Families Who Live in Chronic Poverty: Meeting the Challenge of Family-Centered Services

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Family-centered occupational therapy services are based on a collaborative relationship that does not always come easily. Role performance in parenting a child with special needs and being a consumer of occupational therapy services can be partially understood in terms of environmental context. Although occupational therapists recognize the need to adjust services to the cultural and economic backgrounds of families, most of the available literature has examined the contribution of ethnic differences.

A particular challenge for occupational therapists may be treating clients and their families who live in chronic poverty. This article examines chronic poverty as it shapes parenting the child with special needs and subsequently the caregiver's participation in occupational therapy services. A framework for understanding cultural differences is used to suggest contrasting value orientations between families who live with persistent poverty and occupational therapists. A family-centered approach challenges the professional to understand varied influences on caregiving. Suggestions are offered to enhance communication between therapists and caregivers.

For pediatric occupational therapists, there are two arguments for continued study of parents or primary caregivers who meet the parenting needs of children. First, identifying and adjusting services to different values and beliefs of individual parents is a critical step toward establishing a collaborative parent-professional relationship (Anderson & Hinojosa, 1984; Bailey, 1987). Second, recognizing the importance of context on skill acquisition and performance intervention (American Occupational Therapy Association [AOTA], 1994) may lead to helping the parent identify and adopt different caregiving behaviors. To appreciate the complexity of changing behavior associated with the parenting role, such as feeding or holding the child, one needs an understanding of factors that determine occupational performance of the adult. Knowledge of performance components that influence caregiving may be just as important to successful intervention as is an understanding of developing components of function of the infant or child.

Although literature on adaptations for cultural status (DeMars, 1992; Mevers, 1992; Skawski, 1987) seems to be increasing, Krefting and Krefting (1991) have pointed out that often adjustment to cultural status of consumers is based on the clinician's institution of practice and personal experience rather than on an understanding of cultural differences. An increased awareness of the nature of differences can enhance cultural sensitivity (Dillard et al., 1992; Mead, 1956). Information about ethnic groups, their beliefs about child development, parenting, and health is available (Anderson & Ferichel, 1989; Lynch & Hanson, 1992), but ethnic background is just one factor contributing to a group's culture (Locke, 1992). The purpose of this article is to initiate a discussion of chronic poverty as it shapes parenting and, subsequently, the consumer's participation in occupational therapy services.

Caregivers Living in Poverty and Occupational Therapists

When consumers live in chronic poverty, larger systems issues, such as societal attitudes about the poor and funding for assistance programs, contribute to the tension inherent in the caregiver-therapist relationship. Persons who live in poverty are acutely aware that other persons, such as case workers, control the resources for living. The funding to meet the needs of all low-income families is not adequate (Brown, 1987; Children's Defense Fund, 1991). As a result, an adversarial relationship between recipients who need more and professionals who do not have enough to give has evolved. In addition, too frequently, persons who live in chronic poverty have had depersonalizing experiences with other social institutions such as schools and health care services. Even when occupational therapy is not associated with the welfare
institution, professionals, in general, may be viewed as the opposition who come from a different world.

Demographic characteristics of occupational therapists may contribute to problems in establishing a working, collaborative relationship with some poor families. Occupational therapists come primarily from the dominant ethnic group and have a background that includes higher education, professional status, and regular employment (AOTA, 1991). In addition, the profession's philosophy is rooted in middle-class values with a strong emphasis on individual achievement, the importance of independence, and the belief that the individual can overcome problems (Fondiller, Rosage, & Neuhaus, 1990). When any culture or social subgroup comes into contact with a dominant group, a secondary cultural characteristic may be distrust of the dominant group (Ogbu, 1988). Instruction from members of the dominant group may appear to the receiver as an effort to diminish the cultural identity of the minority person.

MacPhee, Kretzner, and Fritz (1994) have suggested two factors that contribute to inadequate preparation on the part of service providers to work with families who live in poverty. First, research in child development, which should guide instruction, has blurred critical factors such as family structure, minority issues, and economic status. The knowledge base for preparation of professionals does not capture the impact of diverse environmental influences of poverty on development. The second factor contributing to inadequate preparation of professionals is that faculty members may be reluctant to discuss multicultural topics. Concern for offending minority students or eliciting insensitive remarks can limit the discussion of cultural differences. My experiences as an occupational therapist in home-based early intervention programs that included families living in poverty prompted me to explore the implications of low socioeconomic status of clients and their families on occupational therapy.

