Poverty and Mental Health Practice: Within and Beyond the 50-Minute Hour

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Despite the high and increasing prevalence of poverty in the United States, psychologists and allied professionals have done little to develop mental health interventions that are tailored to the specific sociocultural experiences of low-income families. In this article, we describe the sociocultural stressors that accompany the material deprivations of poverty, and the mental health difficulties to which they often give rise. Next, we outline the psychosocial and class-related issues surrounding low-income adults' access to and use of mental health services and suggest a conceptual framework to guide the modification of mental health practice to better accommodate poor peoples' complex needs. This framework describes opportunities for practice modification at three levels of intervention, beginning at the individual level of traditional individual psychotherapy and subsequently targeting increasingly broad contextual elements of poverty. © 2012 Wiley Periodicals, Inc. J. Clin. Psychol: In Session 69:182–190, 2013.

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Poverty and Mental Health Practice

Despite the high and increasing prevalence of poverty in the United States, psychologists and allied professionals have done little to develop innovative mental health interventions that are tailored to the specific sociocultural experiences of low-income families (Lott & Bullock, 2007; Smith, 2008). This paucity is surprising given that poverty is strongly associated with a range of mental health difficulties (Fryers & Melzer, 2003; Sareen, Afifi, McMillan, & Asmundson, 2011; Siefert et al., 2000; Substance Abuse and Mental Health Services Administration, 2010). Moreover, poor communities are less likely to utilize mental health services than their middle-income counterparts (Nadeem, Lange, & Miranda, 2008), and are more likely to discontinue treatment prematurely (Garfield, 1994; Miranda, Azocar, Komaromy, & Golding, 1998; Siefert et al., 2000; Wierzbicki & Pekarik, 1993).

To explain low utilization rates, researchers have pointed to individual level variables such as pragmatic barriers or mistrust of the system (e.g., Abrams, Dornig, & Curran, 2009; Beeber et al., 2007; Levy & O'Hara, 2010; Maynard et al., 1997; Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003), both of which merit examination. However, little or no attention has been given to other deterrents, such as the potential mismatch between what mainstream mental health practitioners offer and what impoverished families need (Goodman, Smyth, & Banyard, 2010). A handful of studies has, in fact, demonstrated positive outcomes for mental health interventions in poor communities when they were developed specifically to address the contextual stressors in low-income people's lives (e.g., Ammerman et al., 2005; Grote et al., 2009; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung et al., 2003). These latter findings suggest the possibility that if modified, mental health services might more effectively match poor families' needs, allowing clinicians to better serve some of the nation's most vulnerable families.

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This article begins with an overview of poverty in the United States, describing the stressors with which it is associated and the mental health difficulties to which they often give rise. In particular, we highlight sociocultural dimensions of poverty that are not often emphasized within the mental health literature, such as the social exclusion and social isolation of the poor. Next, we discuss related issues surrounding low-income adults' access to and use of mental health services, Finally, we suggest a conceptual framework to guide modification of mental health practice to better accommodate poor peoples' social and psychological experiences. Within a discussion such as this one, which comprises a single article, we are able to address only commonalities within the experience of poverty. We wish to note, however, that poverty (like other sociocultural forces) intersects with dimensions of identity such as race, ethnicity, geography, culture, and immigration status, creating unique experiences at each social location. Readers can find an introduction to these considerations in Lui, Leondar-Wright, Brewer, and Adamson (2006).

Poverty in the United States

In the United States, one of the world's wealthiest nations, approximately 14.3% of the population now lives in poverty, the highest level since 1993 (U.S. Census, 2009). Family and child poverty rates have risen especially quickly, with over 15 million American children (or about one in every four) living below the poverty line (Wight, Chau, & Aratani, 2011). Communities of color have been hardest hit: While 8.6% of White Americans meet poverty standards, 25.6% of Latinos, 26.1% of African Americans, 12.5% of Asian and Pacific Islanders, and 31% of Native Americans on reservations are considered poor (U.S. Census, 2009). Women are also disproportionately represented among the poor, with the poverty rate for women approximately 38% higher than that for men (U.S. Census, 2009). Overall, almost one third (29.9%) of families with a female head of household have incomes that place them below the official poverty line (U.S. Census Bureau, 2009), with women of color who are mothers at the greatest risk for experiencing long-term poverty (Thibos, Lavin-Loucks, & Martin, 2007). As high as these percentages are, they leave out many individuals and families who struggle to meet their families' basic needs, as the actual cost of living is estimated to far exceed federal poverty cutoffs (e.g., Boushey, 2002; Thibos et al., 2007).

