

Beyond the 50-Minute Hour: Increasing Control, Choice, and Connections in the Lives of Low-Income Women

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Although poverty is associated with a range of mental health difficulties among women in this country, mainstream mental health interventions are not sufficient to meet the complex needs of poor women. This article argues that stress, powerlessness, and social isolation should become primary targets of our interventions, as they are key mediators of the relationship between poverty and emotional distress, particularly for women. Indeed, if ways are not found to address these conditions directly, by increasing women's control, choice, and connections, the capacity to improve the emotional well-being of impoverished women will remain limited at best. This is the first of 5 articles that comprise a special section of the *American Journal of Orthopsychiatry*, called "Beyond the 50-Minute Hour: Increasing Control, Choice, and Connections in the Lives of Low-Income Women." Together, these articles explore the nature and impact of a range of innovative mental health interventions that are grounded in a deep understanding of the experience of poverty. This introduction: (a) describes briefly how mainstream approaches fail to address the poverty-related mental health needs of low-income women; (b) illuminates the role of stress, powerlessness, and social isolation in women's lives; (c) highlights the ways in which the articles included in this special section address each of these by either adapting traditional mental health practices to attend to poverty's role in participants' lives or adapting community-based, social-justice-oriented interventions to attend to participants' mental health; and (d) discusses the research and evaluation implications of expanding mental health practices to meet the needs of low-income communities.

One in eight people in this country lives below the poverty line (U.S. Census Bureau, 2006). The majority are women and their children, and over half (55%) are ethnic minorities (Miranda & Green, 1999; Proctor & Dalaker, 2003). Compared with 11% of White women, 25% of African American women and 23% of Latinas are poor (U.S. Census Bureau, 2006). Indeed, almost 40% of single African American and Latina mothers struggle with poverty (Center for American Progress, 2007). Despite these high numbers, which reflect a

powerful and inescapable reality for many women, particularly women of color, psychologists and allied professionals have done little to develop mental health interventions that are tailored to the needs of this population (Lott & Bullock, 2007; Smith, 2008).

The paucity of mental health approaches designed specifically to meet the needs of impoverished women is surprising given the large body of research showing that poverty is strongly associated with a range of mental health difficulties. Low-income women suffer a variety of mental health problems at rates well above those of more advantaged populations, including depression (Siefert, Bowman, Heflin, Danziger, & Williams, 2000), posttraumatic stress (Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshal, 2001), substance abuse (James et al., 2003; Zilberman, Tavares, Blume, & Nady, 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999). Not only are these mental health problems difficult to

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bear on their own, but they may also interfere with effective parenting (Graham-Bermann, Coupet, Egler, Mattis, & Banyard, 1996; Swick, 2007) and social mobility (Dearing, McCartney, & Taylor, 2006).

We conceived this special section of the *American Journal of Orthopsychiatry*, called “Beyond the 50-Minute Hour: Increasing Control, Choice, and Connections in the Lives of Low-Income Women,” to explore new and innovative approaches to addressing the needs of low-income women that are grounded in an understanding of the subjective experience of poverty. This introductory article (a) describes briefly how mainstream approaches fail to address the poverty-related mental health needs of low-income women; (b) illuminates the role of stress, powerlessness, and social isolation as mediators of the relationship between poverty and mental health in women’s lives; (c) highlights the ways in which the articles included in this special section address each of these three conditions, by either adapting traditional mental health practices to better attend to the contexts of low-income individuals or adapting community-based, social-justice-oriented interventions to attend to participants’ mental health; and (d) discusses the research and evaluation implications of extending our mental health practices, pointing out that some of the most innovative and context-sensitive approaches to mental health for low-income communities may be the poorest fit for evaluation using controlled clinical trials.

It is important to note at the outset that poverty shapes women’s lives in concert with many other dimensions of social location including race, geography, culture, and immigration status, to name a few. Poverty for an El Salvadoran immigrant woman in Boston, Massachusetts, is a different experience from poverty for a white woman in rural South Dakota. Nevertheless, for the purposes of this article, we emphasize potential commonalities of experience, and highlight new approaches—described in more detail in subsequent articles—that may be effective across subgroups. We do so with the hope that the ideas presented here will enable us to lay the groundwork for more refined work on specific low-income communities in the future.

