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Looking within and beyond the community: Lessons learned by researching, theorising and acting to address urban poverty and health

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Abstract

Urban poverty and health inequalities are inextricably intertwined. By working in partnership with service providers and communities to address urban poverty, we can enhance the wellness of people in need. This article reflects on lessons learned from the Family100 project that explores the everyday lives, frustrations and dilemmas faced by 100 families living in poverty in Auckland. Lessons learned support the need to bring the experiences and lived realities of families to the fore in public deliberations about community and societal responses to urban poverty and health inequality.

Keywords

advocacy, community, health, politics, poverty

Like many of the participants in our research, Jade has ongoing health issues. Many of these relate to a previous abusive relationship. Our field-notes record that Jade's ex-partner had 'knocked several of her front teeth out'. Jade could not afford to access dental care and 'this resulted in her gums becoming seriously infected and many of her other teeth becoming rotten/damaged'. Jade's oral health has a substantial impact on her social participation in that 'bad breath is a side effect of the rotting teeth. She finds this very embarrassing, and is very self-conscious'. It was noted that Jade

> has gone through periods of intense pain with her teeth, including a period where she could not eat and was constantly bleeding from her mouth, and was in huge amounts of pain. She has been on morphine, cepranol, codeine, and tramadol for the pain.

The situation reached the point where Jade 'places Deep Heat and Tiger Balm [both remedies

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for muscle pain recommended for external use only] on sore gums when can't afford medication'. During an interview, Jade stated that 'the pain makes me almost suicidal'. Jade's dental pain is so severe that she has had to call the ambulance on numerous occasions to take her to hospital. Recently, Jade overdosed twice on pain killers while trying to manage the pain and sees the pain as a barrier to her gaining employment and moving out of poverty.

Alongside the complexities of Jade accessing dental care, this case exemplifies the personal health consequences of poverty. Jade's situation could be readily resolved, but the system fails to meet her needs. Such exemplars bring the frustrations, contradictions and consequences of poverty and health inequalities to the fore, embodying inequity in Jade's mouth.

In considering the plight of Jade and people like her, we quickly realise that poverty and related negative health outcomes are inherently political (Birn, 2009). We know that poor people 'get sicker and die quicker' than others and that the increases in socio-economic stratification currently occurring in many societies are associated with increased illness (World Health Organization (WHO), 2010). Poverty impacts lives materially and psychosocially through an interrelated range of societal determinants of health – social and economic exclusions, educational difficulties, stigma, physical hardship, under-employment, inadequate housing, food insecurity, violence and constrained access to health and social services. Adversity associated with urban poverty gets under the skin and into the minds of those affected through processes of 'embodied deprivation' (Hodgetts et al., 2007). We also know that the health sector alone cannot address the health impacts of increased poverty (Birn, 2009) since these are diverse yet interconnected phenomena.

At a time when welfare systems are increasingly subject to resource restraints (cf. Bourdieu, 1998), private social services have an important role to play in meeting both the basic human needs of families and engaging in advocacy work to promote social change that can address the structural causes of inequity, poverty and associated illnesses. Correspondingly, a core task for a relevant and responsive community-orientated health psychology is to generate new insights into the lived realities of people living in poverty, to understand the implications of poverty for health and to develop effective responses at all levels of society. Scholars have called for increased attention to inequality and community processes in health psychology (Campbell and Murray, 2004; Murray, 2012). While further theorising regarding the nature of a community-orientated health psychology is important, the needs of people like Jade are pressing, and we must move beyond the academy towards action that fosters public dialogue and community and political responses. Furthermore, it can be argued that theoretical work has greater value when grounded in empirical engagements with people's lived realities.

We seek a community orientation to health psychology that is responsive to the needs of people living in poverty and adversity, and which advocates for public understanding, adequate resourcing and the need for structural change. A series of key questions orientate our efforts here: How should health psychologists engage with experiences such as Jade's in a manner that leads to change? Should we focus only on local community settings when we know that communities do not always have the answers and that many of the decisions shaping community life and health are not made locally by those affected by poverty? How can we look locally and work systemically to influence such decision-making processes? How do we frame our research in a manner that allows for ongoing engagements with people in adversity and yet leads to effective action? In addressing such issues, we need to look beyond the disciplinary bounds of health psychology and to draw on insights from across the human and health sciences (cf. Wetherell, 2011).

