Local Solidarity and Low-Income Families: Can a Clinical Approach Be Empowering?*†

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ABSTRACT

This article seeks to determine whether a clinical approach can break down some of the barriers that exist between researchers and low-income families and individuals, and whether such an approach can be empowering and raise awareness. Research conducted in Canada on alternative resources for low-income families highlights some of the characteristics and limitations of the clinical approach. While the clinical approach can foster closer links between researchers and disadvantaged people, it does not necessarily challenge structural inequalities or promote empowering practices. A definition of the clinical approach is compared and contrasted with the approach discussed in this paper.

Clinical approaches in social sciences, both in research and intervention, strive to become as close as possible to the individuals, groups and communities in need and to assess their uniqueness, there-

by gaining a better understanding and awareness of their situations (Hall 1990).

Following a short presentation of a current action-research project, the potential and limitations of a clinical approach as a tool for understanding and affecting issues associated with community development and social change are discussed. Can such an approach be empowering? For example, can it be used successfully to improve the situation of low-income, disadvantaged families? What role can these families play in such a context? Are they merely subjects of research or do they have a part to play in shaping their own destiny?

Robert Sévigny's [translated] definition of a clinical approach is used initially:

> This term refers to a practice based on individual cases, especially problem cases, for which solutions must be found. And while it is not a question of curing or providing treatment, the concern is indeed to change, prevent or improve certain situations, to find answers to problems. To understand these problems, the researcher in social sciences also makes "house calls"; he works in the field rather than in the laboratory and tries not only to understand the illness, but to understand the patient. When he passes on his knowledge, he does so not only to professional colleagues, but also to individuals and groups on the other side (Sévigny 1993, pp. 13-14).

This article presents some advantages and limitations of a clinical approach, drawing on our experience working with disadvantaged families.

Poor Families in Canada

During the current economic and social upheaval, the "have-nots" in Canada often find themselves without the minimum protection on which they have been able to depend, to some extent at least, for their survival. Since the 1960s, the Canadian Welfare State, inspired primarily by the Scandinavian countries, has adopted programs that guaranteed some minimal financial assistance to individuals and families in need. However, even these policies led to a widening of income inequalities and to increased poverty among the poorest categories of the population: female heads of households, the urban poor and ethno-cultural minorities in particular.

Cutbacks in services in the 1990s led to even greater inequality and poverty (George and Howards 1991; Campaign 2000 1995). Currently, more than one fifth of Canadian children live in poverty; incomes of

poor families are 34% below the national poverty line (National Coun-cil on Welfare 1993); in Canada families headed by single mothers and teen parent families are identified as being high-risk candidates for pov-erty (Ross, Shillington and Lochhead 1994). In Canada, as in other in-dustrialized countries, feminization of poverty is growing at an alarm-ing rate. The number of poor children increased 55% between 1989 and 1993, while communities with food banks increased by 187% over the same period (Campaign 2000 1995). These are some of the casualties of capitalism, as noted by Belcher and Hegan (1991).

What happens to disadvantaged families in this process of disempowering the poor? How do they survive? Are soup kitchens and band-aid practices the only ways to survive? Do alternatives exist? If so, how are they created? The literature review for a project focusing on alternative resources (St-Amand 1992) revealed very few non-welfare alternatives targeting post-industrial poverty in disadvantaged families (Neisser and Schram 1994).

An Action-Research Project Focusing on Alternatives

In 1992, an action-research project entitled *Poor Families: Alterna-tives to Current Practices* was undertaken, with the financial support of Human Resources Development Canada. This project involved on-site interviews with nearly 60 community organizations using alternative principles and practices in all 10 Canadian provinces. On the basis of these "best-practice initiatives" (Clutterbuck, Davis, Novick, and Volpé 1990), a directory of alternative resources for low-income families in Canada was published (Kérisit, St-Amand, and Molgat 1994). The 1996 revised edition contains twice the number of resources (St-Amand, Kérisit, Martineau, Cloutier, and Malenfant 1996).

Poor Programs versus Inventive Networks

Today's institutional services, such as welfare programs, have at best only perpetuated the poverty of multi-problem families, who face poverty-related difficulties such as unemployment, inadequate housing and isolation (Zinn 1989). The above action-research project did not focus on the negative. Instead, the goal was to demonstrate the strength and dynamism of community-based alternative resources created to com-pensate for the shortcomings of these institutional services (Kérisit and

St-Amand 1995). Two clinical case studies show how these community groups invent resourceful strategies to help counter the effects of poverty and isolation felt by low-income families.

