider the model in light of more recent contributions from narrative and social constructionist approaches (Brymer & Phillips, 2006; Dickerson, 2007; Doherty & Carroll, 2002; Hoffman, 1981, 2002; Hernandez et al., 2005; Kaslow, 2000; Laird, 1995; Lerner, 2000; Liu et al., 2004; McCarthy, 2001; Rank, Yoon, & Hirschl, 2003; Rojano, 2004; Waldegrave, 2005; Walls, 2004; White & Epston, 1990), and at the same time recognizing the special stresses on families that poverty brings and its implications for work with these families (Altman, 1995; Aponte, 1994; Auerswald, 1983; Becker & Liddle, 2001; Berry, 1997; Bobrow & Ray, 2004; Brymer & Phillips, 2006; Doherty & Carroll, 2002; Duncan & Brooks-Gunn, 2000; Eanon & Venkataraman, 2003; Gwyn &

Kilpatrick, 1981; Halpern, 1999; Kelly & Blythe, 2000; Kim Berg, 1994; Laird, 1995; Liu et al., 2004; Madsen, 1999; McCarthy, 2001; Minuchin et al., 1967; Minuchin, 1974; Minuchin et al., 1998; Osmond & Grigg, 1978; Rank et al., 2003; Rojano, 2004; Tubbs et al., 2005; Waldegrave, 2005).

In Chapter V, I elaborate further on the theories presented in Chapters III and IV and examine the possibilities for synthesizing and integrating the two models. This chapter also highlights the progression of the paper including the general findings, clinical implications, and concluding remarks. In this chapter, I also critically review the project's strengths and weaknesses. My central interest is in exploring what theories and models offer the greatest potential in our work with families experiencing poverty.

As the national economy continues to falter and an increasing number of families are facing the stresses of poverty, unemployment, and homelessness, in addition to the economic and social interventions needed to restore economic health, it is also important to continually examine whether our direct work with families is strengthening and empowering. Are we meeting the mental health needs of this vulnerable yet deserving population? What have history, research, and the sheer determination and trial and error of direct practitioners offered families experiencing poverty? What have these families taught the various professionals who provide social services? This study is an attempt to examine the previous research as a means of ensuring successful outcomes in the present, with an eye towards the evolution of future programming.

CHAPTER II

FAMILY POVERTY AND FAMILY THERAPY

In the introduction, I offered a snapshot of different trends and parallel movements in the United States regarding mental health and family treatment. Certainly, as a history, my introduction was not complete. One could spend an entire project simply perusing the family literature. One issue that has at times been ignored in the mental health literature in general, and in the family therapy literature in particular, is that of social class. Social class, and especially the issue of poverty, must be considered in any examination of the history of family theory and intervention.

Overview: History, Social Class, and Family Therapy as Intervention

Clinical theory and intervention in the United States was and continues to be heavily influenced by psychoanalytic and psychodynamic theory (Beels, 2002; Kurzweil, 1989). However, interest and attention to the family play an important role in the history of the mental health professions, especially in the history of social work's professional development (Beels, 2002; Ehrenreich, 1985; Hartman & Laird, 1983).

Social workers currently practice in a variety of settings, including non-governmental agencies, community agencies, hospitals, schools, and private practice offices. The profession's wide-ranging breadth and vision is rooted in a long history of ebb and flow between social control and social reform (Hartman & Laird, 1983).

Early leaders, Grace Abbot and Mary Richmond, considered the family the focus of intervention (Hartman & Laird, 1983). Due to trends in immigration, community need, and increased population with the rise of industrialization (Ehrenreich, 1985), social work at the turn of the 20th century was defined primarily through trial and error and direct practice. The work was family-centered (Hartman & Laird, 1983).

Modernism, a movement of thought increased in national popularity around the beginning of the 1920s with its underlying assumptions regarding the potential and psychology of the individual. Modernism was an important factor in the larger shift that moved social work away from family intervention. Despite heated debates and questions regarding social work's professional development and progression at National Conventions, through publications, and with the rise of training programs at hospitals, colleges, and universities, as the mental hygiene movement focused on the individual (Hartman & Laird, 1983) and as psychoanalytic thought developed and engaged the nation at large (Danto, 2005), social work similarly responded and embraced individualized treatment.

This focus on individual treatment was a generalized trend across all mental health services until roughly around the 1950s when the family's larger role in treatment re-emerged (Hartman & Laird, 1983). Similarly, and not surprisingly, the history of child psychiatry also mentioned early direct practitioners working with families decades prior to the emergence of the family therapy field (Ackerman 1937, 1967; Beels, 2002; Rojano, 2004).

Social class as a clinical consideration followed a similar trajectory. The influence of individual concerns and the rise of modernism as a movement not only took mental

health away from being family focused in the United States, but also considerably farther away from its being socially focused as well. With the emphasis on the helping relationship and the concept of “transference,” practitioners lost sight of the social and economic context. In the field of mental health and preceding the national “War on Poverty” (Duncan & Gunn, 2000; Hartman & Laird, 1983), it was not until 1958 that a study concerning social class and issues of mental health was published (Altman, 1995; Hollingshead & Redlich, 2007).

Hollingshead and Redlich’s *Social Class and Mental Illness: A Community Study* exposed major and problematic differences in the mental health field in the treatments afforded patients from various social classes. It was reported that patients of lower socioeconomic standing received inferior treatment, were denied treatment because of discriminatory policy, and were often unable to afford the cost of treatment as well (Altman, 1995; Hollingshead & Redlich, 2007). The poor were considered unreachable as therapeutic clients because of these issues and misunderstandings. A significant amount of literature devoted to family poverty as an issue of importance in family intervention, as identified by social workers, psychologists, family therapists, and psychoanalysts alike eventually began to emerge on a national scale in the early 1960s.

In 1964, Riessman, Cohen, and Pearl wrote *Mental Health and the Poor*, a series of articles that provided a substantial analysis of the relationship between socioeconomic issues and mental health. These articles focused on social context. Poverty was again linked to inferior treatment, as well as early termination in treatment due to the associated daily struggles of living in poverty. Prevalence, diagnosis, and type of treatment were identified as being different for the poor. Other more generalized inequalities of treatment

were identified such as cost, scheduling, and frequent misunderstandings based upon the lack of cultural competency in clinics as well.

These studies have been critiqued as emerging from a middle-class viewpoint, just as the earlier case conceptualizations of the poor were unsuccessful for their inability to address the significance of social class in an individual and family's life. Despite the large amount of research that emerged in the early 1960s, meanings and interpretations of poverty were varied. A "culture of poverty" was theorized (Lewis, 1966) and then fought against vehemently (Leacock, 1971). These trends continue as some still argue for ethnic and even racial interpretations of poverty (Murray & Herrnstein, 1994) in a family's life; whereas, more and more support continues to favor structural explanations of why poverty persists in America today (Rank, et. al., 2003, Rank, 2004).

It is the family that links an individual to society, as has often times been conceptualized and suggested (Hartman & Laird, 1983). Perhaps this explains why both family-centered practice and social class as an understood treatment context disappeared as major trends in clinical practice for several decades. In further support of this formulation, it was not until the late 1950s that theories about "systems" and communication began to emerge, challenging traditional, western, ideas of causality and linear thinking (Hoffman, 1981). The re-emergence of family treatment coincides with the beginning research focused on social class and treatment intervention.

One of the major thinkers who had great influence on the infant family therapy movement was anthropologist Gregory Bateson (Hoffman, 1981). Bateson began to write about what Hoffman summarizes as a circular epistemology (1981). This had direct

implications for and influence on the emergence of family therapy as a field of clinical intervention (Dickerson, 2007; Hoffman, 1981, 2002).

Communications theory inspired Bateson's work greatly. Rooted in Norbert Wiener's probability theory, communications theory was further expanded by Claude Shannon's research in the late 1940s (Hoffman, 1981). This work grew out of wartime interests in connecting mathematics to science to issues of coding and cryptography during World War II ("Claude Shannon", n.d.). Shannon's work was eventually referred to as information theory whereas Wiener was applauded as the father of cybernetics, or the interdisciplinary study of systems ("Claude Shannon", n.d.; "Cybernetics", n.d.). *Cybernetics* defined the concept of feedback to refer to signals, loops, and processes that describe how information and communication move ("Cybernetics," n.d.).

Bateson was impacted by these ideas (Hoffman, 1981, 2002). He began to apply the idea of a *system*, defined as "any group of objects that work in concert to produce some result," to his work in the social sciences ("Systems Theory," n.d.). His collaboration with others such as Haley, Weakland, and Jackson further explored cybernetics and communications theory leading to a breakthrough of thought constituting cultural change. They began to think of families as "systems" complete with feedback and both observed and described by mathematical understandings of change (Hoffman, 1981).

In family therapy, in the 1960s and 1970s, and growing out of this changing epistemology, a number of "schools" and models of practice were developed, which held significant and lasting meaning for how mental health and psychopathology would be defined and treated (Beels, 2002; Hoffman, 1981, 2002). The individual patient began to

recede as the focus of clinical intervention in this dynamic way of thinking about the newly understood interconnected systems in the world.

In 1956, in fact, Bateson had begun to work in Palo Alto with other systems pioneers interested in the phenomenon of schizophrenia, how the family might be implicated in its development and perpetuation, and what clinical and systems treatment might be developed (Beels, 2002; Hoffman, 1981). Although many of these ideas of causality were later discarded, this research and practice was influential in the field of family therapy as systemic and strategic therapies emerged (Dickerson, 2007; Hoffman, 1981). These ideas helped to give theory and voice to the family as a system in a new and pivotal way. Poverty as a clinical consideration is today overwhelmingly identified as sitting entrenched in “a family-larger-system perspective” as well as in a larger sociopolitical context as a result (Imber-Black, 1991, p. 371).

Influential in the early years of the family therapy movement were other merging ideas from psychoanalytic theory with systems concepts, seen particularly in the work of Nathan Ackerman and in the multigenerational systems approaches in the work of Murray Bowen and Lyman Wynne (Beels, 2002; Guerin & Chabot, 2007). Other early leaders embraced a more experiential approach as seen in the work of Virginia Satir and Carl Whitaker. Their influence on the field, as humanistic clinicians, is more lasting than is often recognized because of their emphasis and focus on their work as teachers and practitioners (Hoffman, 1981). Satir’s optimism and Whitaker’s humanism provide a legacy for work with all populations, as they seemed able to transcend issues of class, by both understanding and acknowledging context. This reflexivity and use of self arguably

allowed Satir and Whitker to serve their clients well no matter the family's socioeconomic standing or issues of wealth and financial health outside the office.

Within family therapy intervention, however, poverty as a clinical context was first explored most significantly in relationship to the ecological and systems approach of Edgar Auerswald (1983), the structural approach to family intervention developed by Salvador Minuchin and colleagues (Minuchin et al., 1967), as well as in the eco-structural approach eventually surfacing in the writings and leadership of Harry Aponte (1994). Due to the populations being served and the focus on clinical context associated with these models, family poverty and poor families in particular were arguably first captured by these family therapy pioneers (Hoffman, 2002).

Auerswald, Minuchin, and Aponte: Pioneers In Working with the Poor

Edgar Auerswald, working in New York City, was at the helm of the Gouverneur Health Services Program from 1964 until 1969 (Auerswald, 1983; Hoffman, 2002). Auerswald, working with Dr. Howard Brown, drew inspiration from and based the program's design on an ecological worldview. This program was developed to implement community-based health care for the economically poor and those living along the East River and the neighborhoods in New York City's lower east side.

Auerswald is remembered for his charity with clients as well as for his clinical ingenuity (Hoffman, 2002). An example of Auerswald's creative generosity is the mobile crisis units that he envisioned as a more comprehensive means of streamlining mental health and general health services. Auerswald's ideas in fact were similar to those of the Bateson's Project, in the sense that he incorporated a systemic and ecological model.

However, his work focused on the economically poor in particular (Auerswald, 1983, 1998).

Auerswald explains how one's viewpoint, or epistemology, rather than the needs of the client, affect and shape intervention. His *Afterthoughts* of the Gouverneur project today remain political as well as formulaic,

I believe the major lesson to be learned from these events is that there is a gap in the socioeconomic ladder in our country. There are rungs missing between the poor at the bottom and those in the middle and at the top. And, there is a *qualitative* difference between the segments below and above that gap. This means that whenever people from the top segment design programs, which are the same for both segments, such programs, *will not fit* the bottom segment. The Gouverneur program was designed with only the bottom segment in mind, in cooperation with people from that segment. It *did* fit. And it can be replicated. (1983, p. 22)

While Auerwsald was a part of the significant work happening in New York with the poor and in the service of family mental health in the 1960s, on another front Salvador Minuchin, working at the Child Guidance Clinic in Philadelphia, was pioneering the "structural model" (Hoffman, 2002; Minuchin et al., 1967; Minuchin, 1974). This work was described in an important volume, published in 1967, *Families of the Slums: An Exploration of Their Structure and Treatment*. The book incorporates family therapy ideas that grew out of a research project at the Wiltwyck School for Boys in New York City.

For some time now, structural family therapy has occupied a central place in the family therapy field. Structural family therapy has been modified and changed over the years and is still part of a practice foundation for both beginning and experienced clinicians. Structural concepts and terms are dropped casually in clinical conversation due to the charisma and influence of Salvador Minuchin and the concrete directives

associated with such concepts as boundaries, subsystems, enmeshment, power, and relational function or dysfunction occurring within a family system.

Working with Families of the Poor represents Minuchin's structural model in both a comprehensive and refined fashion (Minuchin et al., 1998). After years of working with poor families, Minuchin and his colleagues identify certain themes as continuously troubling poor families. They believe many poor families often receive so many services that the services are frequently confused, fragmented, and uncoordinated.

This text reviews the weaknesses and strengths of various services and highlights a continuation of the Bateson Project's legacy--that a general systems theory is a helpful way to discuss family intervention (Minuchin et al., 1998). In the structural model, Minuchin and his colleagues also highlight the idea that the family may be understood as a system, with patterns of repetition and various subsystems. In fact, the family may be viewed as a small society. In this view, it is the bonds between the members of society structural family therapists utilize in order to help families change.

In *Working with Families of the Poor*, the multi-crisis poor are considered in depth (Minuchin et al., 1998). Several factors render poor families in particular more vulnerable to various kinds of breakdown. These are described as being family specific although often due to the thematic issues of unemployment, homelessness, and a chronic family history of trauma or illness. Furthermore, practitioners often overlook the strengths of poor families. Well-meaning interventions that attend only to one family member, for example, can split a family apart. In addition, families can be disempowered as the focus on problem and dysfunction, chronicled in a growing institutional paper trail, shapes a negative family narrative.

