# APA GUIDELINES
# for Psychological Practice for People with Low-Income and Economic Marginalization

APPROVED BY APA COUNCIL OF REPRESENTATIVES
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AMERICAN PSYCHOLOGICAL ASSOCIATION

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# for Psychological Practice for People with Low-Income and Economic Marginalization


**APA Task Force on Developing Guidelines for Psychological Practice with Low-Income and Economically Marginalized Clients**

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# INTRODUCTION

Socioeconomically disadvantaged adults and children constitute a large and relatively stable proportion of people in the United States. More than 48 million people live in low-income working families, and more than 10.3 million working families in the United States earn less than 200% of the poverty level income (U.S. Department of Commerce, 2015). In 2018, the official poverty level for the continental U.S. was $12,140 for an individual and $25,100 for a family of four. The supplemental poverty measure (Fox, 2018) uses a more inclusive set of factors than the official poverty level, and results in a slightly higher percentage of U.S. citizens living in poverty. For example, in 2017 12.3% of Americans lived in official poverty according to the U.S. Department of Commerce (Fontenot, Semega, & Kollar, 2018) and the supplemental poverty measure identified 13.9% of Americans living in poverty (Fox, 2018).

The U.S. Department of Commerce reports that the percentage of people living in poverty, as defined by federal policy, has consistently remained between 10–16% since 1965 (U.S. Department of Commerce, 2017). Further, as economic inequality has increased in the United States (Congressional Budget Office, 2013), it has been accompanied by a growing disparity in mortality rates (Bosworth, 2018). Unlike other developed countries such as Canada and European nations, U.S. citizens with lower levels of income and education are dying younger at increasingly higher rates than those with greater income and education (Bosworth, 2018).

Economic marginalization is a complex and multifaceted social issue that can be examined in many ways. One of the ongoing difficulties that this complexity presents is a lack of common terminology, constructs, or measures. In one review of the literature, Liu, Soleck, Hopps, Dunston, and Pickett (2004) discovered that there were over 400 different terms being used to describe social class and related constructs. Because such a variety of language is used in the literature, as well as in public policy and the media, these guidelines have adopted an encompassing term—low-income and economic marginalization (LIEM)—that is intended to cut across the common characteristics of current language. In order to further explicate the definitional issues of this area of study, we have provided a set of definitions of common LIEM-relevant language. The definitions (Appendix A) serve two purposes. The first is to provide a common language with which to discuss social class concerns within the field. The current differentiation within the language contributes to confusion and inefficiency in reviewing literature, which stifles the acquisition and growth of knowledge. The second purpose of the definitions is to better inform psychologists of culturally sensitive language that can be used when describing economically disenfranchised people and the societal constructs that contribute to marginalization. The goal of establishing the term LIEM is to draw attention to the contextual importance of economic marginalization, not to serve as an identifier. Throughout the guidelines, we have attempted to reinforce this by using phrases such as "persons from LIEM backgrounds," rather than "LIEM individuals" to ensure that person-first language is not compromised by this new terminology.

We propose that developing a common language, such as LIEM, will actually help to foster effective research and applied work in psychology. This is intended to be an umbrella term that incorporates many aspects of what it is to be economically oppressed, including both limited financial resources and marginalization related to social class. However, we recognize that the existing literature is saturated with the wide variation in terminology in current use. Further, the words researchers have used in formulating questions and measuring variables may have influenced the conclusions and implications drawn. Therefore, the language in these guidelines is consistent with the original works that are cited, in an effort to maintain accuracy, and the extant variation in language will be apparent throughout the guidelines, as social class, socioeconomic status (SES), working poor, lower income, and similar terms are used throughout all of the supporting evidence relevant to the guidelines and the application. When more inclusive observations were available in the literature, we utilized LIEM to include all aspects of income and economic marginalization. We also used LIEM to identify the recommendations and contributions specific to the guidelines. We encourage others to use the common language established in these guidelines in future research.