Influences of Poverty on Parenting

Poverty can be defined as inadequate financial resources to meet daily living needs (Huston, McLoyd, & Coll, 1994). Low income leads to many conditions that are known to compromise the parent’s ability to maximize the child’s development. It influences the health of women and subsequently increases risks for complications associated with pregnancy (Jacobson, 1993). Low income also is associated with factors such as poor housing, overcrowding, nutritional problems, and neighborhoods that fail to offer a safe environment for play or social support to compensate for family problems. These factors contribute to poor developmental outcomes in children (Duncan, Brooks-Gunn, & Klebanov, 1994; Halpern, 1990; Kaplan-Sanford, Parker, & Zuckerman, 1991; McLoyd & Wilson, 1991).

Furthermore, persistent, low family income can contribute to poor parenting (Halpern, 1990; McLoyd & Wilson, 1991). Women, who are most likely to be the primary caregivers, are at higher risk of mental health problems when they are confronted by poverty (Belle, 1990). The stress of inadequate resources can affect the primary caregiver’s energy to respond to a child’s bid for attention. Excessive demands on time and energy are the reasons given by mothers with poor economic backgrounds who use feeding practices that they know are not good for babies (McLoyd & Bryant, 1989). The lack of money to purchase necessities such as diapers can change caregiving practices. One mother may be reluctant to change diapers too frequently, making one diaper last as long as possible, whereas another mother may introduce table food early, hoping to save on expensive formula.

Cultural Context Created by Chronic Poverty

Culture reflects a system of learned values, norms, and behaviors that are acquired through early socialization (Kretfing & Kretfing, 1991). Cultural systems evolve in response to environmental demands, such as an isolated living condition and an inability to acquire resources to meet basic needs. In her classic work in an African-American community, Stack (1974) demonstrated specific values, norms, sanctions, and roles that have evolved in response to conditions associated with chronic urban poverty.

With the disproportionate number of minorities living and raising their children in destitution, one cannot anticipate just one cultural group to be associated with chronic poverty. There is disagreement regarding the nature of interaction of ethnic identity and economic status. Clark (1983) has suggested that cultural traditions associated with an ethnic background may be more distinctly expressed among groups in the lower socioeconomic groups. On the other hand, Locke (1992) has suggested that the variations attributed to an ethnic group may actually be due to the effects of poverty. In reality, the interrelationship of an ethnic group’s culture of origin, history of economic concerns, oppression, and experience with racism since coming to this country offers a more complete picture of cultural context (Locke, 1992). The contribution of poverty to the culture of a social subgroup can be discussed by examining the potential influence of poverty on values.

Model of Value Orientation

Kluckhorn and Strodtbeck (1961) proposed “value orientations” (p. 1) as a cultural group’s complex pattern of principles that guide human activity and thought. Their model continues to be used to contrast different ethnic groups in work on cross-cultural understanding (Locke, 1991; Spiegel & Papirohn, 1986). In this article, the same
universal questions are applied to the potential effects of economic status to suggest how occupational therapists may differ from caregivers who live in poverty in their fundamental world views. After reviewing possible value orientations of the occupational therapist and of families living in poverty, examples are given to help the reader consider the implications for practice.

Kluckhorn and Strodtbeck (1961) suggested that there are five universal problems and that from the social group's solutions, a pattern of value orientations can be discerned (see Figure 1). The value orientations of occupational therapists and of caregivers living in chronic poverty for the five problems are suggested in Table 1. Kluckhorn and Strodtbeck proposed that differences between cultures can be described by identifying a preferred order of solutions expressed by two groups. Individual differences in the pattern of value orientations within a culture exist as a result of varied life situations, experiences, and unique personalities. Examples used in this article to illustrate values are not intended to suggest that every member of a social subgroup thinks and behaves in the same way.

**Time Orientation**

One frequently identified problem solved by cultures is the issue of time orientation or the temporal focus of the group (Kluckhorn & Strodtbeck, 1961). The options for time orientation are an emphasis on the past, present, or future. A culture that places priority on the past might stress the importance of traditions and ancestors in organizing behavior and patterns of life. A priority on the present is suggested by a "live for today" philosophy. Future orientation is expressed when a group works for anticipated benefits and delays gratification.

The time orientation of the dominant culture in the United States appears to be toward the future with little emphasis on the past (Spiegel & Papjohn, 1986). Occupational therapy and the rehabilitation process are based on expectations that the future of the client will be better with work and intervention. The therapist's image of the client in the future is shared with the client as part of the intervention process (Fleming, 1994a). In pediatric practice, the clinician would share an image of the child's future with the family members. The image of the child at a later time may be a motivating reason for the parent to participate in therapy.

