Counseling People Living in Poverty: The CARE Model

LOUISA L. FOSS, MARGARET M. GENERALI, AND VICTORIA E. KRESS

Counselors frequently counsel clients who live in poverty. The authors describe the new CARE model that addresses the influence of multiple systems on poor clients’ experiences. A social justice, humanistic intervention, the CARE model emphasizes cultivating a positive counseling relationship with poor clients, empathizing with their unique realities, and working to remove barriers to future success and well-being by building on their strengths.

A large proportion of the clients served by community mental health centers are individuals classified as working poor and those living in poverty (Gilens, 1999). Indeed, people living in poverty tend to be among the most marginalized and stigmatized people in the United States (Gilens, 1999). Despite the need this population has for counseling services, the values, expectations, and requirements for participating in counseling may be at odds with the needs of many poor people. This is often the case because most traditional counseling models are more consistent with middle-class values than with values exhibited by poor people in U.S. society (Gonzalez, 2005; Javier & Herron, 2002). People struggling to have their personal and psychological needs met may find that the services provided by community mental health centers in general and professional counselors in particular do not meet these unique needs, nor do they honor the myriad strengths that are commonly manifested by many poor persons in society.

In this article, we introduce a model that is useful in conceptualizing effective counseling strategies for people living in poverty. The model is titled the CARE model, which highlights the need to cultivate relationships, acknowledge realities, remove barriers, and expand the strengths of poor clients. A unique aspect of this model is that it addresses the impact that multiple systems have on poor clients’ lived experiences. This model emerges from a humanistic perspective that encourages the growth and the development of clients as outlined by the American Counseling Association’s (ACA) Code of Ethics (ACA, 2005; Preamble and Section A, Introduction).
Because the CARE model is developmental in its focus, it is grounded in the belief that people (a) are dynamic rather than static and (b) have an innate propensity to healthy growth and purposeful living (Sperry, 2002). Developmental perspectives are inherently humanistic in that they offer hope that a client’s problems are not permanent and that positive change is always possible. Central to the humanistic and developmental perspective is the belief that people have the capacity to move forward, to change, to become empowered, and to ultimately attain wellness (Fitzsimons & Fuller, 2002).

The ACA Code of Ethics (2005) mandates that counselors provide culturally and contextually sensitive and competent services when working with clients. Multicultural competence includes the recognition that it is important to understand and address broader societal influences when counseling clients in marginalized and devalued groups (Sue, Arredondo, & McDavis, 1992).

Multiculturally competent counselors are also aware that persons with less power in society commonly experience a greater level of stress from multiple sources. These heightened stressors greatly increase poor people’s biological predisposition and psychological vulnerability to various health problems as compared with individuals in more privileged and empowered groups (Belle & Doucet, 2003). Culturally sensitive, developmental, humanistic, and social-justice-minded counselors do not separate clients’ difficulties from their sociocultural group experiences. Instead, these practitioners search for culturally competent and responsive ways to foster the health, well-being, and empowerment of persons living in poverty.

MENTAL HEALTH AND THE CULTURE OF POVERTY

The Diathesis–Stress Model predicts that life stressors may interact with genetic or physiological variables to cause various mental health problems (Barlow & Durand, 2005). Specifically, poverty-related stressors such as poor health care, housing problems, and limited access to basic resources may incite heightened forms of psychological stress and dysfunction (Lustig & Strauser, 2007). Regardless of causation, it is clear that there is a correlation between poverty and mental health problems (Belle & Doucet, 2003; Costello, Compton, Keeler, & Angold, 2003; Kessler et al., 2008; Wadsworth & Santiago, 2008).

Some research suggests that people living in poverty are two times more likely than those of middle-class or upper-middle-class incomes to manifest psychological distress in their lives (Bruce, Takeuchi, & Leaf, 1991). Despite the high rates of mental health problems manifested by many poor people in the United States, people living in poverty routinely underutilize counseling services that may be available to them and often prematurely terminate counseling when they do access such services (Coiro, 2001; Gonzalez, 2005). To effectively provide counseling services in culturally competent ways with people living in poverty and to reduce the probability of premature
termination when working with poor clients, it is important to understand the cultural values and expectations of this population. The behavioral and relational patterns manifested by poor persons constitute what has been referred to as a *culture of poverty* (Lewis, 1966, p. 19). As used in this article, the term *culture* refers to the values, norms, and symbolic interactions that a distinct group of persons collectively exhibit in their lives.