Working with Families of the Poor also insists upon a social service critique, due to the knowledge and repeated successes and failures of its authors. Their musings are political in that they document the tough paradoxes poor families are left to negotiate daily. I mentioned the pros and cons of individual treatment as one complex issue. Minuchin and his colleagues also address the sociopolitical context of poverty including attitudes in society towards the poor, predominantly the moralistic legacy whereby families and individuals are blamed for larger societal systems and structures.

The structural family therapy model has grown to consider all families, but it is its origins and application with families experiencing poverty that has helped to both define its success, as well as allow those families to be understood more accurately. Structural approaches now incorporate narrative ideas, as therapists encourage individual and family stories in ways that are respectful. Originally, however, *Families of the Slums: An Exploration of Their Structure and Treatment* pathologized homosexuality, single-parent families, and was structurally rigid in regards to familial gender roles (Minuchin et al., 1967). Minuchin's later publications have since included the acknowledgement that to feel understood and respected as a family is indeed one of the necessities of successful clinical work.

Working with Minuchin for many years in Philadelphia and eventually becoming the director of the Child Guidance Clinic, Harry Aponte worked with poor families as well. He has focused his work on observations and understanding of this population clinically (Aponte, 1994; Hoffman, 2002). His experience and success with families experiencing poverty in treatment was published in *Bread & Spirit: Therapy with the New Poor* (1994). In my reading, Aponte's ideas seem to provide the academic bridge

from the family therapy pioneers to many of the more community and “family-larger-system perspective[s]” popular with clinicians working with poor families today (Imber-Black, 1991, p. 371).

Aponte, in his work and writings, developed an eco-structural approach that combines the best of both Auerswald’s and Minuchin’s models (Aponte, 1994). The metaphor of “bread and spirit” is the thread throughout this text, as he weaves the spiritual with the pragmatic and concrete in describing the various complexities associated with working with impoverished families.

Aponte’s eco-structural model draws on structural ideas in a way that includes the individual, family, as well as the community (Aponte, 1994). The presenting issue, the ecosystemic context, and the immediate and long-term goals the family holds are all examined. Aponte is elegant in his ability to both observe and prescribe. He encourages an enactment from the therapist centered in the clinician’s ability to understand their own person and train their own spirit and self-understanding accordingly.

Likewise, Aponte highlights the frequent under-organization of the poor family, emanating from the difficult social conditions that can so often have a harsh effect on their lives (1994). He is conscious of the values of both the families and clinicians alike but implores therapists by suggesting,

If we do not have the courage to address frankly the damage to the socially disadvantaged, we cannot repair the harm. (p.14-15) Moreover, work with low-income families by its very nature calls for an even more active approach. Therapists must put more of themselves into the work to repair the effects of social deprivation and damage of the psyche and family. (p.154) At the heart of it all, under organization represents the arrest of both functioning and spirit in the family. (p. 19)

Aponte speaks of the dialectical balance between the thesis and the antithesis of society, whereby the poor are exposed and vulnerable to societal critique, while the wealthier can hide their individual and social deficits.

His point here is biting. There is no way to hide from the cultural, spiritual, and communal deficits that poverty fosters; therapy is only a band-aid in the larger process of obtaining meaningful life and familial health in all its contexts (Aponte, 1994). Writing on the cusps of the constructivist and more postmodern trends building in the field of family therapy and in academia at large during the time of *Bread and Spirits* publication, Aponte's reflexivity and warnings today remain pertinent.

Throughout his career, Harry Aponte managed to both observe and respect the poor families he encountered clinically (Hoffman, 2002). Aponte's secret, which he shares ardently, is in his willingness to acknowledge the strengths and vulnerabilities of these populations, as well as the relational and familial issues that arise in all families, issues transcending social class, despite the importance of social, political, and ultimately clinical context (1994).

Auerswald, Minuchin, and Aponte all worked with families and contributed greatly to how family therapy and intervention might look with families experiencing poverty, a legacy that is influential and affects how family therapists are working with poor families today. Structural family therapy, an ecological worldview and perspective, as well as an eco-structural combination provide the backbone for community intervention nationwide. Prior to looking more closely at family intervention with the poor today, however, narrative therapy and a solution-focused approach to therapy must too be considered.

Narrative and Solution-Focused Therapy with Families

Narrative Means to Therapeutic Ends (1990) introduced the United States to the writings and clinical work of Michael White and David Epston's narrative therapy. Inspired by social constructivist ideas emerging in anthropology, linguistics, literary criticism, philosophy, and other fields, White and Epston highlight the idea that our lived experiences are shaped by the language we use to describe these experiences. We, in turn, draw on our larger familial and cultural narratives, or stories, to make meaning. White and Epston are particularly concerned with the issue of power and the ways in which individuals can be disempowered when they are unable to shape their own self-stories.

Their work has had substantial influence in bringing consciousness to themes of culture, gender, ethnicity, poverty, and other aspects of social discourse that defeat hope and promote individual, family, and community "problem-saturated" narratives (White & Epston, 1990, p. 16). White and Epston's clinical technique is to start where other interventions have not been effective and have, in effect, let families down. From letter writing to award offering, the model is intentional in the sense that each family's needs are differently addressed and there is a large emphasis on the family doing the work with mere tweaking and facilitation by the clinician. To "externalize" issues is at the core of the narrative model (p. 38). People are not problematic, their experiences are, and their stories are. Thus, a poor family is not seen as "dysfunctional" in this way of thinking, but as having a problem with ill health, unemployment, discrimination, and so on.

Many others have drawn inspiration from the works of Michael White and David Epston in work with poor families (Eanon & Venkataraman, 2003; Madsen, 1999;

McCarthy, 2001; Waldegrave, 2005). Solution-focused therapists, leaning on the original work of Insoo Kim Berg and Steve de Shazer, also focused on empowering and strengthening families. In fact, solution-focused therapy, with its emphasis on helping families to gain a new and refreshing understanding of their situation, has become a central model in clinical work with the poor (Madsen, 1999).

Solution-focused treatment for families experiencing poverty speaks directly to the social services critique offered by Auerswald, Minuchin, and Aponte, namely, the social and national trend of blaming the poor rather than looking structurally and systemically at the causes of family poverty. The model's pioneers, in fact, wrote specifically with poor families in mind in offering solution-focused therapy as a tool in family-based services (Kim Berg, 1994). Grounded in a belief that change is inevitable, Insoo Kim Berg offered these three simple rules to help establish clinical work with families:

1. If it is not broke, do not fix it.
2. Once you know what works do more of it.
3. If it does not work, do not do it again. (1994, p. 15-16)

The Brief Family Therapy Center in Milwaukee is the home and origin of the solution-focused model. Insoo Kim Berg and her husband Steve de Shazer worked with colleagues exhaustively to provide a differing view of change. In the preface of *Family-Based Services: A Solution-Focused Approach (1994)*, Kim Berg is encouraging of the clinician, transparent, honest, and directive about her approach, the model, and its setbacks. Solution-focused intervention includes the worker's stance of patience with the family, and an overarching optimism and focus on the solutions in a family's life. Kim

Berg's ability to encourage the clinician shows how empathetic and understanding she too was with families and particularly with families experiencing poverty.

The influence of narrative and solution-focused therapies cannot yet be fully measured. These and other approaches to helping families face difficult challenges today, as they do not fit neatly into the dominant medical model, the insistence on diagnostic categories, and the variety of insurance-driven mandates. Families experiencing poverty, like all families, are complex, and they face enormous social and economic stresses, which influence every aspect of family life.

The Pioneers Meet the Postmoderns

The rise of modernism with its emphasis on the individual, as well as the popular culture's reception of psychoanalysis in the United States (Danto, 2005), all help to denote the family losing ground as the focus of treatment until its re-emergence clinically circa 1950 (Hartman & Laird, 1983). Generally, the family began to emerge at this time as a new unit of interest in the mental health professions (Hoffman, 1981, 2002).

The family therapy movement began with communications research leading into systems theory used to help describe families. The field eventually grew to include a deeper understanding of context across an individual's lifecycle. Systems theory influenced several early models of family intervention and I have introduced Auerswald, Minuchin, and Aponte as pioneers for their work with poverty as a clinical context in the lives of families.

In the 1980s and early 1990s solution-focused ideas, emanating from the work of Kim Berg and de Shazer, as well as narrative ideas growing out of White and Epston's

work in Australia, brought a breath of fresh air to the family therapy field. As ideas were spread and re-considered, models were developed and generalizations made. General systems theory, which influenced the work of the pioneers Auersawld, Minuchin, and Aponte, emerged as the glue linking early family models together, as well as the strengthening agent when working with families experiencing poverty at this time (Imber-Black, 1991; Rojano, 2004).

The shift in thought occurring in the late 1980s and early 1990s that is reflected perhaps most vividly in the rise of narrative therapy (Beels, 2002; Brymer & Phillips, 2006; Dickerson, 2007; Doherty & Carroll, 2002; Guerin & Chabot, 1997; Hernandez et al., 2005; Hoffman, 1981, 2002; Kaslow, 2000; Laird, 1995; Madsen, 1999; McCarthy, 2001; Waldegrave, 2005; White & Epston, 1990) has been labeled postmodernism, social constructionism, and poststructuralism.

Dickerson (2007) suggests that family therapy theories express different ways of thinking about how to work with people in relationship. She continues by describing an epistemology as an overarching worldview, which describes how we think about how we think. Thus, many theories might emerge under the same umbrella, from the same epistemology.

Freedman and Combs (1996) also speak to this distinction. In their book: *Narrative Therapy: The Social Construction of Preferred Realities*, they compare different metaphors used to guide the clinician. There is a narrative therapy influenced by both postmodernism and the work of White and Epston. They consider the “systems” metaphor as potentially limiting the authenticity of the work, since it is a mechanistic metaphor that can distance the therapist from relationship issues and everyday lived

experience. Freedman and Combs advance a clinical model that favors the metaphor of “story” over that of “system,” believing that the notion of “family system” might limit the ability to see a larger flow of possibility, ideas, and discourse when working with families.

Thomas Kuhn’s (1962) *On the Structure of Scientific Revolutions* first introduced the concept of *paradigm* and *paradigm shift* to represent the sociology of thought as a basis for better understanding the history of science and how new ideas emerge culturally. Overall, postmodernism can be thought of as a paradigmatic shift, which marks a break with the modern world or the modern perspective.

The postmodern turn has encouraged the development of new metaphors in the field of family intervention in general, and for our purposes here, is influencing the way family work is developing. The significance of the postmodern perspective in the field of family intervention is directly tied to the epistemologies or “metaphors” associated with clinical models and how family treatment might be approached. Its relevance to our work with families experiencing poverty is lasting, which again highlights perhaps most notably the implication of intellectual trends and the continuous effects of paradigm shifts in the social sciences every day.

Family Poverty and Clinical Treatment Today

Alongside recent publications from the pioneers (Aponte, 1994; Minuchin et al., 1998), and together with the narrative thread and implications of postmodern and social constructionist thought, some experienced practitioners have continued to publish with the poor as the focus of their work. To consider the history of family therapy is indeed to be surprised by the paradigm shifts and the ideological revolutions the field has undergone (Crago, 2006). Similarly, several family therapists have responded to these trends and models in conceptualizing ways to refashion work with poor families. Madsen's (1999) *Collaborative Therapy with Multi-Stressed Families* is an influential example of such integration.

Madsen writes with a nuanced understanding of poverty as a familial stressor. He acknowledges that this model of collaborative therapy has been influenced by narrative therapy, as well as solution-focused intervention (1999). With a mission to re-humanize therapeutic relationships, Madsen establishes each family as a micro-culture, while asking what it means to intervene. Madsen argues that the medical model takes little account of context. He also introduces the concept of the "multi-stressed family," eschewing the earlier conceptualization of the "multi-problem family." His emphasis on language is a direct reflection of the postmodern influence on his work.

Madsen (1999) is also keenly attuned to the history of family therapy with its various innovations and metaphors, incorporating, for example, the metaphor of "culture" as well as some of the other emerging work in the field on ritual and storytelling (Laird, 1989; McCarthy, 2001). Madsen's synthesis of the past with the present argues for family empowerment and links family intervention to its founder Gregory Bateson, who

was trained primarily in anthropology. Madsen explores therapy as cultural anthropology, all the while directing the clinician to reflect on their own assumptions and biases, including assumptions about social class, which are deeply rooted in approaches to family treatment.

Others too have organized treatment models to meet the plethora of needs and negotiations associated with the clinical treatment of families experiencing poverty. Community family therapy was created in response to poor families in an urban environment (Rojano, 2004). This model is a blend of family therapy and community outreach. The therapist is urged to confront issues of poverty directly, to address ecosystemic issues, as well as those issues largely personal and familial. Community family therapy embraces a social justice mission so that the work is not just therapy, but intently focused on civic engagement. The model extends the ecosystemic approaches by insisting upon a “citizen therapist” who both understands the family system, but also the larger socioeconomic contexts that systemically affect the poor.

Similarly, “Just Therapy”, an approach to helping developed in New Zealand, was created with diverse low-income families in mind (Waldgrave, 2005). Addressing contextual issues is seen as crucial to working successfully with low-income families due to inequalities in health and other negative correlates of health associated with poverty today. “Just Therapy” is concerned with social justice and critical of therapists who do not take seriously their responsibility when witnessing the pain of those impoverished.

This model is strengths-based and narrative-focused, similar to Madsen’s *Collaborative Therapy with Multi-Stressed Families (1999)*, but further extending the role of the clinician to include ethical implications of being a service provider. This

includes both the class counterplay between the interventionist and the family being served, as well as the clinician's role as a "thermometer of pain" (Waldegrave, 2005, p. 270). "Just Therapy" questions interventions that might help people adjust or tolerate poverty rather than work to dismantle such oppression. The goal is to empower individuals to overcome their social status through active individual, familial, and communal intervention.

To further report on family interventions viewed as successful when working with low-income families is to continue to balance the history of family therapy and family intervention, as well as the emerging acknowledgement of the importance of context in the treatment relationship. Social class, status, and concerns of socioeconomic standing are now considered as important case constructs, no matter the family model. Madsen's question of "what does it mean to intervene?" continues to be the query most pertinent, as issues of ethics and social justice are highlighted in response to how one conceptualizes family poverty (1999, p. 157).

Home-based work with low-income families has also gained in popularity (Boyd-Franklin & Bry, 2000; Imber-Coppersmith, 1983) and several nationwide models of intervention are rooted in community ideas associated with universities (Woolston, Adnopo, & Berkowitz, 2007), as well as community mental health agencies. Multi-systemic therapy (Henggler & Borduin, 1990) and multi-dimensional family therapy (Liddle & Hogue, 2001) are examples of programs that can be linked back to the earlier work of pioneers Auerswald, Minuchin, and Aponte.