Poverty and Mental Health: The Psychosocial Implications of Material Deprivation

Clearly, a crucial component of poverty is the lack of sufficient income to support basic individual and family needs like shelter, food, and health care. With its survival-related implications, it is not surprising that this component is the one most often emphasized in mental health professionals' conceptions of poverty. Nevertheless, that component is accompanied by a psychological and social experience that is also characteristic of poverty-and that is also damaging (Smith, 2010). As Ringen (2009) has framed it, poverty is . . .

> an enforced lack of basic material power to live as one wants or as reasoned fear that one might fall into that situation. It is to live under the dictatorship of material necessity without choice and control in one's daily life. That's what poverty is, it's about freedom and power and the lack thereof. (p. 7)

Ringen's conceptualization expresses the linkages between the material deprivation of poverty and its individual and sociocultural ramifications, which in turn may be understood to have emotional and interpersonal sequelae. Research on the psychological effect of poverty has featured variables that correspond to these psychosocial correlates, and has linked them with mental health outcomes. These correlates can be grouped into three broad categories: stress and strain, social isolation and exclusion, and powerlessness.

Stress and Strain

Empirical research has consistently demonstrated the multitude of chronic and acute stressors that face people living in poverty (House et al., 1994; Mickelson & Kubzansky, 2003; Turner, 1995). Most obviously, the inability to meet basic needs exerts daily strain in the lives of families. Many experience "food insecurity," or the lack of available, adequate food to feed one's family (DeParle, 2009). Secure housing is also tenuous for many poor families: As of 2005, an adult working full-time at minimum wage could not afford a one-bedroom apartment anywhere in the country at the fair market rent level established by the U.S. Department of Housing and Urban Development (National Low Income Housing Coalition, 2005). Beyond an absence of the basics, poor families are far more likely than their nonpoor counterparts to experience a broad range of traumatic life events, including infant mortality, community violence, marital dissolution, imprisonment of self or spouse, intimate partner violence, and other crimes (Bausman & Goe, 2004; Belle et al., 2003; Cunradi, Caetano, & Schafer, 2002; Greif, 2005; Pearlin, 1999; Vest et al., 2002). Furthermore, for low-income people of color, these events often occur within the context of trauma related to racial discrimination (Bryant-Davis & Ocampo, 2005; Root, 1992).

Ongoing exposure to stressful and threatening environments has been linked to negative affective responses such as hopelessness, hostility, anger, fear, and worry, as well as behavioral responses such as chronic vigilance, attributions of negative intent, and isolation among people living in poverty (Chen & Matthews, 2003; Gallo & Matthews, 2003). Moreover, as parents attempt to support their families in the midst of these stressors, poor people must interact with a variety of bureaucratic systems–systems that are so fraught with complexities and obstacles that they can be considered stressors unto themselves (Dodson, 1998). The power imbalance between poor families and those who are in charge of distributing resources via these systems creates conditions that can invite disrespectful treatment or worse, including exploitation, sexual harassment, and coercion (e.g. Reed, Collinsworth, & Fitzgerald, 2005).

Social Isolation and Social Exclusion

Even in the midst of dense urban areas, poor people often experience a diminished availability of social connection that could provide emotional and/or material support (House, Landis, & Umberson, 1988; Krause & Borawski-Clark, 1995; Michelson & Kubzansky, 2003; Roschelle, 1997; Turner & Marino, 1994). Such support is an important buffer against stress for individuals of any class, and serves as a major predictor of physical and emotional well-being for low-income families (Groh, 2007; Mickelson & Kubzansky).

More broadly, widely held attitudes that attribute poverty to personal deficits isolate the poor from their higher income counterparts. One study, for example, demonstrated that participants endorsed substantially more negative traits for the poor than for members of the middle class; descriptors included words like *unmotivated, uneducated, unpleasant, dirty, angry, stupid, criminal, violent, immoral, alcoholic*, and *abusive* (Cozzarelli, Wilkinson, & Tagler, 2001). Poor people of color are doubly vulnerable to stigmatizing attitudes that exemplify both classism and racism as typified by the so-called "welfare queen," a stereotype referring to Black women who supposedly take advantage of public assistance (e.g., Gilliam, 1999). The receipt of public assistance itself has been found to inspire deeply negative attitudes: A study of individuals' responses to 17 different stereotyped groups found that welfare recipients were the only group that was both "disliked" and "disrespected" (Fiske, Xu, Cuddy, & Glick, 1999).