Indeed, people living in poverty often share a common knowledge, language, and set of life experiences. Many individuals living in a culture of poverty are also noted to demonstrate an unusual level of resilience in the way they cope with the multiple stresses that are associated with living in this cultural group. To expand on the latter point, researchers report that many people living in poverty exhibit a broad range of adaptive coping strategies, high self-esteem, effective problem-solving skills, and/or other intellectual abilities that underlie their sustained resilience (e.g., Buckner, Mezzacappa, & Beardslee, 2003). These aforementioned qualities represent important personal assets that are useful in dealing with stressors related to ongoing financial shortfalls.

An overarching theme for those living in poverty is the daily challenge of coping with circumstances that compromise basic survival needs. Such stressors are often associated with the daily challenges of securing and maintaining an adequate living environment (Campbell, Richie, & Hargrove, 2003). The constant strain of facing such survival challenges results in poor people developing a strong present-time orientation that is in sharp contrast to the future-time perspective that characterizes the development of many persons in more privileged economic classes.

The present-time orientation from which many poor people operate is useful in addressing concrete and immediate challenges linked to realities such as securing transportation to and from work, figuring out how the next rent payment will be made, assessing where their next meal will come from, and getting help with child care. This sort of present-time orientation serves as a lens through which reality is viewed, values are developed and maintained, and decisions about daily living are made.

Payne (1996) commented further on additional ways that poor people’s values and decisions are affected by the culture of poverty in which millions of people in U.S. society are entrenched. For instance, Payne noted that entertainment is a highly valued dimension of life for many poor people because it provides a temporary escape from the unique and heightened stressors poor people routinely experience in their lives.

The present-time, survival perspective that characterizes the psychology of many poor persons frequently affects how persons living in poverty generally view money. In short, many poor people are not known to save money for future expenses and investments but instead view money as a commodity that should be spent today. This present-time notion about spending money when it is available is frequently driven by (a) the pragmatic pressure to satisfy immediate survival needs for oneself and one’s
family, (b) the desire to engage in entertainment activities that result in positive interpersonal activities with others, and (c) a realistic concern that one never knows when additional money will be available.

Payne (1996) also discussed why many persons living in poverty value personal relationships over material possessions. In an environment in which possessions can be stolen, taken, broken, or are inaccessible, investing time and energy in maintaining positive interpersonal relationships with others is viewed as being one of the few and consistent sources of personal joy and satisfaction in many poor people’s lives (Payne, 1996). Thus, helping family members and neighbors to meet their basic needs often takes precedence over other self-advancing activities, including acquiring advanced education or securing employment opportunities.

Counselors who work with poor clients are encouraged to take all of these factors into consideration when tailoring services to this population. To assist counselors in this endeavor, we describe in the following sections of this article a comprehensive intervention framework that we refer to as the CARE model.

THE CARE MODEL

The adverse effect that the culture of poverty has on millions of people in U.S. society is complex and multifaceted. Recognizing the complicated and multidimensional impact that economic injustice has on poor people’s lives, culturally competent counselors are aware of the need to implement a comprehensive approach to mental health care when working with these persons (Wadsworth & Santiago, 2008). Addressing these issues in more detail, Black and Krishnakumar (1998) discussed the importance of implementing multilevel interventions at community, group, and individual levels of poor clients’ lives.

Rather than focusing solely on intrapersonal or individual issues when counseling poor clients, Black and Krishnakumar (1998) asserted that effective counseling interventions for these persons need to encompass (a) an appreciation of the multiple systems that affect these clients’ lives and (b) suggestions for dealing with the unique needs of clients living in poverty. The CARE model represents the sort of humanistic and social justice framework that addresses the aforementioned issues. To reiterate, the CARE model is a stage approach to counseling clients living in poverty that consists of four basic elements that focus on the need to cultivate a positive relationship with poor clients, acknowledge the harsh realities poor clients routinely face in their lives, remove barriers for healthy human development, and expand the unique personal strengths that every poor client possesses.