The Failure of Mainstream Mental Health Approaches

When researchers and policy makers consider mental health interventions for low-income individuals at all, they usually do so using the framing of barriers to access (e.g., Siefert et al., 2000). Research demonstrates, for example, that low-income women may be unable to access services for a variety of reasons ranging from the logistical and material (e.g., cost, inadequate child care, and transportation difficulties; Belle & Doucet, 2003; Rosen, Tolman, & Warner, 2004) to the experiential and historical (e.g., expectation of stigma, demeaning or judgmental provider attitudes, negative past experiences, and/or prior trauma that contributes to significant distrust of others; Lazear, Pires, Isaacs, Chaulk, & Huang, 2008; Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003) to the cultural (e.g., providers’ lack of sensitivity to participants’ sociocultural context; The Commonwealth Fund, 2006; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Laughon, 2007).

We contend, however, that beyond the problem of access lies the more fundamental problem that mainstream mental health interventions *themselves* currently do not meet the mental health needs of low-income women (Goodman, Smyth, Borges, & Singer, 2009; Smith, 2005). Our central argument rests on this premise: Oppressive social conditions are a significant causative variable in the mental health issues faced by those struggling with poverty (Fancher, 2003; Prilleltensky & Nelson, 1997; Smyth, Goodman, & Glenn, 2006). However, mainstream mental health practices are largely predicated on the supposition that mental illness is a product of biological, cognitive, and emotional factors—and thus tend to be short term and symptom focused. For example, cognitive behavioral therapy (CBT), which is one of the major empirically supported treatments for depression, is based on the idea that emotional reactions are caused by dysfunctional cognitions and attitudes (Beck, 1993). This idea, and the treatment that follows from it, can feel (and be) insufficient, or even inappropriate to an isolated and anxious single mother without a safe place for her children to sleep, or to a low-income immigrant woman faced with the choice of staying with her abusive husband or leaving the only community she has ever known (Goodman & Epstein, 2008).

Although therapeutic practices such as CBT have a role in addressing the mental health of individuals living in such difficult conditions, especially when they are adapted to fit the life contexts of particular participant groups (see e.g., Le, Zmuda, Perry, & Muñoz, this issue; Miranda, Azocar, Organista, Dwyer, & Arean, 2003), they are unlikely to be sufficient. As a result, even those low-income women who manage to overcome the myriad barriers to seeking help may end up participating in interventions that do not address their full range of needs or even their most pressing concerns. Researchers and practitioners interested in the mental health of impoverished communities must therefore consider not only barriers to access to mental health treatment but the very relevance of the treatment itself.

As shown in the next section, economic and material deprivation, difficult enough by themselves, often create yet another layer of hardship, characterized by high stress, pervasive powerlessness, and social isolation and exclusion. These, in turn, are powerful contributors to emotional distress. We join others (e.g., Falconnier & Elkin, 2008; Prilleltensky & Nelson, 1997; Smith, 2005, 2008) in our contention that these core conditions of poverty are too tightly linked to emotional distress for mental health professionals to bypass them as targets of intervention. Indeed, we argue that if we do not find ways to ameliorate these key mediators, we are significantly limiting our capacity to improve the emotional well-being of impoverished communities. Psychologists and allied professionals must begin to explore approaches that go beyond the restricted focus on women’s intrapsychic, relational, or cognitive behavioral difficulties to address directly and collaboratively the stress, powerlessness, and isolation caused by poverty itself. We need to find ways to offer opportunities for real choice, control, and connection to others.