Up to now, I have not addressed the issue of ethnic diversity or the strong links between race and poverty. These links do exist, however, and reflect the history of

institutionalized racism in the United States. Family therapists have placed considerable emphasis on issues of ethnicity and race. This, in part, is due to the lingering weight and economic impact race continues to carry as a social construct and barrier to equality nationwide. Other significant aspects of identity such as ethnicity, gender, immigration status, sexual orientation, health, marital status, location and region, family composition, as well as class standing are also receiving continued attention as these and other issues of clinical context hold great significance for improving aspects of direct practice in our work with families experiencing poverty.

Ethnicity and Family Therapy (McGoldrick, Pearce, & Giordano, 1982) and *Black Families in Therapy: A Multisystems Approach* (Boyd-Franklin, 1989) are both examples of seminal texts first addressing the contextual backdrops of ethnicity and race respectfully. These authors urge attention to issues of race and ethnicity in clinical work, arguing against cultural stereotyping or absolute pictures of family life. In addition, social class has been also considered alongside parent management trainings (Eanon & Venkataraman, 2003), cultural construct models (Hernandez et al., 2005), and even suggested as its own separate, therapeutic knowledge in the social class worldview model utilizing modern classism theory (Liu et al., 2004)

This emphasis in the past few decades of contextualizing clinical practice and understanding class implications for all families in treatment has been shaped by postmodern theory with its attention to issues of power and also by the results of empirical studies in the social sciences. Since the 1958 publication of *Social Class and Mental Illness* (Hollingshead & Redlich, 2007), other negative correlates of mental ill health and poverty have been continuously identified.

Research, Poverty, and Concluding Considerations

Research has identified poverty as a chronic stressor in the lives of families (Altman, 1995; Becker & Liddle, 2001; Doherty & Carroll, 2002; Eanon & Venkataraman, 2003, Gwyn & Kilpatrick, 1981; Hernandez et al., 2005; Liu et al., 2004; Madsen, 1999; McCarthy, 2001; Rank, 2005; Rojano, 2004). In addition, multigenerational family poverty is negatively linked to issues of mental ill health (Becker & Liddle, 2001; Eanon & Venkataraman, 2003; Gwyn & Kilpatrick, 1981; Hernandez et al., 2005; Liu et al., 2004; Madsen, 1999; McCarthy, 2001; Rojano, 2004; Waldegrave, 2005). Poverty in America has been argued as a structural failing as well (Becker & Liddle, 2001; Doherty & Carroll, 2002; Gwyn & Kilpatrick, 1981; Hernandez et al., 2005; Liu et al., 2004; McCarthy, 2001; Rank et al., 2003; Rank, 2004; Rojano, 2004; Waldegrave, 2005).

Beyond these considerations, studies nationwide continue to find poverty problematic. As example, The Great Smoky Mountain study, running from 1993-2000, found poverty to be an independent risk factor for major mental illness (Foley, Golston, Costello, & Angold, 2006). The study also continuously found poverty to be a risk factor for suicidality in populations of both youth and adults of this region. Furthermore, in this study, socioeconomic deprivation in general was linked to social fragmentation, abuse, trauma, and deliberate self-harm.

The literature has also exposed the negative ill effects of poverty on childhood development, which is a concern for not just families but also the public nationwide (Ackerman, 1967; Becker & Liddle, 2001; Brymer & Phillips, 2006; Davies, 2004; Duncan & Gunn, 2000; Eanon & Venkataraman, 2003; Foley et al., 2006; Gwyn &

Kilpatrick, 1981; Minuchin et al., 1998; Osmond & Grigg, 1978; Rank et al., 2003; Rank, 2005; Rojano, 2004).

In sum, these issues heighten the complexity of poverty as a clinical consideration, as my reading has raised significant questions regarding the impossibility of separating this low-income issue apart from other social and family stresses. Race, ethnicity, and gender, issues of language, immigration, education, all compiled under the identifying, yet elusive title of “culture” (Park, 2005), seemingly cannot in this country or in the global, capitalistic world, be considered separately from socioeconomic standing, social class, and prejudice and discrimination based on classism. The “relational matrix” (Mitchell, 1988) is a relationship of literal environment, context, and societal structure.

Today as communities continue to try to meet the needs of poor families and as grants and funding are constantly re-negotiated to allow this work to happen, family therapists continue to seek new ways of socially thinking and working with the poor. Now, as systems theory merges with the stories of narrative therapy and the successes of solution-focused treatment, families experiencing poverty are clinically considered from multiple perspectives. Social justice models are asking more of the traditional therapist and epistemologies are being blended despite their original intent. “What does it mean to intervene?” (Madsen, 1999, p. 157) remains the pertinent question clinicians are still looking to the history of family intervention to help answer, as well as to newly understand. Chapter III will extend this review by exploring family preservation philosophy at length.

CHAPTER III

FAMILY PRESERVATION PHILOSOPHY

Family preservation philosophy runs parallel to while simultaneously reflecting the evolution of family intervention and family therapy, as described in Chapter II. Family preservation is rooted in the field of child welfare rather than any one mental health profession or family therapy model (Berry, 1997; Halpern, 1999; Whittaker & Tracy, 1990). The field of child welfare has, much like the trend in mental health treatment, also since moved to again becoming family-focused (Berry, 1997; Forsythe, 1990; Halpern, 1999; Hartman & Laird, 1985; Kelly & Blythe, 2000; McGowan, 1990; Nelson, 1990; Whittaker & Tracy, 1990). Poverty is the common thread linking family intervention to child welfare services, as today social services remain associated with social support and social aid to poor and low-income family's nationwide (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990).

Child Welfare Services in the United States

Social services might be considered an umbrella term under which morals, monies, policies, and eventual social interventions unfold (Halpern, 1999). This study is focused on clinical work with families experiencing poverty as well as the advancement of social work and the social attitudes concerning this population. In his *Fragile Families, Fragile Solutions: A History of Supportive Services for Families in Poverty*, Robert Halpern explores the broad scope of social services by acknowledging that such

services might both be “simple supports” as well as “the most complex and subtle of interventions” (1999, p. 11).

With this in mind, the history of the 20th century again provides a suitable backdrop for understanding the emergence of child welfare and its interventions. The history of child welfare services in the United States began with social workers attending to families (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990); family therapy and child welfare share the same beginnings. This chronology includes an emphasis on the same themes ranging from Mary Richmond’s publication of *Social Diagnosis* in 1917, to the history of the settlement movement, to the transitioning nation at the turn of the century, due to the emerging impact of urbanization, industrialization, and patterns of immigration at that time (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990).

Dating back yet a bit further, child welfare service’s initial roots reside in a national post-Civil War regrouping, as children abandoned and orphaned in cities after the war were placed into homes, “orphanages, industrial schools, [and sent elsewhere on] orphan trains” (Berry, 1997, p. 4). Before “the public sector began to take responsibility for the welfare of [its] children” (Berry, 1997, p. 11), informal systems of helping provided some acknowledgement of poverty as a familial stress (Berry, 1997; Halpern, 1999; McGowan, 1983).

In his review of social services, Halpern (1999) operates with a central thesis that might help us to better understand this history. Halpern suggests that social services and social service providers are too often asked to accomplish individual treatment goals as a means of alleviating larger and societal issues of poverty. This thesis, juxtaposed against

the seemingly circular aspects of reform and ideological trends in the field of child welfare (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1983, 1990; Whittaker & Tracy, 1990), highlights repetitive themes of social theories regarding the causes of poverty as well as what can be done to help. Halpern shares,

Supportive services to poor families have been shaped, buffeted, and occasionally paralyzed by Americans' moral and ideological uncertainty – about human nature, and the causes and meaning of poverty, inequality, and dependence; whether pluralism is a strength or a problem; the role of the state in problem-solving; and the nature of collective responsibility for vulnerable members of society and of those member's own responsibilities in turn. American society has made only modest progress over the course of the century in its debates about the values, priorities, and assumptions it holds regarding both poor people and poverty itself and therefore about what should guide the provision of services. (1999, p. 17)

This observation of morality and ideology as fueling reform and social service initiatives certainly remains pertinent to the fields of intervention and family welfare.

It is difficult to view child welfare services apart from context. This is in large part due to the history of child welfare services and the many policy changes that have occurred (Halpern, 1999; McGowan, 1983, 1990). Due to our governmental structures and the process of federal and state funding, political maneuvering is easily exposed as playing a central role in the field of child welfare. When reviewing the policies, monies, and even organizations that have emerged to filter the services provided by child welfare services, these underlying motivations are crucial and necessary to keep in mind.

Again, to look backwards on our nation's history, city life brought unprecedented challenges in the early 1900s (Berry, 1997; Halpern, 1999; McGowan, 1983, 1990). The beginnings of child welfare mark a shift in social thought as well, as prior to this type of social aid, children were seen as property and were without rights (McGowan, 1983,

1990). In 1853, the Children's Aid Society emerged, and in 1883, the Children's Home Society began as organizations for the children of those unable to adjust or successfully adapt to the century's new and unique family stresses (McGowan, 1983, 1990). These people, most of them recent immigrants, were at the time considered "paupers, who were socially condemned" (McGowan, 1990, p. 66). They were thus considered ill fit to parent their children; there was a strong moral and superficial "Christian" framework applied (McGowan, 1983, 1990).

In the decades that followed, a continuous energy towards social control of the nation's growing population and the social reform and homogenization of recent immigrant neighborhoods, the very energy that founded the social work profession, likewise influenced national and social attention towards family life, stressors of poverty, and the rights of children (Berry, 1997; Halpern, 1999; McGowan, 1990). In 1909, the White House had its first conference on children (McGowan, 1990). The established charity techniques of home-based treatment and the importance of keeping children in their families when possible were contrasted with the emerging moral attitudes of the time, which had recently identified the social right to interfere in family life (Halpern, 1999; McGowan, 1990). This issue of parental rights vs. children's rights today remains hotly debated.

In 1912, the government began to report annually on the state of the nation's children and established the US Children's Bureau (McGowan, 1990). In 1921, the Sheppard-Towner Act "gave the Bureau responsibility for administering grants-in-aid to states for maternal and child health care" (McGowan, 1990, p. 69). In this way, the informal beginnings of child welfare eventually grew to include the federal government's

involvement in the 1930s with the establishment of Mothers' Aid and the Federal Aid to Dependent Children programs (Halpern, 1999). These Titles IV and V were passed along with the Social Security Act of 1935, all of which allotted funding for child welfare services, which essentially created a nationalized framework for these services to unify (McGowan, 1990).

The 1940s and 1950s are seen historically, because of the national focus on World War II and its aftermath, as a time that distracted attention from domestic issues, such as race and class, to help war veterans and families re-stabilize post-war and post depression (Berry, 1997, Halpern, 1999; McGowan, 1983). These years are remembered as a time of national peace and economic growth, practical social work and social aid provided only where necessary (Berry, 1997; Halpern, 1999; McGowan, 1983).

Toward the end of this wave of social stability and optimism (Berry, 1997; Halpern, 1999; McGowan, 1990), research on child development and attachment began to influence the field of child welfare (Berry, 1997; Halpern, 1999; McGowan, 1990). In 1959, Henry Maas and Richard Engler published *Children in Need of Parents* (Berry, 1997; McGowan, 1983, 1990). This content influenced the further establishment of foster care as intervention; the text highlighted the interconnected issues of neglect, abandonment, parental illness, and poverty in the lives of children nationwide (Berry, 1997; McGowan, 1983, 1990).

In these last years of the 1950s the revitalization of the family as the focus of clinical intervention began to emerge nationally both in the rapidly growing field of family therapy as well as by way of community intervention. As an example of community intervention and the continuing difficulties plaguing immigrant, ethnically

diverse, and impoverished families in the United States, in 1959, the Neighborhood Improvement Project in New Haven, CT, was directed towards the Farnham Court's housing development (Halpern, 1999).

This program was documented in 1967 in an article by Geismer and Krisberg entitled *A Forgotten Neighborhood* (as cited in Halpern, 1999). The article exposed the social aid and economic growth of post-WWII USA to have not extended fully to all families (Halpern, 1999). By focusing on one neighborhood, the article provided a snapshot of class, ethnic, and racial issues in the United States, issues which the war had distracted attention from for a period of time (Halpern, 1999).

After the war, coincidentally, domestic issues re-emerged and the "multi-problem family" became the focus of social control (Halpern, 1999; McGowan, 1983). A new balance between disorder and reform was sought. *Social control* refers to the widespread tendency to blame individuals and families themselves for their own poverty and to resist issues of social reform. The increasing wealth of many was amplified by the continuation of poverty throughout the nation as well (Halpern, 1999). This truth, despite the unprecedented leaps in standards of living nationwide, was dealt with and explained in various ways.

Issues of social reform and social control, thus, included both a revived focus on civic engagement, which would gain greater popularity in the 1960s, as well as the prolongation of "blaming the victim" as a satisfying answer for many nationwide (Berry, 1997; Halpern, 1999; McGowan, 1990). Poverty, as it again tied to issues of urbanization, immigration, and industrialization, was continuously identified as a national theme with

an increasingly complex relationship to the field of child welfare (Berry, 1997; Halpern, 1999; McGowan, 1983, 1990).

The 1960s are remembered today for community renewal, community resources, and community development (Berry, 1997; Halpern, 1999; McGowan, 1990). Community mental health projects were federally funded during this time (Ehrenrieck, 1985) and the post war optimism (Berry, 1997; Halpern, 1999; McGowan, 1990), lingered slightly, ultimately situating three amendments to the Social Security Act that would help expand public social services (McGowan, 1983, 1990). The first came in 1962, the second in 1967, and they both supported foster care programs rather than family of origin interventions for children (McGowan, 1990). The third came in 1971, as Congress' Aid to Families of Dependent Children (AFDC) monetarily "offered no incentive to states to develop alternatives to foster care" (McGowan, 1990, p. 71).

The nationalized "War on Poverty" had arrived. This movement attempted to encompass social services and service reform (Ehrenrieck, 1985; Halpern, 1999; Hartman & Laird, 1983). In retrospect, much of this war was fought in the abstract, however, as poverty was linked to "people unprepared for industrial society" (Halpern, 1999, p. 118). The "prevailing services and social institutions [were viewed as] unresponsive" to the nation's shifting needs as a result (Halpern, 1999, p. 122). In addition, in the 1960s states broadened the definition of child abuse and neglect, which "clarified and expanded mandates for reporting suspected violations, and increased public sensitivity to the symptoms and signs of child endangerment" (Nelson, 1990, p. 13). This legislation led to the expansion of boundaries within the field of child welfare although from the start

“unrealistic expectations, conflicting objectives, hopes, and fears [were] quickly developed among advocates and skeptics alike” (McGowan, 1983, p. 76).