Cultivate Positive Relationships With Poor Clients

This positive relationship aspect of the CARE model addresses the importance of building the sort of therapeutic alliance with poor clients that
is grounded in a general acknowledgment of the unique challenges and strengths that characterize the lives of clients living in a culture of poverty. The therapeutic alliance previously described includes the creation of a bond between the counselor and poor clients that involves collaborating to determine the goals of counseling. It also involves a willingness of both counselors and clients to accept the responsibility of fulfilling specific tasks that may contribute to successful outcomes that have been identified in a mutually collaborative process of goal setting (Bordin, 1979; Vasquez, 2007). Research on the therapeutic alliance suggests that it is essential in fostering positive counseling outcomes regardless of the clients involved in the helping process and the counseling theory used by the practitioner (Johnson, Wright, & Ketring, 2002). However, there are unique issues to consider when building a therapeutic alliance with clients who live in a culture of poverty, some of which are discussed as follows.

Like other disenfranchised groups, clients subjected to economic injustice are frequent targets of criticism and stereotyping (Schnitzer, 1996). Counselors and other mental health practitioners are not immune to stereotyping poor people. Whether consciously or unconsciously maintained, negative stereotyping of poor clients typically results in overgeneralized and unwarranted criticisms of persons in this cultural group (Smith, 2009). If left unexamined, counselors’ personal values and stereotypes related to poor people will have a negative impact on the counseling process and replicate the macrolevel power differences that underlie much of the economic injustice that is perpetuated in U.S. society. This can predictably result in detrimental effects among poor clients who are in need of professional assistance.

An exploration of personal biases begins with one’s notions about what causes and maintains poverty. Explanations that focus on poor people’s morality, character, ability, or motivation may result in an overemphasis on the individual client’s responsibility for being poor (Amatea & West-Olatunji, 2007; Hirshberg & Ford, 2001). The aforementioned perspective results in a deficiency-based construction of poor people’s lives that places excessive blame for the economic injustice these individuals experience on poor persons themselves. This, in turn, adds to the overarching oppression poor clients face in their lives.

Conversely, sociocultural explanations of poverty that focus exclusively on the failures of society to provide for economically disadvantaged persons may help to perpetuate a victim status among some poor clients. Operating from the perspective that they are the victims of uncontrollable structural forces that lock people in poverty enables some poor clients to forfeit any sense of responsibility to make changes that can improve their lives (Boyd-Franklin, 2003).

Recognizing that people of color are overrepresented among individuals who live in poverty in the United States (U.S. Census Bureau, 2007), advocates of the CARE model encourage counselors to become knowledgeable about culturally competent ways to build a therapeutic alliance with poor
clients of color. In the literature on therapeutic alliance, mutual goal setting is exemplified as a practical way to foster the empowerment of clients in racially marginalized and devalued groups (Johnson et al., 2002). Working with these clients to identify realistic and achievable goals increases the client’s investment in and benefit derived from a collaborative counseling process.

Working with people living in poverty requires relationship-building efforts that differ from the standard methods in that counselors are challenged to address, early in the helping process, specific issues that are associated with living in a culture of poverty. This includes (a) acknowledging the counselor’s understanding of the barriers that impede many poor persons from actualizing their untapped human potential and (b) communicating a genuine sense of respect for the forms of resilience that poor clients routinely manifest when subjected to the structural injustices that underlie a culture of poverty (Smith, 2009).

**Acknowledge the Realities of Poverty**

The CARE model addresses the importance of acknowledging and honoring the lived experiences and daily realities that clients who are subjected to economic injustice routinely experience. In striving to acknowledge and honor these fundamental factors when working with poor clients, it is important for counselors to assess the manner in which they, themselves, believe in the American dream.

The American dream is grounded in the notion that all people can achieve financial security and class mobility through persistence and hard work. Although this concept has been proven to be a myth in numerous sociological studies, it remains a pervasive social construction that is largely perpetuated by the dominant cultural group in the United States (Scott & Leonhardt, 2005). Inherent in this social construction is the basic notion that if a person works hard enough, he or she can possess a home, a car, and other symbols of economic achievement and personal worth.