Delayed gratification and working for a later reward require a belief that the future is under the person's control. Persons living in poverty experience a decreased sense of efficacy that is further lowered the longer they have been on assistance (Popkin, 1990). For persons living in chronic poverty, future orientation would be the least important among the three solutions and the present would be the most salient. For example, orientation to the present is reflected in a teenager's decision to drop out of school to make money for a car even though he or she recognizes that an educational degree promises a

<table>
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<td>Time</td>
<td>Past, traditions, and old ways have value</td>
<td>Present, now is what matters</td>
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<td>Self-in activity</td>
<td>Doing, success and achievement to some standard</td>
<td>Being—becoming, for aesthetics or intellect development of person</td>
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<td>Relations with nature</td>
<td>Harmony—with nature, wholeness with nature</td>
<td>Mastery—over nature, technology to overcome</td>
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**Table 1**

**Contrasts in Which Value Orientations Would Be Greater Than Others for an Occupational Therapist and Parent or Primary Caregiver Living in Poverty**

![Figure 1](http://ajot.aota.org/pdfaccess.ashx?url=/data/journals/ajot/930172/) An adapted summary of the universal issues and alternative value orientations proposed by Kluckhorn, F. R., & Strodtbeck, F. L. (1961). *Variations in value orientations*. Evanston, IL: Row Peterson.

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better income in the future.

Goal planning is an area where differences in temporal orientation between occupational therapists and parents living in poverty can lead to different responses. Families are assumed to be an important element in the planning process. However, caregivers who live in chronic poverty may not perceive the importance of developing 3- or 12-month goals because of their temporal orientation toward the present. Seeing goal planning as irrelevant, the caregiver may not give priority to meeting with the intervention team. Without understanding the caregiver’s temporal orientation, the clinician may interpret a parent’s behavior as lack of interest in the child or in the value of services.

Human Activity

In a culture, the options for meaning and purposes of activity orientation are doing, being-becoming, or being (Kluckhorn & Strodtbeck, 1961). An orientation for doing is reflected by valuing activity as a means for personal accomplishment or for reaching a recognized criterion. The view that human activity is a means to achieve a status is reflected by a question such as “What do you do?” A person who values activities as a way to achieve recognition may take painting lessons to acquire the skills needed to become a recognized artist. The being-becoming orientation stresses the importance of activities as a means for aesthetic and intellectual growth. A person with a strong being-becoming orientation may take painting lessons for the pleasure of creating a pleasing painting and in anticipation of the sense of fulfillment. The being orientation is expressed by placing a high priority on an activity that permits spontaneous expression. Spray painting statements on a wall would be an activity reflecting a being orientation. With the being orientation, there is no emphasis on development or change through activities (Kluckhorn & Strodtbeck, 1961).

Occupational therapists, in keeping with the dominant culture, appear to put doing first in activity orientation (Spiegel & Papjohn, 1986). Use of occupation as a means to learn new skills and become more competent was an early theme in the profession (Schwartz, 1992). The question, “What do you want to do?” from the occupational therapist’s perspective might imply, “What do you want to accomplish?”

Persons who live with few economic resources may be more oriented toward being in their activities. Therefore a caregiver living with chronic poverty and oriented toward the present would emphasize spontaneous self-expression in his or her activity orientation. The question, “What do you want to do?” may be translated by the caregiver as “What activities would express your feelings?”

Differences in orientation toward the meaning of activities could lead to serious miscommunication about program suggestions for activities in the home. The occupational therapist may propose activities on the playground as a way of helping the child achieve new motor skills. If the child expresses the desire to watch cartoons, the parent with an activity orientation for being rather than doing would see no value in encouraging the child in the playground activities. The therapist would be told that the suggested activities did not work because the child “did not feel like doing them.” If the therapist tries to persuade the child to do an activity, it may appear to the parent that the therapist does not respect the child’s feelings.

Human Relationship

The three options for interpersonal relationships and the nature of power and responsibilities within a group are lineal group, collateral group, or individual needs (Kluckhorn & Strodtbeck, 1961). In the lineal group, the emphasis is on continuity of the group and power is hierarchical, with a leader deciding what is best for the whole. Meyers (1992) described a lineal orientation among Hmong families where the oldest man is the head of the household and the welfare of the family has priority over individual needs. A culture that emphasizes the collateral group creates a sense of obligation to a lateral network of interpersonal relationships. Power and responsibility are shared among group members. If either group relational orientation is valued, socialization creates a sense of interdependence with others. Group sanctions are brought against the person who acts on his or her own needs rather than the needs of the group. When a culture assumes that the needs of the individual take precedence over the needs of the group, the orientation is said to be on individualism. The expression “You have to do what is right for you” suggests an individual value orientation.