Insights for developing a community-orientated health psychology that promotes community wellness and addresses issues

such as poverty can be gained from traditions within the human sciences which foreground the obligations of scholars to share knowledge with the wider citizenry and to contribute to the development of more equitable societies. These traditions include Participative Action Research (Kindon et al., 2007), the Public Intellectual movement (Posner, 2001), Liberation Psychology (Martin-Baro, 1994) and the Scholar-Activist tradition (Murray, 2012). Recently, Murray (2012) extended the argument for a politicised and collectivist approach to community health psychology based on a social justice ethic that challenges inequitable social structures and works to improve the living conditions of lower socio-economic groups. It is in response to such calls to politicised action that we are currently working.

The development of a community-orientated health psychology requires a conceptual approach to research, theorising and action that centralises the lived experiences and dilemmas of people such as Jade. We have ordered 'research, theory and action' in this way because we do not accept that abstract theorising devoid of ongoing relationships with community groups is appropriate. Where possible, theory should come from research engagements or the bottom up, be kept in dialogue with actual events in society and, through these processes, lead to effective action. Flyvbjerg et al.'s (2012) applied *phronesis* (practically orientated knowledge regarding how to address issues of social concern) approach to social science is central to this orientation. Our focus is on engaging with the experiential knowledge of community members and their understandings of their own situations, thus enabling us to develop situated knowledge that is directly relevant to understanding and addressing the needs of people living in poverty. Such experiential wisdom is not simply cognitive in nature, it is also embodied and emplaced (cf. Hodgetts et al., 2007) through feelings of frustration, fear and anxiety and the texturing of spaces such as Welfare offices, which often communicate a lack of care, sympathy or interest to people in need. People experiencing poverty have a stock of experiential knowledge (*phronesis*), and we draw on close engagements with them in order to develop contextualised understandings of poverty, to theorise the societal processes at play, to develop effective responses and to promote change at the systemic level (cf. Hodgetts, 2012). As Flyvbjerg et al. (2012) argue, 'phronetic social science can deliver on the promise of mainstream social science to speak truth to power, to inform society, improve decision-making and enhance social life' (p. 11). For example, knowledge of what happens in interactions between institutions and families is centrally important in improving these interactions and challenging the social structures which are (re)produced through them. Such knowledge provides an advantageous basis for advocacy work that engages the broader public in issues by focussing on particular people and using their narratives 'to access and examine larger questions of oppression, resistance, emancipation and liberation' (Landman, 2012: 34).

Briefly, our work involves bringing local insights and examples into conversation with conceptual abstractions and then subjecting these experiences and theories to critical scrutiny in order to co-construct actionable knowledge in a similar manner to Freire's notion of 'voice' (e.g. Hodgetts et al., 2010). In other words, the *phronetic* knowledge of scholars (expertise and theory) is brought into dialogue with the *phronetic* knowledge of research participants (experience and embodied knowing). There is a subtle shift that comes with such work, involving a move from academic researchers to activist scholars working in collaboration with research partners (people experiencing poverty and agencies assisting them) to achieve societal change (Hodgetts et al., 2013).

The complex mix of social determinants of health associated with urban poverty and our approach to action requires a context-rich and engaged research strategy. The Family100 project (http://www.aucklandcitymission.org.nz/information.php?info_id=115&mID=109) at the Auckland City Mission (ACM) provides

exactly this. It explores how families who have been accessing a food bank with high regularity make sense of and respond to their impoverished situations. It does this by engaging with the families in a sustained way, conducting interviews every 2 weeks across a year, exploring a wide range of topics central to poverty, including education, employment, housing, food, health, agency supports, income and debt and justice. The ACM provides an influential site for praxis, where our research can address poverty and health inequalities, as the organisation has a substantial history of addressing poverty through providing key health and social services, including a medical clinic and pharmacy, detox facilities, social work supports, education programmes, a food bank, housing referral and advocacy. The agency thus provides a focal point for enhancing processes that are central for buffering underclass families against the health consequences of urban poverty.

Our involvement with the Family100 project in this setting requires us to build close relationships with stakeholders and to problem-solve with ACM practitioners and clients in how to best meet the needs of real people. Our partnership with the ACM situates us within a broader project of community care and change that draws on community and scholarly capacities to allow us to document actual experiences of lives in poverty while working to theorise these situations and support change (Hodgetts et al., 2010). This project is informed by Simmel's (1903/1964) *principle of emergence* of social phenomenon and his orientation towards looking locally in order to understand systemic elements of the sociocultural world within which people reside. Central to this is an understanding that micro-level systemic relations are reproduced within community settings through everyday interactions and that documenting and conceptualising these interactions systemically provide the basis for action. Family100 thus moves beyond the classic researcher-initiated model of research involving end-users towards a more open, responsive orientation involving ongoing dialogue between researchers, agency staff and clients.