Attitudes such as these, suggesting a view of the poor as inferior "others," are, according to Bernice Lott (2002), the primary characteristic of classism: A "cognitive and behavioral distancing from the poor" by those who are not poor. This distancing plays out in the exclusion of the poor from many of the mainstream opportunities and experiences that other citizens take for granted (Smith, 2010). It extends even to the right to physically occupy public space, a trend that Ehrenreich (2009) has called "the criminalization of poverty." The National Law Center on Homelessness and Poverty and The National Coalition for the Homeless (2009) have

documented the rise in civic ordinances that make it illegal to sit or sleep in public spaces and that drive homeless people away from public areas, often resulting in the loss of these individuals' personal documents, medications, and other property.

Powerlessness

The stress and social exclusion experienced by people living in poverty can mean that they find few opportunities to exercise control over their circumstances, and when they attempt to do so, they may find themselves thwarted by bureaucratic institutions that respond with new stressors and double binds (Dodson, 1998). Repeated experiences with such situations can result in both real and perceived powerlessness (Goodman et al., 2007; Hägglund & Ahlström, 2007); that is, an overall lack of choice or decision-making power within one's life (Goodman et al., 2010; Young, 2000). Over time, these experiences of powerlessness can become internalized as part of one's identity, resulting in feelings of inferiority, self-doubt, and low self-worth (Moane, 2003). The resulting impact of relative social powerlessness is not just speculative: The extensive Whitehall studies of British civil servants (Ferrie, 2004) demonstrated that, independent of a range of individual characteristics, low levels of control, autonomy, and decision-making ability in one's work life were related to higher rates of sickness, heart disease, and mental illness.

In light of the combination of physical and psychosocial hardships that characterize life in poverty, it is not surprising that the Surgeon General's Report on Mental Health (2001) revealed poverty to be a prominent risk factor for mental illness, with individuals in the lowest strata of income two to three times more likely than those in the highest strata to suffer from mental illness. Indeed, the United States National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) found that almost all mental health diagnoses spanning both Axis I and Axis II of the Diagnostic and Statistical Manual of Mental Disorders were associated with lower income levels (Sareen, Afifi, McMillan, & Asmundson, 2011).

Psychotherapy, Social Class, and the Poor

Although poverty places people at elevated risk for emotional distress, there exists only a small body of research addressing mental health practice among low-income adults. Moreover, the scope of this work tends to be limited. For example, when researchers explore why so few low-income adults seem to access or benefit from mental health treatment despite the relatively high rates of psychological difficulties, they most often pursue their investigation from the perspective of material and logistical barriers to treatment. The following section profiles these findings, along with others that suggest that social and psychological factors may also undermine poor clients' treatment experiences.

Barriers to Treatment

Researchers have established that, compared to their nonpoor counterparts, low-income individuals rarely pursue or engage in mental health treatment (Garfield, 1994; Miranda, Azocar, Komaromy, & Golding, 1998; Siefert et al., 2000; Wierzbicki & Pekarik, 1993). A large-scale study of low-income women with reported mental health symptoms found that only 10% of the 1,893 participants were receiving any form of mental health treatment, and less than 5% of immigrant participants reported using mental health services (Nadeem et al., 2008). Furthermore, numerous studies have suggested that attrition increases as income level decreases (e.g., Falconnier, 2009; Garfield, 1994; Wierzbicki & Pekarik, 1993).

Practical barriers. Low-income individuals have been found to face a range of practical barriers to accessing mental health treatment, such as the cost of such treatment, lack of insurance, and childcare needs (Maynard et al., 1997). Many clinics' service hours do not accommodate workers in low-wage positions whose schedules may be inflexible and/or who may work double shifts. Moreover, the time commitment and financial costs associated with public transportation and childcare often preclude poor individuals from participating in mental health

treatment (Beeber et al., 2007; Levy & O'Hara, 2010). Jenny, a 28-year old African American client, felt that therapy was possible for her only because her therapist went outside the usual therapeutic frame to allow her to bring her child into the room–not optimal but better than nothing.[1] As Jenny noted: "[With most therapists], either the child probably wouldn't be able to come, or have to sit outside, or you have to reschedule." In the face of these barriers, she speculated that she would have given up altogether.