The implications of economic marginalization are apparent across multiple aspects of life in contemporary society. The economic and social status into which one is born is a powerful factor in determining one's access to resources and supports and, therefore, access to available opportunities (Blustein, 2006; Evans, 2004). Such limited access has important implications for employment, education, achievement, and physical and mental health—all areas of relevance to psychologists. Indeed, the associations between SES and indicators of health, including behavioral, mental, and physical health, are well-documented (American Psychological Association [APA], 2006; Lorant, Deliege, Eaton, Robert, Philippot, & Anssearu, 2003; Siefert, Heflin, Corcoran, & Williams, 2001; APA, 2010; Smith, 2010; Smith, 2013), and researchers have identified poverty as the most pervasive risk to the health of children in America (Schickedanz, Dreyer, & Haffon, 2015).

The needs and desires of LIEM populations are often neglected, or even ignored, for a multitude of potential reasons. One possibility has to do with a process called distancing. Lott (2002) identified distancing as a key factor in classist beliefs, defining classism as cognitive and behavioral distancing from people who are poor. In simpler terms, this means that classism is often perpetuated by simply making poor people invisible to those in other social class groups. In politics, leaders generally speak to and focus their agendas on the middle-class and poor people are forgotten or degraded (Lott & Bullock, 2007). Additionally, people living in LIEM circumstances are often without representation in the government as positions of power are not afforded to poor people (Smith, 2013). Furthermore, neighborhood segregation often keeps middle- and upper-class people from interacting with low-income individuals, which can contribute to distancing and lead to these individuals being oblivious to the experiences of poor people (Smith, 2013). Low-income people are also often absent from or denigrated in the media (Bullock, Wyche, & Williams, 2001). In the realm of the workplace, when low-income and working-class people organize to attempt to have a voice in work decision-making and negotiations, they are silenced by negative public outcries and absent or negative media coverage (Smith, 2010).

When LIEM populations are made visible, it is often in a negative light. Several studies have shown that the U.S. population continues to hold discriminatory attitudes toward LIEM populations (Bullock et al., 2001; Lott & Saxon, 2002; Tagler & Cozzarelli, 2013; Zhdanova & Lucas, 2016). Such attitudes represent classism, defined as assignment of characteristics of worth and ability to individuals based on their known or perceived social class (Collins & Yeskel, 2005). Classism can occur in everyday interactions, in the form of slights and small insults known as microaggressions (Pierce, 1970; Sue et al., 2007). More affluent individuals may blame social class circumstances on perceived faulty or deficient attributes of poor individuals (Ryan, 1976; Smith, 2010). This process of blame preserves a social system that benefits those in power while creating obstacles that marginalize and exploit poor and working-class populations. Furthermore, these negative views (e.g., poor people deserve their status because they choose not to work hard) are used as justification for the inequities found in education, healthcare, the justice system, the environment, and the ability to access a vocation that provides a living wage.

The Western value of meritocracy—a belief structure that purports that hard work and individual merit will result in commensurate status and rewards—reinforces biased and negative views toward people living in poverty (Kluegel & Smith, 1986). Often framed as the "myth of meritocracy" (McNamee & Miller, 2004), endorsement of this worldview can contribute to greater distancing or discrimination of people who are poor and working class. Amidst vast disparities, many people from low-income backgrounds themselves endorse the belief that the social systems that affect them are fair and legitimate, that equal opportunities characterize the society in which they live, and that everyone receives what they deserve (Jost & Banaji, 1994; Jost, Banaji, & Nosek, 2004; Kluegel & Smith, 1986; Lerner, 1980; McCoy & Major, 2007). These beliefs can be conceptualized as reflecting system-justification ideologies (Jost et al., 2004) and can lead to internalized self-blame among the very people who are targets of classism. Interested readers can find additional discussion of system-justifying ideologies in Appendix B.

## Lack of Representation of SES in Research

SES has long been neglected in the psychological literature, both theoretically and methodologically (Buboltz, Miller, & Williams, 1999; Lee, Rosen, & Burns, 2013; Reimers & Stabb, 2015). Measurement difficulties and a paucity of research in which LIEM populations or issues are the primary focus reflect the limitation in research pertaining to LIEM populations. Attending to these variables within research is critical in building multicultural competency with LIEM populations.