Although this culturally and politically biased perspective may apply in some situations in contemporary U.S. society, it is also true that structural barriers impede the ability of millions of people to realize the American dream (Costello et al., 2003; Dakin & Wampler, 2008). Among the specific structural barriers that contribute to the perpetuation of economic injustice in this nation are overcrowded living situations, increasing levels of homelessness, transience, poor temperature regulation in public subsidized housing areas, utility shutoffs, and an escalation in hunger in the United States (Campbell et al., 2003; Dearing, 2008; Wadsworth & Santiago, 2008).

The harsh realities of clients’ poverty experiences may be difficult to understand for many well-meaning, but ill-prepared, counselors who are unfamiliar with the psychological, social, and emotional challenges that are linked to this complex problem (Boyd-Franklin, 2003). The CARE model encourages counselors to openly acknowledge and empathically explore the
constant and sometimes overwhelming realities of poverty with poor clients. The expression of such empathy when counseling poor clients is likely to strengthen the therapeutic alliance between the counselor and clients living in poverty. It is also likely to increase the probability of promoting positive counseling outcomes while simultaneously decreasing the preponderance of premature terminations that commonly occurs when poor clients receive little indication that their counselors understand the realities of their lives.

An accurate and respectful assessment of the etiology of poverty and the factors that help to maintain this form of economic injustice includes an evaluation of the impact that poverty has on a poor client’s daily life. The problem mapping concept proposed by narrative theorists (Corey, 2009) is a particularly useful counseling strategy to implement as a means to learn more about the realities of living in a culture of poverty. By assessing the etiology and daily impact of poverty on these clients, counselors are able to learn about the struggles that these people routinely face in their lives. Such an evaluation also enables practitioners to more fully understand how poverty affects clients’ relationships, work, health, sense of self-efficacy, and overall well-being. In the process of conducting such an assessment, counselors are able to help poor clients identify various forms of internalized oppression and self-blaming that contribute to their psychological distress. Counselors are also able to discuss how strongly held views about their perceived victimization as poor people contributes to their disempowerment and inability to make changes to better their situation (Brown, 2002; Perese, 2007).

Remove Barriers

There are a number of fundamental barriers that counselors are urged to direct their attention to when using the CARE model with poor clients. One of the most basic considerations practitioners are encouraged to address involves logistical issues. Many poor clients have limited work schedule flexibility. They may also have transportation problems. These and other basic barriers converge to make counseling attendance nearly impossible, which then results in unmet treatment needs (Gonzalez, 2005; Perese, 2007).

Advocating for the establishment of drop-in clinics and flexible scheduling may substantially contribute to assisting many poor clients to engage in counseling. Other helpful approaches include in-home counseling, lobbying for support to finance transportation services for poor clients, securing public transportation passes, and implementing creative strategies that result in the provision of free day-care services (for dependent children) during specific hours when poor clients receive counseling. Also, when possible, mental health counseling clinics need to be established in communities that have a high rate of persons living in economically depressed areas (Black & Krishnakumar, 1998).

Other barriers that commonly impede many poor people from participating in counseling include ongoing problems linked to clients’ misuse and abuse of drugs and alcohol, chronic mental and/or physical illnesses, teenage preg-
nancies, and interpersonal partner violence, to name a few (Boyd-Franklin, 2003; Campbell et al., 2003). If counselors fail to explore how these and other barriers adversely affect clients’ lives, then many poor clients are likely to view counseling as irrelevant to their immediate needs. The significance of these points are illuminated by the results of a study survey indicating that a significant number of clients and clinicians reported that the perceived irrelevance of counseling and poor counselor–client rapport were linked to premature client dropout (Stevens, Seid, Mistry, & Halfon, 2006).

Several multicultural and social justice counseling advocates have asserted that positive counseling outcomes are more likely to occur when practitioners become more active and involved in the lives of their clients who are culturally marginalized and devalued. These advocates further noted that positive outcomes were likely to be amplified when practitioners focused on concrete solutions to specific daily living problems when working with underrepresented groups including poor persons (Sue & Sue, 2008; Westefeld & Heckman-Stone, 2003).