Based on Paolo Friere's philosophy (Freire 1979; Berryman 1987), this research project reflected the belief that multi-problem families are not problems in and of themselves. These families have resources and can develop original strategies for survival, mutual aid and problem solving. The project's principles are based primarily on the *Family Center Project*, run by the Brotherhood of St. Laurence in Melbourne since the early 1970s (Liffman 1978), and the *Best Practices Survey* (Clutterbuck et al. 1990), a Canadian study of innovative and exemplary services, programs, training and resources designed to improve the life chances of children whose families live on welfare and are from historically dominated cultures. The Appalachia project (Gaventa and Lewis 1989) and Michael Lerner's work (1991) have also demonstrated that grassroots initiatives should focus on self-empowerment in order to eradicate poverty. Saul Alinsky (1946) and his Industrial Areas Foundations have proposed pragmatic social action modes that many alternative resources use in their quest for equality and justice (Lancourt 1979). All these projects emphasize that disadvantaged people have encountered problems with the traditional systems and institutions created to assist them; yet, political leaders often try to find mega-solutions to today's social problems, rather than recognize the strength and diversity of local initiatives.

These alternative-type projects demonstrate that the community is where social problems are experienced and dealt with on a daily basis.

Example One: A Resource Center for Disadvantaged Families

This Center is located in a public housing project in a multiracial, low-income neighborhood in eastern Canada. This Parent Resource Center started as a small group of single mothers who began meeting to hold informal discussions on common problems they encountered in raising their families on low incomes. They decided to form an ongoing mutual aid group and were supported by a local health clinic in approaching the city for funding. They received support for a coordinator's salary and then secured rent-free space in the housing project where they all live.

The organization provides a meeting place for parents (generally young mothers) and their children. It has a drop-in day care center and organizes activities designed to reduce the isolation of parents and chil-

dren. It also organizes community solidarity activities and develops community economic development projects. The Center is run solely by the participants, who design the programs based on their needs.

The members have established a nutritional food cooperative and organized a nutrition course. As a result of this initiative, the Center introduced a community-operated catering service. It also runs activities and programs for teenage mothers and their children, organizes parent support groups and has established a committee against violence.

The Center has established links with other Canadian and international organizations and works to promote women's rights and the rights of people belonging to racial minorities.

One of the major needs of the members is employment and training, particularly for young black mothers, who are a majority at the Center. A group of members developed an action-research project to identify obstacles encountered by young single mothers when looking for work or seeking training.

This whole-hearted participation in the Center's activities and operation, coupled with the formulation of service requirements based on concrete projects in the community, has given the Center credibility in both economic and community development.

The title of the directory stems from this project. When a protection worker walked in the Center one day and asked to interview a woman regarding alleged abuse of her children, she was simply asked to leave. "This is our place," replied the coordinator.

Example Two: *A Community Resource for Native People*

This alternative resource organizes a wide range of activities and programs for low-income status and non-status Native people in a western Canadian city. Based on a holistic approach to social problems, this organization attempts to promote unity, respect and acceptance of all people through practices rooted in Native cultural traditions, such as the involvement of Elders.

Some 40 activities and programs are organized: social services, culture and language retention programs, employment training, literacy programs, recreation, drug and alcohol counseling, a hot meal program, a Native ministry, programs for young offenders, cultural camps and child care.

The holistic, culture-based approach of the organization is its unique feature. The Medicine Wheel is the core of its approach, which seeks to

link empowerment to individual, family, community and global development. Healing of the individual and the community are seen as related to each other. Physical, emotional, intellectual, social and spiritual well-being constitute a whole. Counseling aims both at personal well-being and at restoring a balance with the gifts every individual receives from the Creator.

This organization's approach emphasizes the unique gifts that all individuals possess and their ability to create. Participants can express this ability through the many varied activities they themselves organize.

The Clinical Approach and Research Perspective

A preliminary definition of an alternative resource was developed in conjunction with community organizations. More than 100 organizations fitting this description were then surveyed. This initial survey demonstrated that:

- Many projects exist throughout Canada that are similar to those just described. Their efforts to survive and prosper are often hampered by financial difficulties and lack of acceptance by institutions and professionals;

- These projects are usually born out of local need and created from community resources, sometimes with the cooperation of professionals. Their development and survival depend largely on committed individuals who devote time and energy to them. This means that local leaders are more involved in helping low-income individuals and families than experts or professionals;

- These initiatives cannot easily be reproduced in other contexts, since they are linked intrinsically to the social, economic, political, cultural and even spiritual dimension of the host environment (St-Amand, Kérisit and Vuong 1994). However, their underlying philosophy and empowering strategies can serve as an inspiration to community resources elsewhere;