Thus, as the field of child welfare expanded, the issues become more clear-cut in some respects, yet more complex as well (Berry, 1997; Halpern, 1999; Nelson, 1990; McGowan, 1983, 1990). Social services were asked to solve problems beyond the appropriate reach of providers, interventions, and casework (McGowan, 1983). Social standards were raised for family life, yet poverty was identified and arguably indiscriminately linked to the same individuals most often considered ill fit to parent (Berry, 1997; Halpern, 1999; McGowan, 1983; Nelson, 1990). Therefore, the welfare of children as a social concern became a national issue; but the ideological matter of poverty was not grasped appropriately when left to this immediate issue of service involvement (Halpern, 1999; McGowan, 1983, 1990).

The ideological matter of poverty included the longstanding moral and social debates about 1) why people are poor and 2) what can or ought to be done to help (Halpern, 1999; McGowan, 1983, 1990). At this point, poverty had long been established as a correlate to issues of child abuse and neglect (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1983, 1990). Poverty was considered a generalized and chronic stressor that could lead to the immediate service involvement of child welfare intervening in a family’s life (McGowan, 1983). As a result, “foster care, [despite its popularity and its function as] a social invention” (McGowan, 1990, p. 81), was tied to the emotional issue of child placement, as well as the subjectively vague definitions of child abuse and parental neglect as state laws (Magazino, 1983).

Opposing views have long been debated in the field of child welfare including those that favor preventive services, those that favor protective services, and those that prioritize the continuous need for emergency and triage care for children in communities (Magazino, 1983). Child welfare policies and services have, as a result, flip flopped repeatedly due to the political issues inherently tied to the legislation. The growing literature regarding child development has also influenced changes in child welfare services. The 1960s saw the growth of a child advocacy movement (Hartman & Laird, 1985; McGowan, 1983), which led to the consideration of a “least restrictive environment” as a new emphasis in the field (Hartman & Laird, 1985; Janchill, 1983).

Thousands of children lingered in foster homes, were moved in placement multiple times, and many were abused in foster care settings. As a response, the “least restrictive environment ” emphasized positive socialization and, when possible, stability for children and families involved with the department of child and family services (Hartman & Laird, 1985; Janchill, 1983). As a result, this criterion provided an alternative to foster care and fueled an interest in permanency planning (Hartman & Laird, 1985; Janchill, 1983). These continuity issues raised concerns about the importance of stability for a child (Hartman & Laird, 1985; Janchill, 1983), as well as a related and national focus on deinstitutionalization (Hartman & Laird, 1985), help to explain family preservation services as an organic attempt to better meet the needs of children and their families in the 1970s and 1980s (Berry, 1997; Forsythe, 1990; Nelson, 1990; McGowan, 1990; Whittaker & Tracy, 1990).

Further, child development literature and research has continued to influence social services (Hartman & Laird, 1985; McGowan, 1983). Despite the increasing

emphasis on family-centered and family-focused interventions, the rights of children began to favor and influence a child-centered approach in the field of child services (Hartman & Laird, 1985; McGowan, 1983). A child's right to optimal development, normalization, as well as consistency and family life, helped a child-centered approach blend with a family-focused approach to permanency planning and social service intervention (Hartman & Laird, 1985; Janchill, 1983; McGowan, 1983). Ultimately, the "least restrictive environment" became a standard of appropriate service and permanency planning for children (Hartman & Laird, 1985; Janchill, 1983).

Several federal laws were passed from 1974 to 1980 that directly influenced child welfare services (McGowan, 1990). The first was the 1974 Child Abuse Prevention and Treatment Act, which "created the National Center for Child Abuse and Neglect" (McGowan, 1990, p. 72). This act is retrospectively viewed as increasing the number of children identified as needing help yet not providing adequate resources to help them (McGowan, 1990). This law grew out of the rise of media and the social concerns of the 1960s (Halpern, 1999; McGowan, 1990) but was geared towards investigation rather than intervention and treatment (McGowan, 1990).

In 1974 the Juvenile Justice and Delinquency Prevention Act was passed, which further separated "youth from adult offenders" in regards to funding (McGowan, 1990, p. 72). Title XX was passed awarding block grants to states for funding as well (McGowan, 1990). This was an amendment to the Social Security Act and was part of President Nixon's "New Federalism" that emphasized the de-centralization of government nationwide (Halpern, 1999; McGowan, 1990).

In sum, the very complexities that were identified in post -WWII America continued to fuel a political game resulting in a federal focus on administrative reform with every new cycle of opinionated campaign (Halpern, 1999). Generally, the 1970s and 1980s are today identified as a time of crisis and reform in child welfare services due to both the growing demands and challenges placed on the field, as well as the quickly changing and ever opposing views of how to accomplish best those goals (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990; Nelson, 1990).

Monies funding the community and neighborhood programs of the 1960s were set aside as the Reagan Administration took office in the early 1980s. As Halpern (1999) stated, “[t]his would cripple social reform initiatives for the remainder of the century” (p. 199). Social services were left ill equipped during this conservative climate and personal responsibility was favored as a solution for child abuse and child neglect (Halpern, 1999). “Accountability” was stretched and conceptualized, as cultures and groupings of people most disenfranchised were blamed and targeted (Halpern, 1999).

The Adoption Assistance and Child Welfare Act of 1980, federal law PL 96-272, eventually brought social service reform full circle in just two decades, as money was offered to states to prevent foster care placement (Halpern, 1999; Kelly & Blythe, 2000; McGowan, 1990; Ronnan & Marlow, 1990). Specifically, PL 96-272 gave money to services that focused on prevention and reunification (Allen & Knitzer, 1983). PL 96-272 went as far as fiscally penalizing states that did not have or begin to work towards this type of programming (Allen & Knitzer, 1983). *Permanency planning*, the issue of a child’s welfare throughout development, was addressed and encouraged by PL 96-272 and public responsibility was emphasized (Allen & Knitzer, 1983; McGowan, 1990).

Family of origin involvement was encouraged when possible, as parents were strategically invited and included at case reviews and when establishing goals and planning for interventions (Allen & Knitzer, 1983).

This legislation arose in part due to the special successes of several family preservation programs running nationally alongside rising concerns regarding the success of foster care placement (Berry, 1997; Halpern, 1999; McGowan, 1990). In Oakland, California, the Alameda Project is currently highlighted as one of the original organizations that began to work towards family preservation in the 1970s (Berry, 1997). The Homebuilders Project of Tacoma, Washington is perhaps the most highly cited program, which initially began in the 1970s through trial and error and the direct practice needs of its clients (Berry, 1997; Halpern, 1999; McGowan, 1990). Both programs were instrumental in the development of family preservation as a philosophy and movement.

The equilibrium between child protection and family preservation services has since been continuously considered. The intersection between the 1974 law sanctioning the protection of children vs. the 1980 law protecting families offers one example of opposing interests balanced on the child welfare seesaw of policy and practice (McGowan, 1990). These two laws provided “conflicting objectives” and again challenged families, caseworkers, and courtrooms alike to strike a balance between parental vs. children’s rights in issues of family functioning (McGowan, 1990, p. 77).

In addition, despite poverty as a significantly identified correlate to child abuse and neglect (Berry, 1997; Halpern, 1999; McGowan, 1990; Nelson, 1990), legislative reform in the field of child welfare has not been able to alleviate poverty even though this as an underlying, albeit naïve hope (Halpern, 1999; McGowan, 1983). Nationally, social

services continue to be evaluated and measured by the emotional and social expectations that casework, therapy, and temporary assistance programs might provide a substantial answer to the more chronic realities of poverty and economic disparity nationwide (Halpern, 1999; McGowan, 1983).

My exploration of the history of child welfare services and its reforms highlights the political interests and varying attempts to both understand and solve entrenched issues of equality, responsibility, and both personal and national interests. This small piece of history allows us to consider now family preservation philosophy as it represents one attempt to respond to these challenges (Berry, 1997; Forsythe, 1990; Halpern, 1999; Kelly & Blythe, 2000; McGowan, 1990; Nelson, 1990; Ronnan & Marlow, 1993; Whittaker & Tracy, 1990).

Family Preservation Philosophy

As a philosophy, family preservation represents a belief in the importance of family for both children and society (Berry, 1997). *Family preservation philosophy* focuses primarily on strengthening the family as a means of reaction and support in times of crisis (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994; Ronnan & Marlow, 1993). The emergence of family preservation philosophy signaled a radical departure from foster care, (Berry, 1997; Forsythe, 1990; Kelly & Blythe, 2000; McGowan, 1990; Nelson, 1990; Whittaker & Tracy, 1990) as foster care was being critiqued for its inability to effectively meet the needs of developing children (Berry, 1997; Halpern, 1990; Kelly & Blythe, 2000; McGowan, 1990; Nelson, 1990).

The philosophy of family preservation is about keeping families together, which is inherently a family-centered intervention (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994; Ronnan & Marlow, 1993). It is a philosophy utilizing a strengths-based approach, as well as solution-focused home-based intervention in order to gain information efficiently and to meet the families in their home environment (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994; Ronnan & Marlow, 1993). Values of family preservation philosophy include client empowerment, varied definitions of family, and the family as experts in their own lives, significant worth placed on diversity and uniqueness, as well as a flexible stance of case conceptualization, treatment goals, and course of intervention (Berry, 1997; Ronnan & Marlow, 1993). The philosophy of family preservation is a systemic understanding that helps to situate a brief and concrete plan to preserve troubled families (Berry, 1997; Kelly & Blythe, 2000; Ronnan & Marlow, 1993).

The goal of preserving, building, and improving families represents the natural progression of this treatment philosophy (Berry, 1997; Kim Berg, 1994; Ronnan & Marlow, 1993). Family stability is the overarching focus, with equal emphasis given to child protection, increasing family competencies, as well as facilitating the family's use of resources (Kim Berg, 1994; Whittaker & Tracy, 1990). The history of service reform in child and family services illuminates this "new" philosophy of family preservation as having its roots in the beginnings of the social work profession with links to the home-based work of the settlement houses and charity organizations popular at that time (Berry, 1997; Kelly & Blythe, 2000; Ronnan & Marlow, 1993).

Family Preservation Programs

Family preservation philosophy is perhaps best exemplified by the foundational programs that began and in a sense created this larger movement. These service models are otherwise known as Family-Based Services, Intensive Family Preservation Programs, as well as Family Preservation Services. The program models have expanded considerably since the 1980s (Berry, 1997; Halpern, 1999; Ronnan & Marlow, 1993).

It has been reported that 20 programs existed nationwide in 1982, whereas over 260 were up and running by 1988 (Halpern, 1999). Initially, however, the Alameda programs in Oakland, as well as the Homebuilders program in Tacoma, were the first to work from this philosophy (Berry, 1997; Halpern, 1999).

The Homebuilders Program has seven guiding principles of respect for clients (Berry, 1997). These principles are listed as:

1. It is our job to instill hope.
2. We cannot know ahead of time if a situation is hopeless.
3. Clients should have as much power as possible.
4. Clients are our colleagues.
5. Respect is contagious.
6. Not knowing can be valuable.
7. We can do harm. (Berry, 1997, p. 72)

Beginning in Tacoma, Washington in 1974, the Homebuilders Model was founded on a premise of small caseloads with 24-hour clinical and response availability (Berry, 1997).

Services were organized into “hard” and “soft” skill components (Berry, 1997).

Examples of “hard skills” include concrete objectives such as housing, food in the home, as well as family employment, whereas “soft skills” referred to relationship skills and other patterns of family communication and learning (Berry, 1997).

Other examples of family preservation program models include the Illinois Family First Program, New York's Lower East Side Family Union, the Yale Child Study Center's Intensive Family Preservation Program, as well as initial models in Iowa, Michigan, Minnesota, Oregon, Utah, Northern California, and Nebraska with similar program objectives (Berry, 1997). Due to the rapid expansion of family preservation philosophy to program implementation nationwide (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990; Nelson, 1990; Whittaker & Tracy, 1990), it is now easier to discuss common features of these programs rather than each specific model and location.

Common features of these programs include the reflection of a strengths-based perspective, services provided in the home and community, a focus on the whole family as part of intervention, services provided to families in crisis, as well as these services existing at a high level of intensity for a shorter duration (Berry, 1997; Halpern, 1999; McGowan, 1990). Variations in the models arise for many reasons, including different theoretical influences such as crisis intervention theories, social learning practice methods; and family systems as well as functional practice methods (Barth, 1990; Berry, 1997).

Family Preservation's Promise

The promise of family preservation philosophy resides in its intersection with direct practice, which the Homebuilders Model has helped to capture and chart throughout its own course of development as a program (Forsythe, 1990; Kelly & Blythe, 2000; Whittaker & Tracy, 1990). Justification for family preservation philosophy is

argued on both an emotional as well as a rational scale (Berry, 1997). Specifically, the moral grounding for family preservation argues in favor of family life, whereas the methodological grounding is rooted in its observed efficiency and potential in saving foster care and programming dollars (Berry, 1997; Kelly & Blythe, 2000).

Social, economic, and legal rationales are strengthened further by an empirical base in favor of preserving families (Berry, 1997). Research supports the claim that keeping families together is more humane (Berry, 1997; Kelly & Blythe, 2000). In addition, it is argued that an ecological perspective flows naturally into the family preservation model, whereby resources have been acknowledged as necessary mediators in the lives of families under and experiencing heightened levels of stress (Berry, 1997; Kelly & Blythe, 2000; Ronnan & Marlow, 1993). Services aimed at families have been argued as more effective, as well as more just, on various grounds, including the family as the child's optimal environment for healthy growth and maturation and the negative psychological effects of repeated separation and loss (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994).

An ecological systems approach, as it relates to the family preservation philosophy of both empowering and connecting families to resources, has been linked to the prevention of child maltreatment (Berry, 1997; Kelly & Blythe, 2000; Ronnan & Marlow, 1993); just as correlates of child abuse and neglect include issues facing families experiencing poverty and families that are multi-stressed today (Berry, 1997; Ronnan & Marlow, 1993). Conceptually, it has also been considered that the integrity of the family is at the heart of an American national identity, so that family preservation philosophy is

culturally and personally a moral and ideological fit with the country's traditions (Whittaker & Tracy, 1990).

The family as the most advantageous environment for children has also been supported in the literature of child development and attachment theory specifically (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994; McGowan, 1990; Nelson, 1990). A continuity of identity is considered meaningful across the life cycle and this perceived moral argument is contrasted with the costs and doubtful outcomes of placement. It has further been suggested that children are better off in their own struggling family rather than in a more stable family that is not their own (Berry, 1997; Kelly & Blythe, 2000; Kim Berg, 1994).