Commenting further on these latter points, Westefeld and Heckman-Stone (2003) proposed the use of a crisis intervention model—the Integrated Problem-Solving Model of Crisis Intervention—when working with poor clients. This intervention strategy is thought to be a useful match with many poor clients because it draws from cognitive behavioral approaches that complement culturally competent counseling and social justice advocacy helping methods.

The Integrated Problem-Solving Model of Crisis Intervention includes several crisis intervention strategies that are congruent with the CARE model’s approach to addressing the needs of persons living in poverty. These strategies include building a positive rapport with clients in crisis, focusing on efforts that foster clients’ empowerment, helping to identify and build on clients’ assets when addressing their problems, and working collaboratively with clients to identify and assess the attainment of specific goals in counseling (Westefeld & Heckman-Stone, 2003).

Expand on Strengths

The CARE model emphasizes strengths. Despite the multiple risk factors that mark many poor people’s lives, resilience studies point out that people living in poverty commonly use a range of coping strategies that contribute to their psychological health, even in the face of unimaginable obstacles to their well-being (Buckner et al., 2003; Seccombe, 2002). This includes primary and secondary coping strategies.

Primary coping strategies are manifested in people’s problem-solving abilities, emotional expression and regulation in stressful situations, self-understanding of their ability to successfully cope with crisis conditions, and an internal locus of control orientation when presented with stressful life events.

Secondary coping strategies are reflected in people’s acceptance of certain contextual circumstances, their ability to restructure their thinking about
their problems (e.g., cognitive restructuring), and positive thinking (Buckner et al., 2003; Wadsworth & Santiago, 2008). These coping skills are natural starting points for counselors and poor clients to explore and build on when faced with stressors that adversely affect the health and well-being of persons living in poverty.

Identification and expansion of client and client-system strengths help provide a basis from which realistic hope for movement toward wellness can be nurtured (Myers & Gill, 2004). Myers and Sweeney’s (2008) wellness counseling model is a very useful framework to identify what is working well for poor clients when they use specific coping skills, work to build and maintain social connections with others, engage in spiritual self-care, and attend to their own physical needs in positive ways. This evidence-based counseling theory is designed to help clients from diverse groups and backgrounds assess their own wellness in these areas and develop a personalized plan for increasing their overall health in a holistic manner. In this way, a counselor can intentionally work to build on poor clients’ strengths that may be noted in their sense of self-esteem, problem-solving abilities, emotional intelligence, family support, and spirituality. Efforts to build on these and other personal strengths that many poor clients bring to counseling are important elements in the CARE model (Buckner et al., 2003).

SUMMARY

On the basis of prevalence data, it is probable that most counselors will be called on to work with clients living in poverty at some point in their career. This article has highlighted three key points to apply in doing so. First, it is important for counselors to understand how and why the needs of people living in a culture of poverty are distinctly different from those of more economically privileged Americans. Second, counselors need to reflect on the ways that their professional training experiences and personal values may conflict with the survival needs and lived experiences that are unique to poor clients. Third, clients living in poverty require a unique approach to mental health care counseling that addresses a broad range of individualistic and contextual challenges that millions of poor people routinely experience in their lives.

In specifically addressing the third point just listed, we have described a new theoretical model that is intentionally designed to promote poor clients’ health and well-being. We referred to this new framework as the CARE model. The four components of the CARE model that are described in the preceding sections are presented to assist counselors in considering the types of social justice helping approaches that complement the needs, values, and strengths of poor clients. This includes the importance of cultivating a solid therapeutic relationship with clients living in poverty, acknowledging the realities of poverty, identifying methods to remove barriers, and helping poor clients to use and expand the types of coping strategies that underlie much of their resilience.
It is hoped that future research in this area will be conducted to empirically test the effectiveness of using the CARE model with clients who come from diverse groups and seek help in various counseling settings and modalities. In the meantime, we suggest that the CARE model represents an innovative framework that new and seasoned counselors can use to stimulate the health and well-being of many persons who are denied the right to realize untapped dimensions of their human potential as a result of having their lives invaded by the toxic impact of poverty.

REFERENCES