We are hardly the first to highlight the effects of oppressive contexts on mental health. For many decades, advocates within social work, and counseling, community, multicultural, critical, liberation, and feminist psychology, have called attention to social oppression as a critical obstacle to emotional well-being

(see, e.g., Aldarondo, 2007; Bryant-Davis & Ocampo, 2005; Israel, 2006; Moane, 2003; Prilleltensky, Docecki, Grieden, & Wang, 2007; Sullivan, Mesbur, Lang, Goodman, & Mitchell, 2003; Vera & Speight, 2007). Some have challenged us to develop new methods for addressing the mental health needs of impoverished communities specifically (e.g., American Psychological Association, 2006; Goodman, Glenn, Bohlig, Banyard, & Borges, 2009; Smith, 2008). A recent National Institute of Mental Health workgroup, for example, called for modifications to existing interventions or the development of new ones to address the needs of lower socioeconomic status individuals (Hollon et al., 2002). In response to these calls, a number of researchers and practitioners have adapted traditional interventions to incorporate the role of poverty as well as culture in participants' lives (see, e.g., Miranda et al., 2003). As the article by Le and colleagues in this section demonstrates, these adaptations substantially improve the relevance of our models to the lived experience of low-income participants. But even these important innovations target only indirectly the stress, powerlessness, and isolation that follow from material deprivation.

At the same time, alternative forms of intervention into the social and material well-being of low-income communities have always existed outside the bounds of mental health as a discipline. Antipoverty programs, community organizing efforts, participant-led organizations, and countless other interventions designed to empower those living in poverty are scattered across our country. These efforts do not target participants' mental health directly, and they usually do not involve mental health professionals exclusively (or at times at all). Yet, by ameliorating some of poverty's most pernicious consequences, they may in fact do a great deal to alleviate participants' mental health difficulties.¹ What can we learn from these practices? What might collaboration between mental health professionals and community-based programs yield?

The Role of Stress, Powerlessness, and Social Isolation

The U.S. Census uses a set of income thresholds that vary by family size and composition to determine who lives in poverty. If a family's total income is less than the corresponding threshold, that family and every individual in it is considered impoverished. But this narrow conceptualization does little to illuminate the wide range of experiences captured by the word *poverty*, particularly when that poverty is persistent. Although proposing a new definition of poverty is well beyond the scope of this article, we offer Ringen's (2009) more "experience-near" characterization of persistent poverty as a way to frame the conditions we then describe in more detail:

[Poverty] manifests itself in the lives of persons and families as 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)

As we will show, the shortage of "material power" that lies at the very core of persistent poverty produces a number of toxic processes that mediate poverty's impact on low-income women. Three of the most pernicious are stress, powerlessness, and isolation, each of which is discussed next.

Stress and Powerlessness

We define stressors as chronic conditions or acute events that present challenges to well-being, particularly with respect to choice and control, and stress as the experience produced by attempting to manage or alter those stressors without the capacity or resources to do so effectively (Goodman et al., 2009). When stress becomes sufficiently intense and/or sustained, it often induces both real and perceived powerlessness, which we define here as lacking control of significant aspects of one's life (Goodman et al., 2007; Hägglund & Ahlström, 2007). Empirical research has consistently shown that lower income women are more likely to experience chronic and acute stressors than are higher income individuals (House et al., 1994; Mickelson & Kubzansky, 2003; Turner, 1995). People living at or below the poverty threshold do not have enough income to consistently fulfill basic individual and family needs like shelter, food, safety, and clothing (American Psychological Association, 2006). Impoverished mothers often wake up hungry and worried about how they will feed their children until the next check comes in (Burnham, 2001; Green, 2000; Siefert, Heflin, Corcoran, & Williams, 2001). At the same time, they must contend with substandard housing, unemployment or inflexible and unstable low-wage jobs, inadequate access to health care, and practical problems like lack of child care or transportation (Goodman et al., 2007; Miranda & Green, 1999). And because the dominant response to those who live in poverty often involves distancing, devaluing, exclusion, and designation of the poor as "other," low-income women must contend with the social condemnation, stigma and associated shame that pervade their daily interactions (Lott, 2002).

Those who are poor are also at extraordinarily high risk for sudden and traumatic experiences like interpersonal or community violence and other crimes (Bausman & Goe, 2004; Greif, 2005; Patterson, 1991; Rattner, 1990) where there are few options for moving or even getting an appropriate, timely police response (Goodman et al., 2009). Low-income women must therefore worry about their own and their children's safety both within their neighborhoods (Halpern, 1999; Lipsey & Wilson, 1993) and within their own homes; indeed, low-income women are much more likely than their higher income counterparts to have experienced interpersonal violence in childhood and in adulthood (Bassuk, Buckner, Perloff, & Bassuk, 1998). Further, for low-income women of color, these kinds of outright traumatic events may occur within the context of more insidious traumatic incidents related to racial discrimination (Bryant-Davis & Ocampo, 2005; Root, 1992).