When poor clients do make it to a mental health agency, there are often fewer clinicians who are willing or able to provide services at lower rates, and clients may therefore face long wait times for appointments (Liberman et al., 2006). Research shows that the longer any client has to wait for services, the more likely she or he is to withdraw from treatment altogether (Barrett, Chua, & Thompson, 2007; Saporito, Barrett, McCarthy, Iacoviello, & Barber, 2003). Finally, mental health treatment settings often require multiple intake appointments before a client can even begin working with his or her assigned clinician, a condition that is difficult for low-income clients to fulfill and may further prolong their ability to receive help (Liberman et al., 2006).

Social and psychological barriers. In additional to these practical barriers, many low-income people experience social and psychological barriers to pursuing and maintaining treatment. Poor women have often had a myriad of negative experiences with authority figures–many of them occupying some sort of "helping" position–and accordingly are highly attuned to signs that a therapist may be disrespectful, lacking empathy, or unhelpful (Abrams, Dornig, & Curran, 2009; Dodson, 1998). They may also be especially sensitive to whether or not a therapist can understand their situations, given the difference in social class membership. For example, in her interviews of working-class women, Chalifoux (1996) found that many women withheld information or modified what they shared because of their feeling that their therapists would not understand. As one woman noted:

> I'm trying to recount my life story and tie it up in sweet little ribbons and make it appropriate . . . . I know a therapist is supposed to be nonjudgmental but–and this is a definite class thing–I leave things out. If I thought somebody was equal to me, I would say more than I would to someone above me. I don't think she is going to understand. (p. 25)

The quotation above raises a key question related to low treatment utilization among the poor: Do low-income men and women perceive mental health professionals as able to meet their needs? The material and logistical barriers to treatment faced by low-income people are certainly significant; at the same time, researchers have devoted almost all their attention to these barriers, and almost none to the extent to which existing services are psychosocially accessible, relevant, and useful in poor communities.

Low-Income Clients and Mental Health Interventions

Given the barriers that deter low-income individuals from accessing mental health treatment, it is perhaps not surprising that the corresponding body of comparative research on psychotherapeutic treatment outcomes is small, mixed, and difficult to interpret, as the constructs "low-income" and "outcome" are defined inconsistently (Falconnier, 2009; Levy & O'Hara, 2010). Overall, researchers exploring the effectiveness of traditional forms of treatment–cognitive-behavioral therapy, behavioral therapy, or interpersonal therapy–have observed that when low-income clients do engage in therapy, they may make fewer (e.g., Falconnier, 2009) or similar gains as compared with their higher income counterparts (e.g., McLeod, Johnston, & Griffin, 2000; Mynors-Wallis & Gath, 1997; see Levy & O'Hara for a review).

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[1]This and subsequent quotations from therapy clients come from low-income women in therapy who were interviewed as part of the second author's ongoing dissertation study, under the supervision of the first author.

Pointing the way towards new types of interventions, however, are a group of studies showing that when interventions are developed, modified, and/or adapted in consideration of the context of poor individual's lives, low-income clients evidence significant positive changes in not only retention rates but also postintervention symptomatology (Ammerman et al., 2005; Azocar, Miranda, & Dwyer, 1996; Grote et al., 2009; Miranda, Chung, et al., 2003; Miranda et al., 2006). Modifications found to be effective include enhanced outreach, such as transportation to and from therapy, home visits, childcare, and flexible scheduling (Miranda, Chung, et al., 2003), as well as case management that involves assessing clients' external stressors and instrumental needs and developing intervention to address them (Grote et al., 2009; Miranda, Azocar et al., 2003). Grote and her colleagues speculated that the success of the contextualized interventions was related to two factors. First, by attending to the stressors and challenges that contribute to or exacerbate mental health symptoms, providers demonstrate a more comprehensive understanding of clients' challenges and needs, which in turn increase practitioners' credibility and promote clients' "buy-in." Second, by addressing contextual stressors, providers enable their clients to focus more fully on their psychological functioning, thereby increasing their ability to benefit from psychotherapy. Indeed, in their extensive review of the literature on psychotherapeutic interventions for low-income women, Levy and O'Hara (2010), noted that "the most effective studies overall made significant, sustained efforts to simultaneously reduce the negative effects practical, psychological, and cultural barriers have on low-income women who seek mental healthcare" (p. 946).