- Their missions vary enormously and take on a local flavor. Whereas some of them focus on a specific problem such as housing, employment or food, others adopt a comprehen-

sive approach to poverty. All rely on the active participation of members and on the dynamic leadership of very gifted, intuitive community leaders and activists. The range of services and links between them reflect the complexity of the problems faced by low-income families;

- These resources do not talk about "services" in the usual sense. The term "client" is not part of their vocabulary. "Those who come here for help are not referred to as clients, and we ask them to become involved in all our activities; the organization does not provide services, but offers support and information. We provide support, and we mobilize and organize," said one community worker;

- Virtually all these resources are created and managed by women, except those for Native people, where some men were present and active. Like Morrissey (1991), we believe that further research in the area of female-headed initiatives should be pursued, given the catalyst role women currently play in creating and maintaining local solidarity.

Three characteristics of the clinical approach emerge from our initial observations. They include sharing of control, exchange of knowledge and adoption of empowering strategies. In our project, these characteristics were reflected in:

- Ad-hoc consultation with an Advisory Committee, comprising a dozen local leaders, representatives of activist groups and researchers, all representing alternative community resources in Canada;

- Publication of an interactive research bulletin, aptly called *Alternatives*. Three issues have already been published, focusing on housing, food, and the concept of alternative resources;

- Publication of two editions of *This is Our Place* (Kérisit *et al* 1994 and St-Amand *et al* 1996). This document describes more than 250 alternative resources for low-income families, in such areas as housing, food, employment and child care; and

- The decision to meet these alternative resources on their own territory, in an attempt to understand the cultural context in which people identify their needs (Lewis, 1966).

This clinical approach established that these alternative resources often differ greatly from the way in which poor families are perceived and treated by institutions and professionals. The latter see these people as being "hard-to-serve, problem families," needing a great deal of professional help. In contrast, these families see themselves, not as handicapped, but as dynamic people, actively engaged in their own survival. "We are sick of living in poverty, sick of welfare," said one member. "People are not problems, they are people," said another one. "We find that through collective kitchens people pass on their knowledge and share their skills" was another comment. As Gary Cameron pointed out, resistance from professionals is just as complex a problem as the poverty of low-income families.

> At the outset, many professional practitioners were doubtful that child protection clients would participate in a Parent Mutual Aid Organization. They argued that the clients they served had too many difficulties in their lives and were too unmotivated or irresponsible to become involved (Cameron 1995, p. 7).

The research method adopted illustrates this key difference between a problem-oriented approach and a resource-oriented approach. The institutions, adopting a pathological approach, focus on deviance and the problems of the individuals and families, expressed in such terms as poor, disadvantaged, dysfunctional or hard-to-reach. In addition, they are described as dependent because they monopolize a significant share of institutional resources.

Two other characteristics of a clinical approach need to be highlighted. By going out to the people, it is possible to determine the specific nature and uniqueness of their resources. Field work is more effective than studying low-income families "in the laboratory."

However, going out to the individuals and communities does not necessarily promote an awareness-raising and empowering approach. Lagache, one of the founders of the clinical approach [translation] "suggested a more dynamic definition, arguing that the subject of clinical research lies in the study of the whole man (sic) *in situ*, in other words *a study of his entire development*" (Lefrançois 1992, p. 62) [our emphasis]. Like André Lévy, we have some doubts about the possibility of effectively transferring the clinical approach into the social field:

[translation]

To what extent and under what conditions can the clinical—in the medical sense, relating to sick individuals—be social, that is to say transposed to work with groups or communities? (Lévy 1993, p. 121).

Inventive Resources

It is possible for disadvantaged families to organize themselves, provide mutual support and sometimes even escape their poverty and marginalization, provided they have adequate support from community workers and institutions? Despite their overwhelming poverty and isolation, poor families continue to survive, fight and hope. To do this, they invent strategies, which take into account their resources and their limitations, including financial constraints. As one mother said, "For me, our center is like a blanket, a woven blanket, everything just works all together, held together very well. That's what it reminds me of, it's a blanket. It's like security and everything is knitted together."

Two other characteristics of this clinical approach are the co-construction of knowledge (Rhéaume 1993) and the non-neutrality of the researchers.

[translation]

Action is rarely neutral. Neither are the debates and decisions about the issues. At least in the long term, and often in the short term, clinical researchers in the social sciences cannot avoid taking sides . . . Their involvement is no longer neutral (Sévigny 1993, p. 24).