Despite poor women's use of adaptive strategies to manage or reduce the chronic and acute stressors they face, even their best

¹ Following passage of the Community Mental Health Act in 1963, mental health providers interested in social change argued that rent strikes and other social protests to relieve poverty and empower people in their local communities should be seen as "mental health" services. But this movement receded over time (Sharfstein, 2000).

attempts often fall short (Belle & Doucet, 2003; Goodman et al., 2009). Poverty is oppressive not only in its deprivation of material needs but perhaps more perniciously in its deprivation of opportunities to change things. The inevitable result is a sense of powerlessness, defined here as a lack of choice or decision-making power over key dimensions of one's life (Goodman et al., 2009; Young, 2000).

Not surprisingly, then, both theory and empirical work indicate that chronic stressful and disempowering experiences contribute to mental health difficulties, particularly depression, among low-income women (Monroe & Hadjiyannakis, 2002; Pearlin, 1999; Sapolsky, 2004). Yet few mainstream mental health interventions target directly the stressful conditions in low-income participants' lives, or work to expand their scope of control.

Social Isolation and Social Exclusion

Low-income women are disadvantaged not only by the stress and powerlessness in their lives but also by the relative paucity of social support to cope with these difficulties (Brown & Harris, 1978; Elliott, 2000; Schulz et al., 2006). We define social support as the availability of instrumental and emotional assistance through informal networks, including family, neighbors, and friends, or through formal networks, including civic organizations, faith communities, or other community-based organizations (Kocot & Goodman, 2003). Social support can expand the scope of pragmatic and emotional resources an individual of any class has to cope with adversity and stress. As such, it can both increase confidence in one's ability to cope with imposed demands *and* provide concrete help with such coping (Eckensrode & Wethington, 1990; Mickelson & Kubzansky, 2003; Thoits, 1986). Thus, social support mitigates the "deprivation of opportunities to change things" noted above as characteristic of poverty.

But while those who are poor stand to gain significantly from social support, poverty diminishes the availability of social networks that reliably fulfill these functions (House, Landis, & Umberson, 1988; Krause & Borawski-Clark, 1995; Mickelson & Kubzansky, 2003; Roschelle, 1997; Turner & Marino, 1994). In one recent study based on a national probability sample of adults, for example, those participants in the lowest income category (making less than \$20,000/year) reported significantly less emotional support and a greater number of negative interactions with members of their support networks compared with those in higher income categories. This held true across ethnic groups (Mickelson & Kubzansky, 2003).

Two overlapping explanations have been offered for the differences in the potential utility of social networks in poor versus nonpoor populations: First, the social networks of those living in poverty are repositories of the networks' members' stress as well as sources of support (Belle, 1983; Belle & Doucet, 2003). As a result, many low-income women may feel that their friends and family members are not in a position to provide sustained support, that they do not want to burden others who are already struggling with enormous difficulties of their own, or that they are worried that leaning on someone today means having to share too few emotional and material resources later (Brodsky, 1996). As Janna Smith (2000) writes:

If it is your check day and not your friend's, you will lend her money, and she will pay you back when you run out. If you have two diapers and your neighbor needs one, you will give it to her. Other mothers will take your kids for weeks at a time if you have trouble. If you are out of food, someone will try to feed you. Do you need to dress up? Someone will lend you a blouse. Do you need a place to sleep? Take the couch and put your kids with my kids in one bed. But the sharing also means that people who have almost nothing are always being asked to part with it. A woman who gets a few extra dollars is immediately hit up by kin and friends, who, if she spends the money on herself instead of them, may be quick to criticize her. (p. 82)

In this passage, we see the inherent tension: Social networks are necessary for survival in low-income communities, but the very need for network members to help each other fulfill basic survival needs may hinder their individual or collective ability to move beyond survival.