The significance of family preservation programs entering the home for a short duration and at a high level of intensity is also considered a strong entry point into a family system, whereby further services might be made available and provided to families who could both utilize, as well as potentially enjoy, such help, be it economic or supportive (Berry, 1997; Halpern, 1999; Nelson, 1990; Ronnan & Marlow, 1993). Home-base services are considered cost efficient for programming and they help to keep treatment and scheduling consistent due to the many transportation concerns affecting families experiencing poverty, which might also include a family's inability to meet during agency hours due to issues of employment or day care as well.

The promise of family preservation philosophy is irremovable from the programs that have paved the way. The history of child welfare services and the vicissitudes of foster care intervention and social service reform are also indistinguishably connected and intertwined. I have listed supportive correlates to family preservation philosophy to

include issues of ideology and national morality, issues of successful development, as well as economic and programmatic concerns. These promises were persuasive and were thus quickly moved to rapid implementation nationwide (Berry, 1997; Forsythe, 1990; Halpern, 1999; McGowan, 1990; Nelson, 1990; Whittaker & Tracy, 1990).

The continued promise of family preservation philosophy and its programming is now left to prove itself in a context where time has afforded a more accurate account of its efficacy in the reality of its implementation. Critiques of family preservation philosophy also exist and help to bring the challenges of child welfare services to the forefront, in light of this call to preserve families nationwide.

Family Preservation's Problems

Since its humble and early beginnings, family preservation philosophy has spread rapidly into policy and program implementation. The pressures for child and social welfare reform led to the quick embrace of family preservation (Berry, 1997; Halpern, 1999; Kelly & Blythe, 2000; McGowan, 1990). This rapid implementation is now considered an organizational and administrative failing by many, as programs and program variations arose before established and newer models were studied and evaluated (Berry, 1997; Kelly & Blythe, 2000).

The characteristics and qualities of mental health professionals working successfully in family preservation programs is a significant issue, as programs with qualified MSWs were found to be more successful in preventing placement (Berry, 1997). Mixed and poor results nationwide have also been found since the spread of these

programs (Berry, 1997; Halpern, 1999; Kelly & Blythe, 2000). Poor outcomes have been linked to the use of untrained workers (Berry, 1997).

On another level, family preservation programs have been criticized more broadly, as professionals within the field question the over-emphasis on these short-term interventions with simple goals, which take money away from more accessible social services that arguably, could be made available to a larger number of families (Forsythe, 1990). It has been noted that family preservation has been inappropriately lauded, as it is only one service, and not close to or deserving of the attention and monies made available (Halpern, 1999). Furthermore, asking these specific programs to provide the foundation of reform in social welfare and child welfare services has been viewed as both setting them up to fail, as well as leading the field further astray in its high expectations (Halpern, 1999).

In this sense, many of the problems associated with family preservation programs are situated largely in the contextual ambiguity and vast challenges placed on the field of child welfare (Berry, 1997; Halpern, 1999; Kelly & Blythe, 2000; McGowan, 1990). Family preservation philosophy arose during the funding halt of the Reagan Administration, which is widely acknowledged as a difficult time for service providers trying to work and run programs, as well as a time unsympathetic to poor families (Kelly & Blythe, 2000; Halpern, 1999; McGowan, 1990). These programs have since cautiously been viewed as only a band-aid or quick fix for what is a much larger and national and social problem, the fact that a significant number of Americans and people live in poverty in the United States today (Halpern, 1999; Kelly & Blythe, 2000; McGowan, 1990). Brenda McGowan summarizes this fear well in saying,

They [family preservation programs] cannot address the socioeconomic forces that contributed to tensions and inadequacies in family functioning nor can they provide the long-term assistance and/or specialized treatment required by some parents and children. (1990, p. 82)

“Too good to be true” is an appropriate colloquialism when it comes to the early attention and responsibility placed on these programs.

In many ways, it was a false hope that applauded family preservation’s beginnings, in part due to the vague issue of risk and prevention, which helps to describe and complicate the service provided by child welfare (Berry, 1997; Kelly & Blythe, 2000). It is hard to determine issues of risk and many questions accompany the ability of time-limited programs to prevent future family issues of child abuse and neglect.

Halpern pushes further on this issue by offering an example:

At their peril, they [those in favor of fast policy and implementation of family preservation programs] ignored the New York City’s Lower East Side Family Union (LESFU) experience, which had suggested strongly that placement prevention was a dubious and overly narrow objective, relying on the impossible task of accurate targeting and timing. (1999, p. 201)

His further critique of family preservation programs includes a recommendation to aim services at homelessness rather than child placement to help the poor in a more predictable fashion, because of the inability of family preservation programs to help families experiencing chronic poverty and stress in such a small amount of time (Halpern, 1999).

Ultimately, the 1990s saw family preservation criticized for a plethora of reasons, for the very philosophy of family preservation, a federal funding deficit that left the states to implement legislation without fiscal support, a continuation of model variation, as well as a media backlash impatient with the promise of these programs (Kelly & Blythe,

2000). This, in addition to the more deep-seated discussions regarding the plight of this nation's poor prompted critics continuing question as to why interventions would be offered to those personally responsible for their poverty (Kelly & Blythe, 2000). A renewed emphasis on removing children from their homes continues to complicate the successes and challenges of family preservation programs as well (Kelly & Blythe, 2000). The problems of family preservation are both significant and much larger than its programs could ever fully answer or withstand.

Family Preservation and Poverty: Present Day

The problems of family preservation philosophy and its associated programming issues are in some respects very similar to the issues that have always plagued social and child welfare reform. These programs, by proven trend rather than by definition, are programs utilized by the poor (Berry, 1997; Halpern, 1999; McGowan, 1983, 1990; Nelson, 1990). Families experiencing poverty are families most often identified for issues of child abuse and neglect. The stress of living in family poverty is well documented and this has been further researched and explained away for quite some time. Meanings and interpretations of poverty continue to be challenged and critiqued. As I write, the national pulse continues to ponder the current economic downturn. Since the spring of 2008, 6 million people have been newly identified as out of work, raising the national unemployment rate by 3.9 percent (United States Department of Labor).

The Family Preservation and Support Services Act of 1993, PL 103-66, was reauthorized in 1997 (Kelly & Blythe, 2000). At this time it was renamed the "Promoting Strong and Stable Families Program" and was included as part of the new Adoption and

Safe Families Act, PL 105-89 (Kelly & Blythe, 2000). This act was initially considered as a balance between foster care, adoption, and family preservation (Kelly & Blythe, 2000). PL 105-89 has since been criticized as lacking appropriate funding to implement the legislation called for and suggested (Kelly & Blythe, 2000). Despite the success of foster care and adoption for many children and families, concerns were raised that the “Promoting Strong and Stable Families Program” marked a hasty return to foster care and away from programs focusing on family preservation. (Kelly & Blythe, 2000).

Was this act a move away from family preservation programs, as it offered monies toward adoption programs? What can be more easily pinned down and discussed is that poverty remains the issue at hand and child welfare services continue to debate whether to allow children to live poorly with their families of origin versus removing them from their homes. Enacted in 2002, the Promoting Safe and Stable Families Program was amended by President G.W. Bush. The Adoption and Safe Families Act of 1997 was also extended in 2003 with the passing of The Adoption Promotion Act. This act was in fact, all in its name, as it concretely promoted adoption.

In sum, and as the reform ripples and policy issues continue, the history of child welfare reform, as I have described, moves with the moral dimensions of American society. Public policy seems to routinely favor solutions without a firm understanding of the problems facing the poor and those families experiencing poverty. Despite the strengths-based collaboration of family preservation philosophy, there is the continuing and complicated issue of judgment, as service providers and government officials are left to decide what families are deserving and then again, deserving of what? The family is seen as the backbone of society although definitions of family are continually debated.

Family preservation philosophy for all of its promise and all of its problems is still viewed as having the potential to reach families experiencing chronic poverty. Chapter IV will explore strategic family intervention, seeking out further understanding and answers.

CHAPTER IV

STRATEGIC FAMILY THERAPY

Jay Haley, a communications analyst, worked as a research associate at the Veterans Administration in Palo Alto during the emergence of family therapy as a field of mental health intervention (Jackson, 1963). Haley was part of Gregory Bateson's team that initially began to research patterns of family communication (Haley, 1963). In the early 1950s, Haley published a paper on paradox, a topic that continued to inspire his approach to therapy throughout his career (1955). Haley's career eventually led to not only his development of the strategic model, but also saw him become the editor of *Family Process*, publish widely, and take the reins as the director of the Family Therapy Institute in Washington (Jackson, 1963). At the start of his career in Palo Alto, Haley was also involved with the Department of Anthropology at Stanford, and the Palo Alto Medical Research Institute (MRI) (Jackson, 1963). He began as part of an academic community that sought to expand communication theory to general observations in the social sciences and in everyday life.

Strategies in Therapy: Haley Situates the Benevolent Directive

In *Strategies of Psychotherapy (1963)*, Jay Haley described the context for his ideas and he laid the groundwork for strategic family therapy, a model that would continue to evolve and expand over the next several decades. Strategic family therapy has since been utilized and described most notably by writers and practitioners at MRI,

Haley and eventually Cloe Madanes, as well as the Milan Group, were influenced heavily by psychoanalyst Maria Selvini Palazzoli (Madanes, 1982).

Strategic psychotherapy has also been explored as a brief symptomatic treatment. Discussed by Richard Rabkin (1977), as well as by Haley initially, strategic psychotherapy encompassed a model that has since morphed and expanded to influence directives of treatment no longer traceable. When I read the strategic literature, I was intrigued to see how perhaps narrative therapy and solution-focused theorists were inspired by the creatively expansive ideas that Haley and his colleagues first put forth.

The notion or idea of “paradox” was not only central in Haley’s beginnings as a professional, but also began to influence how he conceptualized the very transactions that occurred in therapy outside of model, theory, and practitioner (1963). Haley argued the existence of therapy as a paradox, and that the “therapeutic paradox” was central to all forms and methods of treatment. A *paradox* describes conflicting messages that occur simultaneously. For Haley, whenever a person or family engages in a treatment relationship, they are both asking for help, as well as entering an interchange that can only help them if they are able to help themselves. The therapist must accept them as they are, as well as concurrently support their need or desire for change. This is the context for treatment Haley devoted his career to developing, as well as the basis for his *Strategies of Psychotherapy (1963)*, which ultimately led to the development of strategic family therapy.

Situating “symptoms as tactics in human relationships” (1963, p. 1), Haley described the strategic framework as an “interpersonal theory” heavily influenced by the way people communicate (p. ix). Behavior is described and explored as communication

and the “transactions” of treatment are approached like a scale that must be both acknowledged as well as balanced (1963, p, 4). The scales for each problem are different and each problem, person, family, or intervention must be uniquely approached and contextually understood. Strategic therapy uses this conceptual base to explore issues of power, “levels” of communication, including how we communicate about how we communicate, as well as to introduce clinical context into the therapeutic relationship (p. 5). Symptoms are considered issues of communication and resolutions of power in the treatment relationship are highlighted as the crux of successful goal attainment in therapy.

From the onset, Haley was interested in not just what theories clinicians might use, but in the specific actions and procedures of therapy. He launched his strategies for therapy from the family therapy movement, from the perspective of communications theory, as well as by looking back on the history of mental health treatment and through the various schools of intervention. Psychoanalysis, behavioral and cognitive therapies, and experiential treatments are all considered foundational by Haley – they are the point from which his directives sprang forth.

Milton H. Erikson was the practicing clinician, hypnotist, and storyteller that Haley latched on to as he began to expand Erikson’s techniques into a “directive therapy” (Haley, 1963, p. 45) with stylistic and therapeutic “maneuvers” (p. 41) as varied as each individual, family, and practicing clinician. Haley focused his initial exploration of the directives of therapy almost atheoretically, by emphasizing the patients “doing” and the therapist’s role and responsibility for this behavioral activation. He utilized a near literal understanding of the therapeutic relationship, discussed issues of power, and was quick to

question why people were entering treatment, asking was it not the therapist's job to direct, aid, and to help people solve problems (Haley, 1963, 1976). Haley felt change could occur and symptoms could be alleviated outside of issues of interpretation and constant "focus on a person's mental or emotional structure" (1963, p. 67).

Haley established the varied and nuanced levels of communication that occur in every treatment relationship and he described the strategies of the therapist to require almost an omnipotent stance and clinical ability to both accept, as well as to challenge. He also acknowledged the therapist's clinical power to include a cultural force, which might label or stigmatize with diagnosis, force intervention or treatment as a means of social control, as well as disrespect and do harm in the process.

Issues of ethics and concerns for the therapist's use of power were motivating factors that helped Haley to define therapy as inherently "manipulative" (1976, p. 200). He worked to expose this power so that it would not be misused. His writing is filled with case examples, which further exemplified his desire to describe how the work is done, as well as to improve the way clinicians are trained and families and people are not only treated, but also helped.

Haley argued for "adopting a social view of the [presenting] problem" in treatment (1976, p. 4). He argued for brief treatment and explained what this could look like, including how it might start and where it ought to end (Haley, 1963). He discussed evaluating, motivating, influencing, and terminating with clients by focusing on the treatment relationship as a context for emotional integration.

The treatment relationship was the "obvious paradox" of therapy for Haley (1963, p.66). He considered Victor Frankl's technique of "paradoxical intention" a "shift from

the individual to the relationship point of view,” as a way to explain how treatment ultimately provides a context for new experience and change (Haley, 1963, p. 66).

By taking his role as a helper seriously, Haley explored how directives could be given to support the collaboration and co-construction of treatment (1963). He was transparent in discussing power and the therapist’s “one-upmanship” socially and by definition, which ultimately allowed for colleagues and others to apply similar findings from communications research (1963, p. 192).

Interpersonal and family therapy blossomed from this creativity and strategic family therapy has played an integral part in the development of other family interventions, including a mutual and shared relationship with the structural school of family treatment. Eventually, in the preface of *Strategic Family Therapy* (1982), Cloe Madanes described the model and its ability to capture “the positive, benevolent aspects of power” that could grow from such an open acknowledgement of the various doings in therapy and as means to describe the best case scenario that might exist between therapist and family (p. xxi).

The Model and its Progression: From Technique to Theory of Change

The strategic model, because of Jay Haley’s pre-occupation with therapeutic procedure, is not only a model for treatment, but also a systematic progression of what treatment might look like. The model’s progression was established by practice first and then by situating a theory that could encompass the therapeutic activity that was taking place later. Thus, from technique to theory of change, the *Strategies of Psychotherapy* (Haley, 1963), culminated in the more fully developed *Problem-Solving Therapy* (Haley,

1976) and *Ordeal Therapy* (Haley, 1984). Haley's work also served as a foundation for Cloe Madane's *Strategic Family Therapy* (1982).