Like Saul Alinsky (1946) has so clearly demonstrated, particularly through the Industrial Areas Foundations (Lancourt 1979), some organizations, resources and styles of leadership are better suited to assist disadvantaged populations. A key objective of this research was to identify the specific characteristics of resources defined as "alternative." The families we interviewed take the initiative to create links and develop projects with or without institutional help. We were impressed by their dynamism, creativity and sense of solidarity, and touched by the way they welcomed us. So-called disadvantaged families are not passive; they are involved in a process of reclaiming their lives. They are extremely active, interdependent, and resourceful, and are fighting with dignity for recognition and greater social equality.

The Involvement of Researchers

Neither the researchers nor marginalized people are neutral in this process. Moreover, both case studies demonstrate that families and the service providers working with them often operate from a clearly defined socio-political and economic perspective. These people are players, in the broadest sense of the term. "Helping out, not handing out" said one mother. "We're an asset, not a burden on society. We refuse to be considered simply as bundles of problems," said another parent. "The bottom line is this: people treat you the way they're treated. So if you treat people with respect, they behave like people who are treated with respect," added one coordinator.

It is not clear, however, that the clinical approach always encourages this commitment from low-income families and individuals. Awareness-raising research, feminist praxis (Welch 1985) and other alternative activist approaches (Cancian 1993) more clearly politicize the struggles of individuals with problems. This project, therefore, differs from a clinical approach. In this respect, Rhéaume suggests that a relationship exists between the clinical approach and intervention, which benefits research:

> [translation]
>
> The biographical method, life history and participatory observation are akin to the clinical approach: the researcher's involvement in his relations with the target population, seized with a specific action situation. However, the link with action obviously focuses more on research and production of knowledge, and is *less intermixed with a concern to intervene and to help*, as medical practice or organizational consultation would be (Rhéaume 1993, p. 88) [our emphasis].

A further limitation of the clinical approach, at least in this project, is that it focuses less on the intervention aspect *per se*. What opportunities does a clinical approach give us to become closer to disadvantaged individuals and families and their concerns? We are striving for a [translation] "comprehensive knowledge, a general theory that could apply in specific situations, that could help make the link between the general and the specific, between the abstract and the concrete" (Sévigny 1993, p.14). The experience-near concept, rather than clinical research, as proposed by psychoanalyst Heinz Kohut, seems more applicable to what we were trying to achieve:

> An experience-near concept is, roughly, one that someone—a patient, a subject, in our case an informant—might himself naturally and ef-

fortlessly use to define what he or his fellows see, feel, think, imagine, and so on, and which he would readily understand when similarly applied by others. An experience-distant concept is one that specialists of one sort or another—an analyst, an experimenter, an ethnographer, even a priest or an ideologist—employ to forward their scientific, philosophical, or practical aims (Geertz 1983, pp. 57-58).

To describe this crossroads between scientific research and professional intervention, a service provider from one of the resources visited suggested a role for researchers: "to act as a voice for those without a voice."

The Clinical Approach and Local Power

This research uses a non-pathological approach that does not separate the people "at risk" from their problems. It begins by recognizing resources, rather than formulating a diagnosis and then suggesting treatment. The research method used focuses on local knowledge and expertise; thus it encourages empowerment and growth, and recognizes and builds on the competence of disadvantaged families and local leadership. An exploratory approach such as this gives a voice to disadvantaged and low-income families, rather than relying on outside professional resources who are strangers to the community and its social, political and cultural context.

Such a research approach is under-represented in current literature, even in clinical approaches that [translation] "refer to a practice focusing on individual cases, especially *problem* cases, for which *solutions* have to be found" (Sévigny 1993, p.13) [our emphasis]. Is this because their situation makes us uncomfortable, because only the problems interest us, or because their experiences reveal shortcomings in our system? By giving people the opportunity to speak up, we risk hearing what we do not want to hear. We first visited them on their own territory and listened to their experiences, so we could then reach a definition of alternative practices that reflects what they experience, suggest and invent. Rather than trying to find solutions to the problems of these families, we have tried to demonstrate that they had their own solutions, their own resources and, to quote one service provider, that individuals "who not only talk the talk but walk the walk" are best placed to solve their own problems. From this perspective, it is the families, not the researchers, who identify possible solutions. This especially is where power shifts and our dual role as researchers and professionals promoting empowerment becomes questionable.

A Change of Paradigm

Analysis that favors awareness-raising and empowerment requires a change of paradigm at many levels, including research. We need to focus more on mutual aid rather that professional intervention, on local solidarity rather than on "specialist" treatment. This also involves a change in values: from a dependency approach to political recognition of local power, from professional expertise to recognizing local resources, from dependence to interdependence between networks and services. In the clinical approach, therapists speak of cases, good and difficult. In this project, one mother offered a different description of the resource she uses, "here, we're not just a number." Low-income families are often victims of the professional assessment made of them, not only while receiving services, but also as participants in research. Alternative networks reject such approaches to create creative ways of being and working.