Emphasis of individual over group goals is consistent with the dominant culture in the United States (Spiegel & Papjohn, 1986) and seen in occupational therapy when individual goals are written and personal independence is a major outcome of the rehabilitation process. Families are expected to commit resources to support child-focused treatment goals and to believe that it is important that the child do things for himself or herself. In contrast, persons who live in chronic poverty may have to share resources with extended family members or neighbors (Stack, 1974), suggesting an orientation that would stress the group. Whether the relationship orientation emphasizes a lineal or collateral group orientation may depend more on ethnic background. With either orientation, the well-being of the group is seen as more important than the well-being of the individual, even if the individual is a child.

A family’s relationship orientation would influence its decisions about resources such as material goods or time. For example, clinicians may become confused by a family member who sold a child’s adaptive equipment to
help neighbors with their financial problems or who used the afternoon to visit with cousins rather than come to the child's therapy session. Yet, the caregiver may believe that he or she had no choice but to respond to the needs of others rather than use the equipment or time to promote the independence of the child.

**Human Nature**

Part of a culture's orientation could be expressed in the belief that people are naturally good or bad and in the extent that the person can be perfected or corrupted (Kluckhorn & Strodtbeck, 1961). The perceived goodness and the malleability of people could be expressed in parenting practices. Puritans are a historic example of a group that assumed human nature was inherently bad but, with control and discipline, could acquire a relative degree of goodness. A culture that assumes people are both good and bad but tend to be naturally good may encourage parents to discuss right and wrong but allow the child some choice in his or her actions. A laissez-faire approach to child rearing where no control of the child is attempted suggests that parents believe the inherent goodness or badness of human nature will prevail.

The current human nature orientation of the dominant culture in the United States appears to be optimistic and assumes humanity's goodness (Hanson, 1992). Professionals with this orientation to human nature may approach misbehaviors with the assumption that a child will "grow out of it" because he or she is seen as basically good. In this orientation, education is viewed as a means to help the child acquire skills consistent with his or her inherent goodness.

Less information is available on how persons of a culture that developed in conditions of chronic poverty might view human nature. With increased probability of violent crime in poorer, economically depressed areas, persons may assume that human nature is bad. With this orientation, caregiver discipline style may emphasize control and training rather than education. A whipping could reflect the parent's intent of setting the child on the right road. If one's human nature orientation assumes the child cannot be trained to be good, the child may be viewed as having "gone bad" and, consequently, be given little discipline when transgressions occur.

Of all the value orientations, the human nature orientation remains the most speculative. Other authors have chosen not to discuss it in cultural values of ethnic groups (Spiegel & Papjohn, 1986). It is included here because conflict in value orientation about human nature could contribute to parent-therapist tension around discipline and parenting styles. The clinician, believing that eventually the goodness of children will prevail, may approach a child with relaxed interactions. A child's loud behavior and nonresponsivity to adults may be acceptable because the therapist anticipates that with maturity and education will come positive changes. In contrast, parents, doubtful of the goodness of human nature if it is not trained, may expect immediate obedience, and their discipline will seem harsh to the therapist. The therapist's lack of effort to control the child's behavior may make a caregiver question whether the therapist knows much about children.

**Control of Nature**

A culture can define humankind's relationship with natural events through the belief that people: (a) should live in harmony with nature, (b) have control over nature, or (c) are subjugated by nature (Kluckhorn & Strodtbeck, 1961). An orientation toward living in harmony with nature is reflected by the assumption that human kind, nature, and the supernatural are one as reflected by some traditional Native American cultures. Sickness may be viewed as being out of harmony with nature (Joe & Malach, 1992). A cultural orientation that emphasizes control of nature would lead members to expect mastery over nature and value technology that can influence natural events. Developing a drug to cure a disease and the emphasis on disease prevention would be responses of a control-oriented culture. The orientation that assumes people are controlled or subjugated by nature would view a person with an illness as unlucky and expect family members to accept what has happened to the person. The contrast between a subjugated orientation and a control orientation (Kluckhorn & Strodbeck, 1961) is seen in the expression, "God willing" versus the saying, "God helps those who help themselves."