These publications, although they differ in scope, demonstrate the growth of the strategic model. As noted, Haley was one of many players rooted in various regions throughout the world influenced by the therapeutic shift that occurred as communications theory began to influence mental health treatment and aid in the creation of the family therapy movement (Hoffman, 1981, 2002). The family as the unit of treatment set the scene for issues of relationship, language, behavior, and communication to come to life in the therapeutic setting.

To work strategically is to situate ultimately a treatment context and to acknowledge that each problem and each presenting family is different and will be treated and helped in different ways (Haley, 1963). As the model progressed, this issue of context was pushed on and advanced. The therapist was quickly brought into the context of treatment; to work strategically is to engage a relationship with the client or family system and to use this relationship to both gain information, to know them, as well as to provide strategies for change (Haley, 1963, 1976).

Haley emphasized in his early writing that psychotherapy was an art (1963), and that it was always an "oversimplification" to try to describe the strategies or procedures of therapy; nevertheless, this was also his primary interest and motivation in emphasizing therapeutic directives (p. 2). The techniques of directive therapy were to begin from the start in Haley's opinion. The strategic model is a brief model of treatment (Haley, 1963; Rabkin, 1977). Throughout the literature, technique is often explained according to specifics. For example, the hypnotic process is explored at length. Therapy is broken

down into “stages” in the strategic model and despite the therapist as the benevolent director offering support, acknowledgment, and encouragement, if the presenting problem is not solved than the goals of therapy have not been met (Haley, 1976, p. 129).

As Cloe Madanes expanded Haley’s model in later years (1982, 1984) she was also influenced by the structural school of family intervention, which resulted in her breaking down further issues of paradox and control in relationships and her opening up structural ideas of family organization and hierarchy to further strategize and understand behavior as communication. Madanes also wrote specifically about marital problems, child problems, and parental problems – offering technique for each potential paradox, including ways to balance power, how to expose symptoms as metaphors, as well as different “communication modalities appropriate for children” such as pretending, role-modeling, and play (1982, p. 90).

To outline the model, I will attempt to pull from the literature a general overview. The techniques of directive therapy (Haley, 1963) start immediately due to the brevity of the therapy and the necessity to gather information quickly (Rabkin, 1977). From the first interview on, the therapist is required to maneuver and “induce change” (Haley, 1963, p. 41). According to Haley, the paradox is not only the context for treatment, but also an issue of power initially, as the therapist’s strategy must lie not just in gathering information, but also in *how* the information is gathered.

Milton Erickson emphasized, throughout his career, a willingness “to take full responsibility” for the treatment from the onset (Haley, 1963, p. 45), while also accepting the client or family system from the start. Haley was drawn to this activity therapy and he used the hypnotic model of therapeutic process to situate therapeutic “steps” for strategic

therapy (p. 51). Rooted in the therapeutic relationship, this must begin with a hopeful stance that insists, “positive change might occur” (p. 51). The therapist must then “participate in change” with the client or family system and finally then, all parties must “notice change” so that treatment can conclude (p. 51).

The method is to assume responsibility for the presenting problem behavior and to offer directives for the client or family to follow. The main directive, and “the basic rule” of strategic treatment, is to encourage the problem behavior or presenting issue (Haley, 1963, p. 55). To direct more of the same is the therapist’s task, as a means of what Haley called “changing the character of the activity” (p.55). People usually come to therapy with an issue or a struggle that has been defined by someone as problematic. For the therapist to direct and maneuver around this behavior is to both gain information, as well as utilize the symptom to change the symptom. The specifics depend on the presenting treatment context; however, if the therapist can generally shift the meanings behind the symptoms for the client or family system, then such intervention can change behavior and make therapy a success.

The therapist provides an ordeal (Haley 1963, 1976, 1984) so that the paradox of treatment lies in how the symptom is shared in the therapeutic relationship rather than solely held by the family alone. Haley felt that technique would ultimately lie in the “theory used to explain the symptoms” (1963, p. 68). He discussed non-directive therapy as non-existent in the therapeutic context (Haley, 1963). Whenever the therapist was choosing to act or not act, it was still an issue of professional control and choice that situated and provided intervention strategy. The “therapist’s superior position” is a position that includes setting rules, boundaries, and deciding how to communicate with

the family (Haley, 1963, p.72). Haley was first drawn to the strategies of psychoanalysis, conditioning theories, and the philosophy of existentialism, as exemplified by Victor Frankl's logotherapy (Frankl, 1960; Haley, 1963, 1976).

Strategic family therapy was the natural treatment context for Haley's family therapy roots, communication theory, and relational context to flourish. The family as a group balanced by communication patterns allowed him to theorize about the function of symptoms as specific descriptors in getting to know an individual and a family. Conflict was placed in relationship and viewed as existing outside of the family member considered the identified patient or "problem" (Haley, 1963). Strategic family therapy includes the therapist noticing and joining relationships, coalitions and, generally, participating in a family system in order to alleviate issues, conflict, and pain.

Richard Rabkin (1977), in discussing the strategic psychotherapy method, was extremely forthright in scope and explanation. He too acknowledged the beginning of treatment as the most important. The opening of treatment for Rabkin included the therapist understanding generalized "characteristics of the patient" (p. 16). Characteristics Rabkin summarized include the client's being "well-informed" (p. 16), that clients are often "demoralized" by the presenting problem (p. 18), a generalized loss of hope that leads to treatment as intervention (p. 18), and the client's having attempted past strategies that have failed or not lasted (p.29). In turn, Rabkin suggested, the therapist "must offer hope" (p. 38), "negotiate about and define the problem to be addressed" (p.38), and "convince the patient" that the treatment relationship, the therapist, might be of help (p. 38).

This initial engagement included asking about past treatment and asking to hear about the client by the client, which might include a life story or what Rabkin called a “strategy of reminiscence” (1977, p. 39). To start, the therapist “defined the complaint, the goal, and the request” with the client in a method of co-collaboration (p. 48). The issue is named, a diagnosis is established as and, if necessary, the client informed of what the treatment would look like and include.

Methods were “direct” (p. 69) and “indirect” (p. 85) according to Rabkin and might include everything from “ordeals” (p.70), to “interpretations” (p.75), to “crisis intervention” (p. 82), to “flattery” (p. 94), to “indirect messages” (p. 90), to “intense emotion” (p. 77). The list is inconclusive and always expanding. Rabkin discussed the therapist’s job as one of developing a strategy that can explain, modify, teach, as well as change. Therapy ended when progress toward a solution had begun or when it seemed that no progress would be made. Rabkin concluded his *Strategic Psychotherapy: Brief and Symptomatic Treatment (1977)*, by offering the “satisfied dropout” as the goal of brief therapy (p. 218).

Haley, as noted, grew to develop more specifically his general observations of the strategies used in therapy (1976). He outlined four stages of an initial treatment interview to include a “social stage,” “a problem stage,” “an interaction and enactment stage,” as well as “a goal setting stage” (Haley, 1976, p.15). He encouraged no interpretations or observations by the therapist in the first session, but encourages the therapist to gather information and to seek and find meanings in what the presenting family communicated.

After this is accomplished in the first interview, the therapist discusses to meet next and with whom. Haley also recommended a checklist for the therapist’s own review

(1976). The question of whether the first interview is a success can be answered by the therapist's self review of flexibility, acceptance, organization, expertise blended with ignorance, and confrontation blended with reflective listening, and whether or not these clinical ways of being were present in the first interview (Haley, 1976, p. 46-47).

Directives, as the general technique of strategic family therapy, are purposeful in that they make the goals of therapy happen, can be used to "intensify the therapeutic relationship," and can offer invaluable information no matter their outcome (Haley, 1976, p. 49). The question of "what is the directive?" (p.50) and the follow-up of what directives ought to be used will vary. A directive can be as simple as "tell me more about that" (p.50) or as subtle as using the treatment relationship to help a family re-organize. Directives, or tasks, might exist in the session or as homework (Haley, 1976). Tasks might be metaphorical or paradoxical. Just as strategic family therapy exists in stages, so must the tasks of intervention. To respect and utilize what the family thinks is important is how the therapist ultimately observes and directs the family to change.

As mentioned, Cloe Madanes published and worked with Haley's ideas in mind. However, her strategic family therapy was also heavily influenced by structural family therapy and her time spent in Philadelphia working with both Haley and Salvador Minuchin. As a result, she added to the strategic model a focus on not just communication, but the levels of organization within a family hierarchy, as a representative descriptor of the family's overall communication and relationships (Madianes, 1982). This concern with family structure was also balanced with an interest in the family's metaphors, as well as her desire to expose and understand the specificity of symptoms within a family. Madanes used the structural ideas of power and

organization to try to help families change by restoring the family's hierarchy. She also assumed "symptoms [in families] metaphorically expressed problems" and solutions, the same notion that all behavior is communication, which Haley first explored (p.21).

Madanes emphasized the playfulness of directives and the potential of using therapeutic techniques to shift a mood and elicit information in the work (1982). The "posture of the therapist" she described as necessarily adaptive and fluid in response to the presenting problem and the hypothesis and activity that might help the family change (p. 117). In *Behind the One-Way Mirror: Advances in Practice of Strategic Therapy* (1984), Madanes continued to build on her initial musings by establishing further the use of strategy in treatment. She proposed utilizing "the humorous alternative" in treatment and continued to discuss benevolence, positivity, and hope, as an initial and strategic stance to each presenting family unit (p. 115). Madanes proposed that choosing a strategy in treatment is rooted mostly in the therapist's ability to think, rather than to strategize. If a therapist is able to be flexible, respond to the context of treatment, hear and respect the family, and attempt to help the family by means of a brief intervention, Madanes believed that clear thinking would ultimately lead to an appropriate and useful strategy.

Jay Haley published *Ordeal Therapy* in 1984, which further highlighted the charisma and effectiveness of Milton H. Erickson's therapeutic techniques, as well as finally including a theory of change rooted in the ordeals Haley had been writing and situating for decades. Primarily, Haley proposed that the ordeal of activity, which occurred by way of paradox and therapeutic directives, was both a process and procedure that allowed the client or family system to shift their presenting problem to another level

in order to change. His theory of change was that the ordeal was an experience that the therapist helped to shape, leading to behavioral change.

The ordeal as a dilemma could be the overall therapeutic relationship; however, the goal was for the ordeal of therapy, either relational or more task specific, to be the therapist's main concern (Haley, 1984). The therapist's job was to bring about such an ordeal through the strategies of intervention. Haley proposed that often this change would occur only if the ordeal or therapeutic endeavor was as intense as the presenting symptom if not more so.

From technique to "the ordeal as a theory of change," strategic family therapy attempted to apply communications theory to the family as a unit of treatment (Haley, 1984, p. 19). This was done by focusing on the presenting issue and the therapist's role in bringing about and inducing change. Both MRI and the Milan Group also worked with paradox and the procedures and strategies of treatment (Haley, 1963; Palazzoli, Cecchin, Prata, & Boscolo, 1978).

The Milan Group evolved to support a more "neutral stance" by the therapist, and MRI supported and eventually let Jay Haley run loose with his ideas and opinions, so that the strategic model today remains Haley's by way of spirit and publication, and in many respects, Milton H. Erickson's due to responsibility, and a clinical track record of excellence and ingenuity (Boscolo, Cecchin, Hoffman, & Penn, 1987, p. 97). Today, as the rise of cognitive treatments have blended with the postmodern trends of narrative and solution-focused treatment, strategic family therapy has also since merged with structural family interventions, as well as brief psychodynamic treatment worldwide.

Success and Repercussion: Power and the Transactions of Treatment

My interest in strategic family therapy and its progression as a treatment model lies in its creativity and its strong attention to clinical context. Jay Haley's ethical transparency has not kept the model from coming under question, however, due to the maneuvers and power plays that the model acknowledges, utilizes and manipulates. This issue of power in treatment and in the therapeutic relationship is central to the strategic model and has also been hotly debated and critiqued.

Despite Haley's best objectives and the validity behind his generalized observations regarding what is actually happening relationally in the therapeutic alliance, as one might expect, issues of language and responsibility have arisen due to the strategic jargon including power laden terms such as manipulate, maneuver, strategize, control, tactics, directives, and paradox. This arsenal of terms belie the benevolent and hopeful stance intended.

Nevertheless, the successes and repercussions of strategic family therapy are seemingly subjective, in that the therapist's ability to work strategically lies in his or her capacity to control the pace of a therapy that does insist upon activity and use of self in the context of treatment. In 1963, Don Jackson, as part of Bateson's team and the MRI community, provided the foreword to Haley's *Strategies of Psychotherapy*. Jackson anticipated the issue and question of manipulation in the strategic model and likened Haley's exploration to what Sigmund Freud had uncovered in the context of transference. Jackson suggested,

When Freud discovered transference, he discovered that the patient and therapist were involved in an interactional game that required skill on the therapist's part if

both he and the patient were to benefit by the encounter. If the therapist is genuinely interested in helping the patient, and if he is experienced so that he can bring his skill to bear in at least a partially predictable way, then the style of the game he plays with the patient can vary widely and still be helpful. Therapy becomes manipulative, in the opprobrious sense of this term, only when the therapist is using the patient for various covert financial and/or power reasons that have little to do with the patient's best interests. (viii, 1963)

Haley himself also directly spoke to the issues of power, control, and relational manipulation in the therapeutic context (1963). He discussed "the voluntary and the compulsory relationships" of therapy and how the context of therapy, for example, is this work court-ordered, occurring in an institution of power, something the family wants, as factors influencing the necessary approach and therapeutic strategy used by the clinician (p. 183).

Haley was not naïve about the social positioning of the therapist as a helper paid for therapeutic services. He eventually commented on psychiatric diagnosis, as well as the often-tangled web of therapeutic collaboration, as acts of power and manipulation occurring in the therapeutic milieu and in the service of social control. Haley suggested that the "line between therapy and social or political action becomes obscure" (1976, p. 4). This was part of his larger argument for widening the social unit in therapy, adopting a social view of problems, as well as a theme that he identified as occurring repeatedly in therapeutic work with the poor.

In *Problem Solving Therapy* (1976), Haley devoted a full chapter to ethical issues in therapy. He wrote about "fair exchange" (p.195), "controlling information" (p.197) and "manipulation" (p.199), confidentiality (p.205), as well as ethical "awareness" by the therapist (p.206). Haley's observations are relevant to this project's emphasis on clinical work with families experiencing poverty. For our purposes here, just as Chapter II

discussed clinical treatment with poor families, and Chapter III discussed the field of child welfare and the familial stressors and developmental vulnerabilities that regularly affect the poor, the strategic model's direct employment of therapeutic power and relational control in relation to work with the poor should also be discussed.