A second, complementary, explanation for the differential utility of social networks in lower versus higher income communities is the relative absence of "linking social capital" in low-income communities (Woolcock, 2000). For the nonpoor, access to linking capital—that is, connections with people and institutions who wield significant societal power, influence, or control—is simply taken for granted as a source of information, guidance, referral, or support. These networks do not perform the same functions as networks of close friends or relatives might, but they are invaluable when, for example, it comes time to search for a new job, relocate to a new area, find the best child-care options, or get a traffic light installed at a dangerous intersection. Low-income women are much less likely to have access to these kinds of seemingly incidental, but profoundly important, sources of support and lubricants of social mobility (Smyth, 2009).

Whether by overtaxing the resources of social support networks and/or limiting access to linking capital, poverty can contribute to the absence of key relationships or the deterioration of existing ones; this process may, in turn, trigger the experience of social isolation, itself a risk factor for mental health difficulties, particularly depression, among women living in poverty (Belle, 1983; Coiro, 2001). Yet few mental health interventions aim to help low-income participants increase the size and/or utility of their social networks.

In summary, stress, powerlessness, and social isolation are each associated with psychological difficulties. Given their constant presence in the lives of impoverished women, it is not surprising that these women suffer a variety of mental health problems at rates well above those of more advantaged populations.

Mental Health Intervention in the Context of Poverty

As the research literature clearly indicates, women living in poverty experience high stress, low support, and inadequate opportunities for choice and control, which can have damaging mental health consequences. What role, if any, should mental health professionals play in addressing these contextual variables?

The articles that follow in this special section represent a continuum of potential responses to this question. At one end is an adaptation of a traditional mental health intervention grounded in an understanding of women's experience of poverty. At the other end are interventions that target stress, powerlessness, and isolation, with mental health improvement as a collateral benefit. Exemplifying the former, Le et al. (this issue) describe a process for adapting evidence-based treatment and preventive practices, in particular CBT, to make it more relevant to and effective with low-income Latina women. Moving along the spectrum from understanding the consequences of poverty to targeting those consequences directly, Weintraub and Goodman (this issue) integrate instrumental and emotional support in their Relationship Centered Advocacy (RCA) approach, a model in which advocates collaborate with low-income women to expand the women's access to informal and formal social support and increase their scope of choice and control.² Using qualitative content analysis, the authors focus their inquiry on advocates' (mental health counseling masters students) experience with this approach—which is not traditional mental health treatment, but is not entirely divorced from it, either—over the course of a year.

Moving still further along the continuum toward a more direct focus on changing participants' contexts, articles by Ali, Hawkins, and Chambers (this issue) and Smith and Romero (this issue) showcase the use of methods outside the bounds of mental health practice that can nevertheless improve mental health for low-income individuals and communities. Ali et al. describe a microcredit project to improve low-income, predominantly African American participants' financial well-being, while at the same time increasing their sense of mastery and community, ultimately leading to depression reduction. Smith and Romero explore the mental health benefits of participatory action research (PAR) with low-income women of color.

Each of these articles describes a distinct type of process or practice. To different degrees and in different ways, however, all of these articles highlight intervention strategies aimed to reduce stressors, increase control and choice, and increase the size or utility of participants' social networks. These are of course overlapping processes; expanding social networks may increase real and perceived control, just as increasing control may reduce stress. We provide a few illustrative examples here.

Stress

Turning first to stress, Ali et al.'s microcredit model, the only one in this special section that focuses on men as well as women, aimed to reduce stress by providing resources (including business and leadership training, technical assistance, networking opportunities, and microloans for starting business ventures)

that enable participants to create new income streams. This project directly addressed the economic stress and lack of resources faced by individuals in low-income communities as its core purpose. As is common with microlending projects throughout the country and the world, this initial resource exchange occurred within the context of regular meetings in which participants came together not only for financial discussions and resource exchange but also to discuss their progress and challenges in this and other domains, providing emotional and practical support to one another. The results, as Ali et al.'s study showed, were both improved financial situations for participants and reduced rates of depression.