Re-imagining Mental Health Practice in the Context of Poverty

In sum, low-income individuals encounter significant mental health risk factors posed by not only the material deprivation that characterizes poverty but also the stress, social exclusion, and relative sociocultural powerlessness that they may experience on a daily basis. Despite the risk, research indicates that this population often does not fully access mental health treatment. Existing research elucidates some of the reasons behind this situation by highlighting the many obstacles the poor face in initiating and maintaining treatment. Furthermore, treatment outcomes for this population, though only measured by a handful of studies, tend to be mixed. However, the relatively rarely used innovative and context-sensitive approaches demonstrate more positive results. These empirical findings lend support to the notion that there exists a potential mismatch between the mental health needs of low-income individuals and the restricted focus that many mainstream approaches offer.

One implication of the foregoing is that the continued development of innovative, socially contextualized approaches holds promise in supporting the emotional well-being of poor families. In the final section of the article, we propose a framework by which practitioners can begin to envision future efforts in this regard. This framework describes opportunities for practice modification at three levels of intervention, beginning at the level of individual psychotherapy and subsequently targeting increasingly broad social and contextual elements of poverty.

Class-Competent Practice

Given the multitude and severity of poverty-related stressors in the lives of low-income women, one might hypothesize that therapists' attention to these issues would be particularly important for this group. Indeed, one study of predominantly female, White clients diagnosed with major depression found that direct exploration of clients' economic stressors was associated with reductions in depressive symptoms and increases in global assessments of functioning across treatment conditions (cognitive-behavioral therapy and interpersonal therapy) and across income levels (Falconnier & Elkin, 2008). Unfortunately, it is often the case that therapists avoid addressing this type of material with low-income clients, because of their own discomfort and lack of training (Falconnier & Elkin; Parnell & Vanderkloot, 1994; Smith, 2009). Building on existing models of multiculturally competent therapy, clinicians can improve their services to poor clients by working to enhance the social class competence of traditional mental health interventions. Developing class competence may comprise increasing therapists' (a) levels of self-awareness

related to their own social class, (b) awareness of their assumptions about poverty, social class, and therapy, (c) knowledge of poverty's psychosocial impact, and (d) knowledge of effective interventions for addressing the negative psychosocial consequences of poverty. Practitioners who have developed this kind of social class competence would be in a vastly better position to talk effectively with clients about the contextual difficulties in their lives and might empower them to think about how to address these issues themselves.

Voicing her frustration with traditional, insight-oriented talk therapy in the midst of poverty-related crises: Janelle, a 25-year-old multiracial woman, said:

> Because talking may help, yes, but talking isn't going to provide me with food. Talking isn't going to get me a job. Talking isn't going to get me housing, unless I'm talking myself into these situations.

She went on to describe how the therapist's insistence on talking about internal conflict in the face of such severe external stressors made her feel as if she was responsible for what had happened to her, resulting in increased self-loathing and self-blame rather than less.

However, improving therapists' sensitivity to poverty in the context of conventional practice does not fully address the relationship between poverty and mental health. Moving along the spectrum from understanding the nature and consequences of poverty to targeting those consequences directly, professionals would improve their practice with low-income communities by integrating advocacy into the fabric of their practice.

Addressing Individuals' Sociocultural Contexts: Advocacy and Class-Competent Practice

Although some practitioners do work hard to incorporate advocacy into their therapy practice (see, e.g., Ali & Lees, this issue; Toporek, Lewis, & Crethar, 2009), such work often goes unrecognized and unreimbursed–and may even be criticized as inappropriate to the role of therapist. Consequently, advocacy-related work does not often find a place in formal psychotherapeutic theorizing and training, and tends to occur in an ad hoc manner–perhaps via a referral, or a phone call or two. Instead, practitioners whose work takes place in the context of poverty need to develop models that integrate advocacy into the conceptual core of their work while being mindful of preserving the client's agency and self-determination.