To continue, I will try to further establish the ethical transparency of the strategic model. Its acknowledgement and use of power is both substantial and promising, perhaps rendering it a natural fit in clinical work with poor families. If anything, strategic family therapy has been critiqued for being too contextually and socially focused. The postmodern and social constructionist shift that has occurred within the field has also further highlighted the importance of understanding issues of power and the social constructions of normality. This shift signifies the value of understanding clinical context, the therapist's use of self in the treatment relationship, as well as the social concerns and ethics of society. The strategic model takes these themes and issues seriously and issues of context and power are core values of the strategic model.

Chapter V will present my own opinions about the use and employment of strategic family therapy with the poor. In light of the clinical contributions made by narrative therapy and solution-focused treatment, strategic family therapy is a model that can also be deconstructed to include language as strategy and behavior. By encompassing both the activity and ordeals Haley identified as crucial to the paradox of treatment, as well as by considering the postmodern influence on how therapy might be approached and conceptualized, a synthesis of these models and theories may advance further issues of therapeutic technique and strategy in our work with families experiencing poverty.

The enthusiasm of Jay Haley, and his desire to confront directly power issues in treatment, has also been critiqued for its game-like approach to serious issues of cause and concern. The therapeutic relationship as a context of safety and trust must be questioned when a therapist works strategically in an “Oz-like” behind-the-scenes playfulness that could be misused and abused in the wrong hands. One could argue that families and clients in treatment are, on the whole, a population deserving of complete clinical transparency, no matter the ethical lucidity underlying the strategies employed or utilized along the way. This is an argument for complete co-collaboration and co-construction. It is an argument that the therapist ought to work equally with a family rather than in a position of omnipotence, superiority, or expertise.

In their summary of the 1950s through the 1990s in the field of family therapy, Guerin and Chabot (2007) argue that strategic family therapy is a model that fails due to its inability to look internally to individual issues of development. For this reason, they summarize strategic therapy by saying, “therefore it over-values context the same way individual treatment undervalues it” (p. 211). Certainly, other critiques also exist. The reader may have other concerns and imagine how Haley might respond, or simply accept the criticism that the strategies of therapy generate.

Metaphor and Manipulation: Therapy as a Post-Modern Paradox

Storytelling has a long history in therapeutic intervention. The literary merits of Sigmund Freud are well documented and it was his capacity to write that solidified his ideas being shared and explored in the spirit of human knowledge and discovery. Strategic family therapy, defined by its interest in the techniques and strategies of

treatment, continues the tradition of literary agency and experience, by way of its directives, tasks, and the potential use of both metaphor and anecdotes in the progression of treatment (Haley, 1976; Rabkin, 1977).

Richard Rabkin utilized metaphors throughout his text *Strategic Psychotherapy: Brief and Symptomatic Treatment* (1977). Emphasizing Carl Jung's description of "healing fictions," Rabkin explored language as strategy and believed that problems might improve in the context of new meanings (p.38).

In this Jungian sense, [Rabkin suggested] the entire opening phase of strategic psychotherapy requires us, as authors of the diagnosis and prognosis, to distinguish between the mythical (nonexistent) and the mythic (powerful) – between bureaucratic requirements and genuinely therapeutic ritual. (1977, p.38)

Rabkin also considered a client's biography, their "strategy of reminiscence," as a way for the client to both remember his or her past and provide information to the clinician, who might benefit from experiencing the client as a storyteller, but also as a way of utilizing the client's memory and self-story to aid in the attainment of therapeutic goals (p. 39).

Rabkin further anticipated a narrative therapy, by considering diagnosis, during an initial briefing with the client, as a procedure where the therapist and client "name" the issue at hand, as a means of working contextually (1977, p. 45). This strategy of externalizing the behavior, would eventually surface in the writings of Michael White and David Epston as one of the foundational strategies of the narrative model (1990).

Lynn Hoffman, in her *Family Therapy: An Intimate History* (2002), highlighted the "rhetorical emphasis of the Ericksonians," which further signifies not just the experiential and strategic prowess of Milton H. Erickson, but also the strategic legacy as

a course of treatment, which might strategically employ the use of words, stories, and the procedures of storytelling, as a means of therapeutic intervention and ordeal (p. 14).

What's more, Jay Haley, with his *Problem Solving Therapy (1976)*, further supported Rabkin's critique of psychiatric diagnosis, by discussing "the way one labels a human dilemma" as a therapeutic power often misused (p. 3).

Haley eventually tackled "metaphoric tasks: the use of analogies" forthrightly by defining metaphors as not only words, but also as actions (1976, p. 65). Analogies are also considered by Haley as occurring in a family and for their performative quality in a family's pattern and organization. He referred to therapeutic change as a literary endeavor whereby,

The therapeutic process may consist of easing the persons out of the metaphors they are using into more appropriate ones, or the metaphors can be blocked so that others must be developed. (1976, p. 99)

Overall, Haley considered the therapeutic "problem as a [working] metaphor" that would shift as positive change and growth occurred (p. 90).

Cloe Madanes, described by Salvador Minuchin for her ability to "use fantasy and pretending to create alternative realities" helped to further explore the use of language, metaphor, and performance, as a powerful therapeutic capacity in the service of families (Minuchin, 1982, p. xviii). Madanes employed Haley's use of metaphor and descriptions of analogical communication to "change the metaphorical action" in the families she worked with, as well as to "provide metaphors for success instead of failure" (Madhanes, 1982, p. 96). For Madanes, "the posture of the therapist" included use of language, metaphor, and an interpretation of communication as both behavior and organization in

the family system (1982, p. 117). Her conclusion to *Strategic Family Therapy (1982)* anticipated the rise of narrative therapy in the years to come:

The contribution of this book is within the tradition of interest in metaphors, but it introduces new complexities by describing metaphorical sequences of interaction. A system's metaphor and a metaphor in a dream are not the same order. To focus on the metaphor expressed by a sequence of interaction is of a different order from focusing on the metaphor expressed in a message or act. There is a shift to a different level of analysis when metaphorical communication is thought of as expressed not only by individual messages, but also by relationships and by systems of interaction. Strategic family therapy shares with the individual psychodynamic and experiential theories the focus on understanding the metaphor. Within the family therapies, it shares a concern with the organization of the family. The two concerns come together in a strategic therapy based on changing interactional metaphors and manipulating power in families. (p. 227)

Strategic family therapy has been criticized for its perceived arrogance and the idea that the therapist as an outsider might know what was best for a family presenting in treatment (Freedman & Combs, 1996). What I have attempted to outline here is that the strategic use of metaphor in treatment, as a therapeutic technique, is a commonality that is shared by strategic family therapy, as well as by narrative therapy and the general epistemological base of the postmodern trend. This shared emphasis on the social construction of reality and the importance of deconstructing language in the service of knowledge and empowerment is ultimately an issue of power that the transactions, interchanges, and performative aspects of communication and human relationships help to support and expose.

Therapy as a social construction and a context laden with both power and meaning was not only the therapeutic paradox Jay Haley first explored, but also remains the issue at hand in the treatment relationship today. Working with families experiencing poverty is similarly a control-laden position of social influence. The therapist might both

be the benevolent director of the family's positive narrative, as a language provider or as simply a listener, as well as an agent of social control deep seated in the web of therapeutic collaboration Haley readily analyzed and exposed. Chapter V will acknowledge further the similarities and differences between clinical context, technique, and strategic work with the poor.

Poverty as Context: "Strategic Family Therapy in the Trenches," (Bobrow & Ray, 2004)

Since the early 1980s, strategic therapy has continued as a model of treatment. Haley and Cloe Madanes left their work with Minuchin and Montalvo in Philadelphia to start the Family Therapy Institute in Washington, D.C. (Bobrow & Ray, 2004). Theirs became a strategic family therapy, which blended ideas from both MRI's Brief Therapy Center and Philadelphia's structural school. Haley and Madanes established a legacy in the field of strategic family therapy, which is today considered uniquely as the "Washington-School" (Bobrow & Ray, 2004; Keim, 2000).

In *Sex, Love, and Violence: Strategies for Transformation (1990)* Madanes demonstrated the growth of her ideas and practice. Haley too has published a plethora of both articles and books on topics ranging from *Leaving Home (1980)*, to *Learning and Teaching Therapy (1960)*. It is his 2003 book, *Art of Strategic Therapy*, which he published with Richport that has perhaps brought his ideas and publications full circle. The text represents Haley's return to describing therapy as an art form, a topic that had inspired his teaching, writing, and practice since his beginnings as a researcher.

The strategic model continues to be alive and well. In 1999, it was reinstated as an orientation at the Medical Research Institute in Palo Alto (MRI) and the Strategic Family

Therapy Training Center (SFTTC) continues to train and implement the strategies of therapy in their work with clinicians, supervisors, and mental health agencies (Bobrow & Ray, 2004). Strategic therapy has also shared with solution-focused treatment an emphasis on brief therapy, which has led to many publications, trainings, and general therapeutic collaboration (Ray, Keeney, & Stormberg, 1999).

James Keim has arisen as a new writer and practitioner of strategic therapy (Bobrow & Ray, 2004). As part of the “Washington-School,” Keim has focused on oppositional behavior (Keim, 2000, 2001; Ray & Keim, 1997). While Jose Szapocznik has utilized brief strategic family therapy in his work with Hispanic youth and has published generally about the behavior and treatment of teens (2000, 2003).

As the torch has been passed, and the strategic model is today perhaps lauded most for its focus on brevity and solutions, severe and chronic poverty has been continuously identified as a context of treatment that accompanies more complex therapeutic cases (Bobrow & Ray, 2004). Leaders like Jay Haley and Edgar Auerswald noted that in work with poor families there are often many providers with conflicting goals; further confusing and stressing families. Auerswald would often ask, who is “the chairman of the case” when so many service providers were involved (as cited in Rabkin, 1977, p. 187).

MRI recently funded a study where strategic family therapy was implemented as a model for treatment and clinical training with a juvenile mental health system (Bobrow & Ray, 2004). This project paid practicing clinicians and supervisors to learn strategic family therapy (Bobrow & Ray, 2004). The results were surprising for many, as there was “evidence of success” even in difficult settings such as juvenile hall and group

homes (p. 35). In spite of the skepticism of residential staff, in this study, 75% of all presenting problems were successfully resolved. Participating supervisors and clinicians responded during a project follow-up that they continued to utilize the strategic model with success in their work.

As one facilitator, helping to run the project, observed, the toughest part of teaching the model to experienced clinicians was that,

The clinicians [participating in the project], while sympathetic and caring, had been shaped by the work context and environment to assume positions of authority [in relationship to clients and], in this system especially, taking an authoritative stance, unless done as an intentional tactic to fit a particular situation, often has the effect of keeping the therapist powerless. (Bobrow & Ray, 2004, p. 35)

This observation, juxtaposed with the critique that power is used inappropriately in the strategic model, is an interesting finding that challenges those who might consider strategic family therapy to be inappropriately manipulative. For our purposes here, this project (Bobrow & Ray, 2004) has provided one successful example of strategic family therapy being voluntarily utilized by clinicians working with low-income families.

In this chapter, as I have attempted to outline the strategies of therapy, a model for strategic family therapy, as well as a timeline of writers and clinicians, the successes, and repercussions of the model must be weighed against its ability to energize, inspire, and help families in a fashion respectable and uber aware of context. In Chapter V, I will further discuss strategic family therapy, by also taking into account my presentation of family preservation philosophy, as well as the literature base of family therapy, the interventions of child welfare services, and the history of intervention with families that are poor.

CHAPTER V

DISCUSSION

This final chapter is a synthesis of Chapter III and Chapter IV, namely the theory and values of family preservation philosophy and the techniques and directives of strategic family therapy. My objective throughout this paper has been to provide a literature review contextually rooted in clinical work with families experiencing poverty. An extensive review of the literature has been both a strength and a weakness of the project. The overarching question of how to work successfully with the poor, however, required a saturation and mastery of the literature to understand the very importance of asking such a question as well as its potential naiveté.

I initially hypothesized that poverty was a complex national issue; I felt it to be inadequately addressed. In my reading, I have since found few signs of progress in solving the tragic inequalities in family life. Poverty has serious ramifications for childhood development, social health, and public opportunity. Poverty persists despite the wealth of the United States in relationship to the rest of the world.

Rainwater and Smeeding, in their exploration of *Poor Kids in a Rich Country: America's Children in Comparative Perspective (2003)* say that, “the first task of the poverty researcher is to discover the contemporary social standards of what constitutes poverty (p. 11). They further consider the “social measurement of poverty” by explaining,

A social measurement of poverty is concerned ultimately not with consumption but with social activities and participation. Researchers with this orientation do not look at the problem of poverty in relatively affluent societies as one of low consumption per se but focus instead on the social and personal consequences of poor individual's inability to consume at more than an extremely modest level. Without a requisite of goods and services, individuals cannot act and participate as full members of their society, and it is this participation in social activities that confers utility, not consumption. (p. 9)

In highlighting the social context of poverty, Rainwater and Smeeding (2003) also describe the social identity and meanings associated with poverty in America. This identity, I believe, is ultimately our business and main concern as clinicians working with poor families today. Accordingly, the main thread throughout this project, as I looked at the history of family therapy and family poverty in Chapter II, explored family preservation and the field of child welfare in Chapter III, and perhaps found my stride and enthusiasm most successfully as I explored strategic family therapy in Chapter IV, has been the issue of clinical context. I did not so much explore what constitutes a poor family, but rather how we use the power inherent in our professional standing as providers of treatment. The poor as an oppressed population and our social power as clinicians is my finding with, I believe, the most significant implications for how we work and, arguably, how we strike a balance between being agents of both social control and social reform.

Madsen's question of "what does it mean to intervene?" emerged in my reading as an issue of clinical power in the context of poverty (1999, p.157). Ultimately, the interplay between the philosophy of family preservation and strategic family therapy has been the decided locale where I have drifted in my search. My investigation has exposed the difficulty and unreliability of finding one truth or philosophy that might aid us in our

clinical work; however, I have explored thoroughly two schemas that value and respect this question, which represents perhaps the most we can theoretically hope for or expect.

Family Preservation Philosophy and Strategic Family Therapy

There are several similarities between family preservation philosophy and strategic family therapy, which help establish a working marriage between the two models of intervention. Both models support treatment as a brief and intensely focused relationship. Both models establish treatment as family-focused as well, recognizing the importance of the family system in children's lives.