The RCA model that Weintraub and Goodman describe (see also Goodman et al., 2009) also aimed to reduce stressors, in this case among low-income women struggling with depression. RCA advocates were trained to collaborate with their low-income partners to combat stressors in a number of ways: by collaborating with their partners to accomplish tasks that are hard to manage alone (e.g., applying for specific state benefits, organizing tenants to demand changes from a negligent landlord, or role playing before a job interview); by actively taking things off partners' plates (helping with transportation, obtaining information from various community agencies); and/or by helping to build and/or strengthen partners' connections to informal and formal support networks, at times becoming part of these networks.

Powerlessness, Choice, and Control

All of the authors in the special section discuss the ways that their approaches address powerlessness, a central experience of entrenched poverty. For example, Le et al. delineate the shift that they and their predecessors (Muñoz, 1996, as cited in Le et al., this issue) made away from the paradigm of gaining control of their cognitions and behaviors, central to the original CBT model, and toward the notion of "managing" elements of their internal and external reality, respectively. By helping participants distinguish between areas of their lives where they could exercise control from areas where such efforts might well be futile (given the constraints imposed by poverty as discussed above), they aimed to help participants shift from an overall sense of powerlessness to a more nuanced understanding of where personal power might be more successfully exerted.

Smith and Romero also address participants' scope of choice and control, in this case more directly, using the methods of PAR. They 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. Together, the group developed a fact sheet for the community about HIV in the lives of women of color and started a petition drive to gain support for a transitional housing project for HIV-infected women transitioning from prison to the community. In the process, PAR participants described a growing sense of pride and mastery because they felt that they had something to offer to the members of their community and a firmer sense that they could help create change in their own lives and in the lives of others.

² The name Relationship Centered Advocacy represents a change from the original name of the model, Feminist-Relational Advocacy. We changed it in order to better reflect the core component of the advocacy, which is the relationship between the advocate and the partner, and to make clear that this model could be used with populations other than adult women. Please see Goodman et al. (2009) for a detailed description of this model.

Decreasing powerlessness also requires careful attention to practitioners' use of power in their work with participants. As Smith and Romero argue, "the very act of positioning ourselves as [expert] 'helpers' can prompt professional behaviors and attitudes that reinforce the one-down position to which society relegates poor clients" (p. 13), an assertion that has been made about social services to the poor in general (Smyth & Lawry, 2009). In contrast, they argue, a more productive stance is that of "ally." In both Smith and Romero's PAR project and Weintraub and Goodman's advocacy work, mental health practitioners and participants joined together to take shared action based on a mutual and evolving understanding of participants' needs and strengths. In contrast to the traditional expert-client dynamic, the practitioner's role was not to "empower" participants to take action but instead to join with them in shared action. A useful visual image for this concept is that of practitioners and participants aligned shoulder to shoulder, each bringing their own experience to bear on the issue at hand.

Social Isolation

Finally, each of the approaches described in the special section were successful in reducing the social isolation that is so damaging to mental health. Participants in the microcredit program described by Ali et al., for example, emphasized their expanded social support networks, "knowing that they are part of a larger group, being an active member of their neighborhood community or the African American community in general, and connecting with others who are striving to improve their neighborhood" (p. 29).

Similarly, Smith and Romero's participants described the ways in which they were able to shift the nature of their social support networks: Some of the participants reported that their PAR experiences had enabled them to develop the knowledge and skills to be a more effective "resource" for members of their social networks. Others described improved communication skills, leading to improved relationships with family and friends. Still others described their increased involvement in local community organizations and other community change efforts. The sense of self-efficacy that resulted from participants' "believing that they were going to be a part of change in the community through a chain reaction of understanding, commitment, and involvement" (p. 20) was fostered in the context of increased connectivity to the neighborhood community, not of individual treatment or structured support groups.

Research and Evaluation Challenges

Too little has been done to address the specific mental health needs of low-income individuals and families, and mental health professionals need to think more deeply and broadly about how to remedy this neglect. As discussed throughout this introduction and in many of the articles that follow, we need to explore the possibility that the array of interventions that succeed in improving the mental health of low-income individuals and families may be much broader than is currently understood. There are of course a wide variety of obstacles to such an exploration. In the final section of this article, we consider one particular set of challenges related to research and evaluation.