Exemplifying such integration, the Relationship-Centered Advocacy (RCA) model was developed to address the needs of low-income women struggling with depression (Goodman et al., 2007). In RCA, counselors and their partners (service recipients are seen as collaborators rather than clients) work together each week to address both psychological and instrumental goals across ecological levels (individual, interpersonal, family, and/or systemic). The line between counseling and advocacy is purposefully blurred based on the idea that psychological intervention sometimes requires collaboration on changing context just as collaboration on changing context sometimes requires psychological work–and both are dependent on the development of an authentic relationship. Meeting times and locations are flexible and may involve travel to local community agencies that offer useful services and benefits. Incorporation of multidimensional goals and modalities within the RCA model allows it to respond effectively to the complexity of poverty's challenges, and because RCA counselors are able to integrate intrapsychic work and context-change work, they can address directly the ways those two domains of life intersect. For example, if a woman feels shame because the manager at her grocery store told her loudly that her food stamps didn't cover a type of food she was trying to buy, the counselor could not only explore the shame she felt at that moment but could also work with her to change the way this and perhaps other managers speak to people using food stamps.

Expressing anger about how past therapists called social services when they learned about the absence of food in her pantry, Chiara, a 28-year old African American mother of small children, noted:

> I wish they would have helped me approach the situation the same way my present therapist is doing now. If I'm low on food, you know, it's okay, "Come on we'll have a session in the car headed for the food pantry" or "Here, I have a gift card; lets head to the store, we'll talk in the midst of being in there." You know, just providing me with resources that I don't know of . . . . Obviously if I knew them I wouldn't be having struggles with a lot of things that I have struggles with. And just considering that therapists have so much, leverage, it's like okay if you can fix it by just feeding me information I don't know, why not do that?

Addressing Systemic and Community Levels: Antipoverty Approaches, Advocacy, and Class-Competent Practice

Moving still further along the continuum lie a host of interventions that address poverty and mental health at a systemic or community rather than individual level. These approaches involve the integration of antipoverty efforts with advocacy and class-competent mental health practices. For example, Ali, Hawkins, and Chambers (2010) described a microcredit project in Harlem that aimed to reduce stress by providing resources (including business and leadership training, technical assistance, networking opportunities, and microloans for starting business ventures) that would enable participants to create new income streams. This initial resource exchange occurred within the context of regular meetings in which participants came together to discuss their progress and challenges and to provide emotional and practical support to one another. Results indicated both improved financial situations for participants and reduced rates of depression. Participatory action research (PAR), best known as a vehicle by which community members work with professional researchers to create knowledge and action on behalf of the community, also represents a potential vehicle for mental health professionals to address poverty at a systemic level (Smith, 2010). For example, Smith and Romero (2010) collaborated with a group of women from the local community to identify a specific element of their social contexts that participants wanted to change–the lack of affordable housing for low-income, HIV-infected women–and then helped them to develop creative methods for doing so. In the process, participants reported improved emotional well-being as a direct result of the PAR group process itself (Smith & Romero, 2010).

Antipoverty efforts that incorporate into mental health professionals' work such initiatives as community organizing efforts, participatory action research, and microlending approaches–initiatives that clearly cannot be accomplished inside a traditional psychotherapy office–would require the development of collaborative relationships with community-based organizations that already work closely with poor communities, albeit without an explicit mental health focus. These collaborations would need to go beyond cross-referrals to become active partnerships through which mental health professionals could help create organizational capacity to address emotional well-being among constituents. Such efforts could expand dramatically the reach of both community-based organizations and the mental health profession (Goodman et al., 2010).

Taken together, these three levels of intervention would enable a mental health response that simultaneously attends to poor communities' psychological and material well-being and the structural barriers that inhibit their own efforts to bring about social change (Goodman et al., 2007), and it would enable mental health professionals to find new ways to put their skills to work on behalf of people living in poverty.

Concluding Comments

In accepting the challenge to create socially contextualized mental health practice in poor communities, practitioners will encounter a steep learning curve. Moving toward programming that positions practitioners as collaborators rather than as professional experts will require a flexible professional self-concept; the evaluation of this programming will necessitate still more creativity, since conventional clinical trials may be unable to capture these complex undertakings. Moreover, mental health professionals will need to develop ethical parameters in concert with their evolving work. How does one use advocacy effectively while preventing it from undermining

(or supplanting) individual's own efforts? To address such questions, practitioners may be able to learn from existing psychological treatment models that incorporate an environmental and systems-level purview, such as structural family therapy (Aponte, 1994; Boyd-Franklin, 2003); they can also take guidance from allied professions that have long combined therapeutic work with advocacy and structural support (such as social work), or that have built systemic change into the very core of their mission (such as community psychology). Taking up these challenges will not only allow mental health professionals to match their services most effectively to the needs of their poor clients, it will also allow them to aim their skills more broadly toward preventing the harmful effects of poverty on the mental health of all poor families.

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