Further, family preservation philosophy and strategic family therapy were both established in the context of family therapy and crisis intervention, as developing movements implicating policy and the field of child welfare. Additionally, a focus on gaining information efficiently, home-based work in the case of family preservation, is a mutual expectation of clinicians working successfully under both models. The values of family preservation philosophy are also shared by a strategic therapy focused on clinical flexibility, co-constructed treatment goals, as well as a course of treatment that might shift unexpectedly despite the intervention's brevity.

In Chapter III, I presented the Homebuilders Model as a definitive program that has been utilizing a family preservation philosophy for decades now, which has led to its being discussed in the literature, as a groundbreaking approach to treatment. The program established seven guiding principles, including an emphasis on the clinician's job to "instill hope" and the acknowledgement that "we can do harm" as treatment providers (Berry, 1997, p. 72). These principles are also shared and valued by the strategic

therapist. Richard Rabkin (1977) has emphasized that the therapist “must offer hope” in discussing the initial stages of strategic intervention (p. 38). And Jay Haley, in particular, focused on the issue of power in the treatment relationship. He raised significant concerns regarding how this power and social influence might be used or abused by the clinician (Haley, 1976). Haley’s emphasis on clinical context is also (and often) the starting point of intensive family programs and family-based services. Poverty as context and crisis as context represented issues of power for Haley, as he described the therapist’s job as a director of intervention and strategy (1963,1976,1984).

The emotional and psychological tolls of a crisis have long been acknowledged. Both Haley (1976) and Rabkin (1977) understood this and used this knowledge to convey the necessary role a clinician often must play in helping the family not just tell their story, but also remember their strengths, as they begin to move towards a positive and empowered stabilization. That each family is unique and original, is a value of family preservation philosophy that the strategic family therapist has also long assumed. This acknowledgement, although it might seem obvious theoretically, is an approach to practice that can help to establish successfully a strong engagement and an initial mutual respect that can extend a short-term intervention beyond direct contact.

Severe and chronic poverty can also be seen as a “lifestyle paradox” for families trying to disentangle their incomes, homes, neighborhoods, confidence, strengths, and love from the systemic oppression taking its toll on their daily lives. Minuchin and colleagues captured this personal aspect of give and take in their work with the poor. *Working with Families of the Poor* outlines this struggle and the illogicality often

apparent in our work with this population as unrealistic expectations and imposed structures are placed on already vulnerable families (Minuchin et al., 1998).

Strategic Family Preservation Therapy with the Poor

The philosophy and values of family preservation provide the quintessential holding environment for a strategic family therapist to enter a poor and disenfranchised family system. This entry point is not a “tip-toe” of equality – but often a “pound on the door” as intensive family preservation and family-based services are frequently court-ordered and today funded by social services in general and the field of child welfare in particular. Thus, the “therapist’s superior position” is recognized by the family from the onset (Haley, 1963, p. 72). The family recognizes such treatment as an *ordeal* from the start. The presenting clinician must be able to both acknowledge and handle this power.

Over the course of the strategic intervention, this power must be utilized and shifted in order to empower and truly come to know and “see” the family. What I am suggesting is that the overarching technique or strategy is ultimately a deconstruction of the therapist’s social power in relationship to the family being treated in the context of poverty. As the therapist gets to know and positively support the family, the treatment relationship can shift.

The therapist, who was initially seen by the family as an agent of social control, can move into a more significant relationship with the family whereby the family might be helped in aspects of personal reform. This can happen. And it can happen outside of the bureaucratic ways of knowing that so frequently plague interventions that the poor experience as emotional and intrusive. Resources and services might be the goal;

however, depending on the family or individuals involved, the therapeutic directive might wholly exist in listening, talking, and perhaps even just playing with the family.

The social context of poverty refers to the ways that poverty disempowers and excludes. Families experiencing poverty, particularly single mothers, each have their own unique self-story or narrative that is often not acknowledged by the communities and existing social structures where they live. Thus, Haley's emphasis on the social context of "problems" is significantly relevant when it comes to the issues and concerns of poor families in the United States today (1976).

In fact, it would seem that the critique of the strategic model offered by Guerin and Chabot (2007), namely that it fails to identify problems of the individual – in the context of poverty – perpetuates our national desire to continuously "blame the victim". This is a destructive stance, which gives individuals personal responsibility for larger, societal structures. In the milieu of clinical practice, an inability to acknowledge issues of social context sorely lacks not only a more empathetic, but also a more useful case approach.

Moreover, in a model of strategic family preservation therapy, the "paradoxical intention" of such work might lie in the clinician's ability to more openly represent the institutions, cultures, and social structures – the power – continuously keeping the client or family system down (Frankl, 1960). Here, the directive might be to discuss the power blatantly, overtly and fully, and to invite the family or client to share their experiences in relationship to *you*, the clinician, as the symbolized institution.

This performative quality of power might shift, as the treatment relationship can support and re-write a family's narrative into a more powerful story shared by the

clinician in the end. This speaks to the clinician's power as a social informant, and as a "thermometer of pain" – helping communities to better "see" a family as they do, as well as by helping a family system to better understand how to work with what can at times be both painful and discriminating systems (Waldegrave, 2005, p. 270).

The clinician becomes the seesaw of child welfare reform in relationship to the family in a model of strategic family preservation therapy – holding the literature as a source of power and knowledge, as well as issues of policy, ramifications of diagnosis and funding, all within the treatment relationship as a context of technique, hope, and co-collaboration. Family preservation philosophy, thus, might be argued as stratagem or technique, as a foundation for practicing strategic family therapy with poor families today.

No matter the way the models are fit together, funded, or might exist, it is the therapist's flexibility and use of self that both family preservation philosophy and strategic family therapy take seriously. This is a refreshing emphasis on professional responsibility and agency that I am drawn to as I attempt to avoid minimizing the power inherent in being a treatment provider, but to accept it, understand it, and work to try to both simultaneously deconstruct and utilize its influence in my work . This use-of-self might be further guided by the values shared by these two models and in the spirit of goal attainment, benevolence, and respect.

Outside of situating family preservation philosophy as strategic therapy, it should be noted that strategic family therapy is only one way to complete an intensive family preservation or family-based service intervention in the context of child welfare. Specifically, and here the history of intervention with poor families is significant, the

paper trail accompanying a poor family into treatment, a family that might be tangled in a web of collaborating service providers, could be strategically approached by taking a narrative-based, solution-focused stance. Empowering the family to re-story and re-verse their “problems” in a more tangible and positive fashion is the ultimate goal. This might also be done by focusing on neighborhood and community support. The directive called for might simply include the therapist acting as a case manager in finding longer lasting resources that are chosen by the family and relevant to their ongoing needs.

Other possibilities exist for further synthesis of these two models. In some respects, for the researcher, it becomes an issue of language and wordplay, whether and if I am able to convert the language of one model into a fit with the values and applications of another practice. As Harry Aponte argued for the activity and “enactment” of the therapist, however, his stance was that in order to be of service, we must first be-of-self foundationally, as both therapists and as human beings (1994, p. 21). He thought that in order to empathize with how “the personal problems of poor people then become the problems of poverty,” we must also be willing to participate actively with this population, to maneuver, and to strategize in our work (p. 14).

Clinical Work with Families Experiencing Poverty

Much of this project was focused on exploring two specific models of clinical intervention. I have provided a general synthesis. I have discussed a working marriage between two separate theoretical stances. In addition to this project’s specific focus, I have also read broadly on issues of family therapy, clinical practice with the poor, as well as into the history of child welfare and social service reform.

I have considered re-reviewing much of what is already assumed “good practice” with this population. I have since re-considered. A lengthy or thorough review of this information, due to its already being available and arguably better captured by many approaching more specific aspects of family poverty, has already been done and done quite well. What might better support this project and our work at this time, however, is a more general discussion focused on thematic aspects of practice that the literature overwhelmingly supports and suggests. Several considerations come to mind.

Overall, since the family therapy revolution, or the re-return to the family as the focus of clinical intervention in the 1950s, the “systems” metaphor has introduced a heightened emphasis on patterns of communication and information as both boundary and power in relationship. In the context of poverty, “a family-larger-system perspective” today still carries weight (Imber-Black, 1991, p.371). This remains overwhelmingly the case, in fact, despite the persuasive arguments made by the social constructionists and those who favor a clinical approach that values “stories” over “systems.”

The “systems” conceptualization remains pertinent due to the reality many families living in poverty negotiate daily. This speaks to a social reality that favors a “systems” metaphor that cannot be made into a fairy-tale or even a strengthened verse until it is both acknowledged and understood. In this sense, the “systems” metaphor must be utilized before it is set aside or a family’s “stories” are re-told.

It is a social narrative that family-based aid identifies. As a result, in order for a family to be supported clinically, and for their family story to be re-claimed, the paper trail must first be accepted and dissected. This theme in the literature is not obviously identified. Support for this suggestion has arisen throughout my reading, however, as the

varied epistemologies and treatment models beg the further creation of a theoretical synthesis that will help to better support our work with low-income families.

A “story” is not yet an adequate introductory approach to families in need of concrete services. This represents well the unfortunate and entrenched thinking nationally, which accompanies our structural inequalities. A Catch-22 in our work with the poor is that the programs are funded systemically, despite how our newer developments in clinical thinking, primarily solution-focused and narrative-based interventions, work specifically to empower and acknowledge uniqueness. Policy does not have this same privilege, which continues to complicate our clinically celebrating issues of both individual and family diversity due to the wide generalizations necessary to summarize in grant writing and legislative reform.

We do the best we can. As a result, conclusively, clinical work with families experiencing poverty cannot make use of an either/or epistemological stance. A both/and approach is what the literature suggests and requires at this time. There undoubtedly remains a theoretical gap in how a further deconstruction or synthesis of all the various treatment options might continue to be advanced in order to meet these families’ needs. The strategic model carries the potential to fill this gap and to help synthesize a future dialogue between the “stories” of our present day and the “systems” of our past.

Our country’s clinical history, a history heavily influenced by not only psychodynamic thinking, but also still trying to incorporate family therapy techniques from the 1960s and 1970s in light of the postmodern contributions arising in the 1980s and 1990s, is apparent perhaps most blatantly in our work with the poor. The poor continue to tell us about ourselves as a nation. They are, at this time, underfunded,

misunderstood, and far too often publically condemned for their more personal and private struggles.

This project has been an attempt to reconcile the postmodern pre-occupation with power and control, shared by both Jay Haley, and arguably initially in the philosophy of Michael Foucault, with the “family-larger-system perspective” critical to the socio-political context relevant to our understanding of low-income families (Imber-Black, 1991, p. 371). The social constructivist approach, the narrative therapy that has since arisen, has considered the therapist as an author utilizing language. My reading has both further validated this approach, as well as supported the therapist character acting in the “systems” and larger treatment context attempting to negotiate aspects of social control and social reform in families, homes, and communities nationwide. Aspects of self and clinical style remain necessary transparencies the beginning clinician must spend time and energy getting to know.

In addition, Cloe Madanes’ emphasis on clear and quick therapeutic thinking, as guiding the therapist to a proper or “right” strategy, is a pertinent thread worth discussing. Namely, an awareness of the structures of poverty and society helps to elicit empathy in our clinical work. This is a simple suggestion, which the early family therapy pioneers embodied so that we, as their successors, might continue to pursue.

It was Jay Haley who, fittingly, in describing strategic intervention wrote that “therapy can be called strategic if the clinician initiates what happens during therapy and designs a particular approach for each problem” (1973, p. 17). This initiative is a finding that transcends program, theory, and family system, and, in summary, it calls attention to

both use of self and therapeutic detail that all of us effective with people in relationship and with programs of social service will do well to remember in our work to come.

Discussing the Project: Strengths and Weaknesses

I initially acknowledged my extensive literature review and scope of thought to be both a strength and weakness of the project. I would further offer other weaknesses to include my lack of focus on empirical results, as a social sciences research project, which has also included my lack of definition and specificity in regards to terms. In my attempt to outline the history of both family therapy and child welfare, I have also perhaps failed to present adequately important aspects of policy and practice.

Ultimately, I have packaged decades of history and national experiences into a few pages. This over-simplification of a nuanced and complex history is a shortcoming of the paper due to its length, and it will remain a significant weakness of the project overall. Lastly, it is a false assumption to suggest a necessary separation of class might exist between our work with low-income families and us as treatment providers. This is important to recognize despite the power inherent in our social influence as clinicians. The more elusive aspects of class and “culture” in this paper, and those critically excluded, deserve some thought and attention as a result.

Strengths of the project include a balanced attempt to hold contradictions and dive into abstract issues in an effort to understand further my role as a beginning clinician. This paper has been influenced by my direct practice. Despite its theoretical nature, this enthusiasm, I believe, has helped encourage my creative exploration and a general willingness to understand the contributions of history.

In addition, I have had the experience of observing the postmodern, radical shift in the field of family therapy arguably quiet in what is now the ridiculous environment of treatment and funding that currently supports a very “American” desire for a cheap and fast fix to complex issues of mental health. In the end, I am confident that no matter the strengths and weaknesses of this project, the experience and procedure of writing this paper has made me and will continue to make me a better clinician. And, as the ultimate strength, it is mine and mine alone to further chew on and explore.

Conclusion

The historical significance of my literature review has situated issues of mental health as being defined and approached according to the viewpoints and political considerations of the time. In this country, since the beginning of the 20th century, issues of treatment, care, policy, practice, and social service legislation and reform have cycled through changing philosophies of working with the poor. At times, poor families have been afforded more attention, services, and social support while, in other periods, poor families have been largely ignored.

Poverty is a family stressor with ramifications for personal well-being, maturation, and growth. Many families, overwhelmingly single, non-white mothers, are today faced with the burden of caring for themselves and their children in a social and national environment with an increasingly depressed economy. Community-based support, a systems approach based upon collaboration and resource, ought to be balanced with a solution-focused optimism. The importance of empowerment and personal agency - issues of metaphor, language, and respect, a narrative-based intervention, is what this

project *strategically* supports. We must work to preserve families, as we also continue to acknowledge the importance of family diversity and creation.

Other findings or further implications of this project remain for the reader to decipher and grab hold. From the onset and despite my attempt to explore the literature as perhaps a researcher ought, I have been biased in that I favor a structural and systemic argument concerning the entrenched and oppressive failings that influence populations, regions, and individuals experiencing poverty in the United States today.

The main technique and directive of treatment seems to be, in the end, how to answer Madsen's question of "what does it mean to intervene?" (1999, p. 157). The answer, after all, is most likely based upon a mixture of governmental and procedural understanding, treatment interventions based upon mutual respect, as well as a steady amount of intuition, empathy, and hope that our clinical work might positively influence our clients, whom, if we are lucky at the end of the day, we have come to better know.

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