The Clinical Approach, Awareness-Raising Research and Social Sciences

The approach used to gain a better understanding of community resources and resourcefulness in this project demonstrates that clinical analysis is a means of understanding and action (Sévigny 1993), with some scope for exploring the potential of individuals and organizations. However, other research practices tend to remain less "neutral" and isolating with regard to certain socio-political issues. It might be better to adopt an approach that focuses on individual and community empowerment, yet recognizes the clinical dimension of problems, and does not dissociate one from the other. Clinical approach methods generally show little evidence of the awareness and empowerment needed for comprehensive, social intervention at a structural level.

If the clinical approach does nothing more than propose a different approach to the other qualitative ones, it may be the perpetrator of illusions. Even if researchers go out to meet individuals or fully empathize with their situation, they do not necessarily improve these people's personal, social or political lot. On the other hand, if a clinical approach overcomes these limitations to create interactive links with disadvantaged groups, it can be a very powerful agent of change and consciousness-raising (Stack 1975).

Some Characteristics of the Clinical Approach: A Summary

Following is a summary of the main characteristics of the clinical approach:

- Proposes that individuals, rather than researchers, are the real people in control;

- Relies primarily on what the subject says rather than on textbooks;

- Works with human beings in the field, not "in the laboratory";

- Adopts from the outset a position of non-neutrality;

- Shares the control and the data gathered;

- Favors an inductive and participatory approach;

- Uses the researchers' intuition, not just scientifically observable data; and

- Searches explicitly for solutions to the problems encountered.

Moreover, this project used some research strategies that are not as pronounced in the clinical approach. The main ones are:

- involvement of people and families in an action-research process; an empowering initiative based on local power;

- awareness-raising based on structural analysis and the principles of action-research; and

- a change of paradigm: from a method emphasizing problems to an analysis focused on resources.

Two years of action-research with disadvantaged families suggest it is vital to draw from all forms of awareness-raising research the prin-

ciples needed for challenging social practices and policies, with a view
to renewing rather than professionally rearranging situations of pov-
erty. A clinical approach may remain neutral and descriptive, merely
presenting the facts, without interpreting them in their social, political,
economic or cultural context. Used in this manner, it constitutes just
another means of oppression, based on illusion, to use Heinz Kohut's
expression. However, it can also be a tool of awareness-raising both for
researchers and families involved in the exercise. In this context, we
have favored research approaches that help lift some of the veils from
what professional practices, both in research and social intervention,
often tend to conceal.

The greatest limitation of the clinical method can be to remain blind
to the conditions that perpetuate poverty, misery, marginalization and
oppression. After all, these very social and personal problems provide
continuing justification for research. Based on Zinn's structural approach
to poverty (1992), the different social, economic and cultural conditions
that separate researchers from marginalized families cannot be ignored
when social structures are taken into account. As one service provider
pointed out:

> There is no short cut to empowerment. It takes time and practice to
> develop skills and learn about the issues, so that everyone can par-
> ticipate effectively in democratic structures. Individuals learn at
> different paces; confidence grows slowly. To cut short the process
> is to stifle the participation of women and other community mem-
> bers who are not customarily involved in decision-making.

Conclusion

We have moved away from the clinical approach as defined by
Sévigny at the beginning of this paper in the sense that, although this
approach "makes house calls," it is not a model that recognizes or fa-
vors links between individuals and their structural problems. Our "re-
search-action" strategies cannot be summed up in a single approach. Is
the researcher's role simply to [translation] "take into account the physi-
cal, physiological, psychic and sociological aspects of all types of be-
havior" (Mauss 1950 cited in Lévy 1993, p.123) or, for example, is it to
intercede as a defender of rights? Depending on our position on these
questions, research may remain illusory, disjointed, barely capable of
awareness-raising, providing little self-empowerment to the disadvan-
taged individuals and families willing to become involved. In this con-

text, the difference suggested by Francesca Cancian (1993) and Corin, Bibeau, Martin, and Laplante (1990) between participatory research and alternative activist approaches deserves further attention.

If the objective were simply to adopt a different approach, a clinical approach would certainly encourage researchers to leave the hallowed hallways of academia. For some, this approach may be quite a challenge, accustomed as we are to our laboratories. But what purpose does it serve to leave our physical walls if the analysis we present remains isolated, detached and trapped within other walls?

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