In the dominant culture of the United States, the value orientation leads people to assume that they will overcome and shape nature. Knowledge and technology are seen as tools to use against natural events such as disease or disabilities. Information about medical conditions forms the basis of a clinician's procedural reasoning process (Fleming, 1994). In addition to comfort in using scientific information to solve problems, occupational therapists are familiar with a variety of technologies. Adaptive devices may appear to be a logical solution to dysfunction as a way to return control of the environment to the person.

When persons experience chronic poverty, much of the world may seem to have control over them. For example, the lack of financial resources for a well-insulated house or for central air conditioning leaves families with less control over the effects of weather. Educational experiences are more likely to stress vocational preparation rather than training to solve problems with knowledge or technology. If the cultural orientation assumes natural events are beyond control, life-style choices are not seen as related to health status. A subjugated orientation may emphasize the importance of accepting a disability and not expecting to change it.
With different assumptions about a person’s ability to control nature, the parent living in poverty and the health care professional could have very different views of intervention. First, for the occupational therapist, outcome is not seen as predetermined, so activities to shape the child’s development are valued. For the parent who believes that human beings are subjugated by nature, time spent in activities to change what he or she believes is unchangeable could be perceived as a waste. The clinician’s efforts to change the child might suggest to the parent that the therapist does not accept the child for who he or she is. Second, the value of knowledge about child development and medical science would lead clinicians to stress parent education as part of occupational therapy services. To consumers living in poverty, knowledge of child development and of the condition or disease processes may not carry much importance. The parent’s behavior, guided by a different value orientation, may leave the clinician with the impression that the parent does not care about or recognize the child’s medical condition. Finally, the occupational therapist and the parent may approach adaptive equipment quite differently. Technology as a means to compensate for nature has been part of the professional’s history, whereas adaptive devices, such as a communication system, would seem alien to the parent living in chronic poverty.

Implications for Better Communication

It is important to consider the effects of poverty on the physical and social environment and of cultural reality on the role performance of parents because they are consumers of occupational therapy services. The process of establishing a relationship with a parent should be viewed within the context of the dynamic influences of low socioeconomic status of the family. Health care professionals typically anticipate that caregivers will share information about the child, make time to meet with the therapist, demonstrate interest in learning new information related to the child, and participate in the occupational therapy evaluation and goal development process. When family members do not share a therapist’s values and priorities, they may appear noncompliant and lead the therapist to express frustration and hostility (Gans, 1983). As a service provider, the obligation is on the professional to examine how to enhance communication.

The first recommendation for improving multicultural understanding is to identify one’s own value orientations (Dillard et al., 1992; Locke, 1992). Personal awareness of value orientations ranges from unconscious, intuitive feelings about values through conscious cognitions developed through self-reflection. Insight into assumptions and priorities that an occupational therapist brings to services can be developed through reading and self-analysis. Readers may want to reflect on examples given in this article and discuss with others how their pattern of value orientations are similar to or different from the pattern suggested here (see Table 1).

The next step in cross-cultural competence is to acquire information about the other culture. Levine (1987) has suggested that occupational therapists obtain a background understanding of cultural differences by conducting ethnographic studies. Ethnography requires direct contact with the social subgroup in that group’s environment. Outreach activities such as home visits are important to the process of learning more about each caregiver’s sociocultural reality. For example, my experience in home-based early intervention and study of families of infants has enabled me to gain some insights into value orientations of persons who live in chronic poverty, but the ideas proposed above remain speculative without systematic ethnographic studies.

Finally, Halpern (1990) has suggested that service providers need to be clear about the expected effects of intervention when the consumer lives in chronic poverty. Occupational therapy should not be viewed as the means to change social policy and institutions. Realistic goals about developing a working relationship and coming to understand and appreciate each other’s values can help therapists and parents avoid unnecessary complications and frustration.

Conclusion

The context of occupational performance includes the physical, social, and cultural factors of the person (AOTA, 1994). Culture evolves from the blend of many different historical and environmental factors influencing a social group. These factors may include ethnic background, religious experiences, regional variations, and economic resources. The purpose of this article has been to expand and encourage a dialogue about poverty as the context for a parent who is caring for a child with special needs. In addition to physical and social factors, culturally based differences in world views have been discussed. Once a broad understanding of cultural differences is achieved by the therapist, individual differences within a social group must be explored. Recognizing the pattern of value orientations of each caregiver can be the basis of the desired collaborative relationship that is the ultimate goal in family-centered occupational therapy.

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References


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