Lessons from over 50 years of community psychology suggest that we cannot solve the issues faced by people in poverty unless we take action beyond the local community. Hence, we also extend our dialogues beyond the organisational context to engage the wider citizenry and policy makers through a variety of advocacy work. The Family100 project provides a strong basis for advocacy that seeks to change social structures impacting community life and perpetuating inequity and poverty (cf. Murray, 2012). We are involved in various forms of advocacy, both within and beyond the community, from supporting direct action events, fostering service developments, presenting public lectures for wealthier community groups, conversing with government bodies (Treasury, Families Commission, Auckland Council), writing policy submissions and engaging with journalists to extend public deliberations about poverty within the mediapolis (Hodgetts, 2012). This work is important because highly politicised discourses beyond the local community constitute a moving landscape open to change, one in which the social contract underlying the provision of both governmental and charity supports for the poor is being directly undermined (cf. Bourdieu, 1998).

Civic spaces, such as those provided by news media, are central to the texturing of interactions in local communities, are centrally involved in social relations that impact health and play important roles in both informing the citizenry about health inequalities and in legitimising or undermining responses to poverty (Hodgetts, 2012). Problematically, the complexities, dilemmas and everyday realities faced by people such as Jade are often missed in contemporary public debates which are increasingly focussed on 'getting tough on solo mums' and reducing government welfare 'liabilities'. Public deliberations about poverty are inflected by symbolic power, where more affluent groups define the poor and their realities (Jeppesen,

2009). Furthermore, the imagined community addressed in such deliberations is not primarily our growing precariat, but rather more affluent members of society. As a result, people such as Jade are often abjectified and socially distanced as strangers rather than included as 'ordinary' members of society with pressing needs that we all have a responsibility to address (Hodgetts, 2012). In this context, it is imperative that community-orientated health psychologists bring into view the experiences of people such as Jade together with a corresponding interpretation of what can be done to improve their situations. To this end, in our advocacy work, we draw on cases from Family100 to extend the range of voices and experiences evident in public deliberations regarding poverty.

Such media advocacy is particularly useful in extending insights from beyond the local community, and doing so in ways that can improve the situation for people like Jade by informing others in society of the need to resource and support efforts to help rather than to punish the poor. We have had some success in this work as key messages we have promoted have gained traction within major political parties in opposition, taking on tropes such as 'poverty is New Zealand's growth industry' and 'being poor is hard and frustrating work'. These tropes, and the examples we use to illustrate the everyday situations of people like Jade, increase public recognition of poor people, enhance understanding of the complexity of their lives, warrant efforts to render assistance and challenge punitive responses that are central to welfare reforms in many countries (cf. Hodgetts, 2012). They also lead to our being asked by the *Institute of Justice* to contribute a 2-hour workshop on poverty in New Zealand for the New Zealand Judiciary annual professional development series (Hodgetts et al., 2013). Essential to our efforts is to challenge the current tendency to treat poverty as a charity issue, because this does not lead to structural change and can foster victim blaming while absolving the economic drivers implicit to increased social inequality from consideration. Such advocacy work speaks to the need for community-orientated health psychology to broaden and politicise the discipline (Murray, 2012).

Finally, like related sub-disciplines such as social psychology, community-orientated health psychology needs to be aware of, and willing to go beyond, the arbitrary and porous disciplinary boundaries that often limit research. It is vital not to leave politics to politicians and political scientists, community development to social workers and social agencies, efforts to change social structures to sociologists and economists, issues of embodiment and embodied deprivation to cultural studies and feminism or the emplacement of deprivation to geographers (cf. Wetherell, 2011). The time is right for a politicised and engaged approach to community-orientated health psychology (Murray, 2012). Social scientists are being encouraged to re-engage with communities. The ranks of the impoverished are swelling. Agencies are looking for new approaches to understanding and responding to the needs of families in poverty, while also attempting to engage the wider citizenry about the realities of everyday life for the urban poor. We have much to offer to public understandings of how social determinants get under the skin and into the heads of people in need and operate to undermine their health. We also have much to offer to revise the agenda and accomplish social change. To be effective, we must move forward to forge close relationships with allies, across a variety of settings and disciplines, who are willing to challenge injustice and to develop more engaged approaches to research, theorising and action as reflected in Family100.

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