Implicit in our call for exploration of new mental health practice models is the need for investigation into which practices might most effectively improve the mental health of low-income individuals and communities. We highlight a few in this special section, but many more can be found in communities across the country. We need to continue to investigate the impact of mental health interventions that are adapted to the cultural and class contexts of specific groups. The chief lesson of this section is that community practices that are not usually thought of as mental health interventions in fact contribute to the emotional well-being of low-income individuals.

This insight raises an important question: How do we fairly and effectively evaluate the mental health impact of these non-traditional programs? Although debate about what constitutes rigorous and relevant evaluation in the mental health field continues, what is most valued (and reimbursable) is usually that which is validated by specific forms of research, particularly randomized clinical trials (Goodheart, Kazdin, & Sternberg, 2006; Norcross, Beutler, & Levant, 2005; Westen, Novotny, & Thompson-Brenner, 2004). This form of research is either not possible for some of the interventions showcased in this special section or not optimal for evaluating their effects (Smyth & Schorr, 2009).

Each of the approaches described in this special section is based on a clear theoretical framework, but most are emergent, nonlinear, and fluid, arising out of a deep engagement with community members who help to develop aspects of the intervention as they participate in it. Improved mental health may be only one of a number of proximal and distal goals (including increased earnings, increased connectivity to others, increased civic participation, among others), and the range of positive mental health outcomes may be broad and varied, depending on participants' needs and goals. Further, participants are not selected for participation based on their meeting criteria for specific diagnoses, and they may evidence a wide range of mental health difficulties. Controlled clinical trials may simply be unable to capture the complex outcomes of these forms of intervention and may in fact interfere with their capacity to evolve continuously in response to participants' needs and strengths.

If controlled clinical trials are inappropriate for certain types of interventions, does this mean that the interventions are less valuable? Smyth and Schorr (2009) have described how the conflation of what is researchable using specific quantitative research methods with what is good or useful may result in the dismissal of certain approaches that address the complex challenges faced by low-income people. We join with them and many others (e.g., American Psychological Association Task Force on Evidence-Based Practice, 2006; Berwick, 2008; McCall & Green, 2004) in calling for a broader understanding of what constitutes valuable, rigorously obtained evidence. For example, qualitative methods, used in all of the articles in this special section, may be well suited to the community-based interventions that target participants' contexts in highly individualized and emergent ways (Kazdin, 2008; Silverstein & Auerbach, 2009). Rigorous qualitative research allows for individualized goals because it targets participants' own reports about their experiences rather than researcher-defined outcomes; participants themselves define the independent and dependent variables that are relevant to them (Silverstein & Auerbach, 2009). Similarly, case study methods

can capture the constant evolution of interventions, as they emphasize the ongoing interrelationships among individuals, programs, and the contexts in which they are embedded, keeping each element in sight at once rather than breaking them into separate constructs for analysis (Weiss, 1998).

To the extent that some of the most innovative and context-sensitive approaches to mental health may be the poorest fit for evaluation using controlled clinical trials, we risk continuing to privilege interventions that are more easily studied by traditional methods over interventions that may be more effective and meaningful, but less responsive to these traditional tools—to the detriment of impoverished individuals and families (Smyth & Schorr, 2009). Alternatively, expanding our notion of what constitutes legitimate methods of evaluation would not only enable us to understand the impact of our work better but it would also extend our reach and effectiveness.

Conclusion

The contribution of this issue, we hope, is to demonstrate that addressing the complex mental health needs of low-income women is within our reach, and a first step is to explore, integrate, and evaluate innovative work already being done. As with any group, low-income women take a risk when they ask for help. In so doing, they not only face stigma, shame, and potential failure, but they must also have overcome a number of pragmatic hurdles to utilize what mental health professionals have to offer. And, after all that, the limited range of interventions available to them may not be relevant to their lives. We suggest that new possibilities for practitioners and participants open when an understanding of poverty's dynamism—its tight grip on people's choice, control, and connections—is built into practice from the outset. As mental health practitioners and as a field, we too must shoulder some of the risk—and be willing to engage in our own change process. The articles in this special section suggest that there is much already in place for us to build on. In so doing, we may well find new power to heal along the way.

Keywords: women; qualitative methods; poverty; powerlessness; stress; social isolation; choice and control; social support; community interventions

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