Measuring SES has a host of difficulties that include invisibility of the identity, multiple operational definitions, a combination of objective and subjective variables, and the unique challenge of multiple fields studying the subject (e.g., economics, sociology, anthropology, political science; Diemer, Mistry, Wadsworth, López, & Reimers, 2013). Currently, the American Psychological Association (APA) publication manual does not require or recommend any mea-

sures of SES variables. As a result, SES has often been omitted from research (Lee, Rosen, & Burns, 2013; Reimers & Stabb, 2015) and, when measured, has been assessed in an unstandardized manner. Even the common triumvirate measures of income, occupational prestige, and educational attainment have challenges. For example, challenges include combining these elements into a singular variable, which obscures the unique impacts of income, prestige, and education; participants feeling like income questions are invasive (although strategies that reduce this feeling have been developed, see Diemer et al., 2013); and the impact of technology and new jobs on occupational prestige measures. Raising these measurement concerns to students can be important for creating competence and criticality when reading and understanding research methods pertaining to SES. Further, variables such as assets, debt, social class of origin, access to loans and banking, family size, documented status, affordable childcare, and many other factors that can easily be considered social class variables may be of greater saliency depending on the research question being asked or the population being studied. Some inroads and clear best practices in measuring social class have emerged; see Diemer et al., (2013) and Roosa et al., (2005) for instructive primers (which include sample questions for a variety of measures) on the measurement of social class.

Because of omissions and measurement inconsistency, there is a critical concern that the full spectrum of SES is not represented in the psychological literature. This lack of representation creates a significant issue as, for instance, APA's Stress in America research has consistently shown that finances, work, and access to healthcare, all of which are SES-related variables, are the top stressors Americans report year after year (APA, 2017). Although APA, and psychology as a field, has become more class conscious in the last decade, there is still considerable work to be done to adequately represent economically marginalized individuals and communities in research (Reimers & Stabb, 2015). This lack of attention has been attributed to many possible explanations, including the desire of professionals to distance themselves from poor and low-income individuals (Lott, 2002), the difficulties inherent in accurately measuring and reporting SES (Diemer et al., 2013), and pervasive stereotypes and negative attitudes toward poor and low-income families by individuals in the dominant culture (Kunstman, Plant, & Deska, 2016).

Eventually, APA challenged the "invisibility of low-income persons" (Lott, 2002, p. 100) in the literature and theories of psychology with an affirmative statement in 2000. Specifically, APA resolved to advocate for and support research and public policy that address poverty and SES (APA, 2000). The APA Office on Socioeconomic Status (OSES), established in 2007, now develops and disseminates relevant fact sheets and reports highlighting the impact of SES and poverty on psychological and social well-being (see http://www.apa.org/pi/ses/index.aspx).

Given the pervasive influence of socioeconomic factors on multiple life domains, it is imperative that psychologists understand the influence of income and economic marginalization on help-seeking behaviors and treatment effectiveness. This understanding will make the realm of psychological practice more welcoming and inclusive of individuals with LIEM circumstances, and help to ensure that people, regardless of wealth, come to view psychological interventions as relevant tools, rather than luxuries intended only for the wealthy. Further, it is important to train future and current psychologists to recognize the impact of income inequalities on individual clients and on the organizational structures that either facilitate or restrict their access to services. Finally, to maintain a lasting effect on practice and training, psychological researchers need to be adequately prepared to attend to economic factors, measure them appropriately, and produce research that can inform effective practice.

## Ethical Considerations for LIEM Populations in Psychological Research

As a final note, the historical context of psychological research with LIEM populations is important to consider in the context of these guidelines. The Iowa Monster Study and Tuskegee Untreated Syphilis Experiment provide a haunting framework for the dangers of economic exploitation within research (Reynolds, 2003; Jones, 2008). As a result of this context, psychologists are now ethically mandated to take into consideration the risk of economic exploitation or coercion when conducting research (Ripley, 2006; APA, 2016).

The risks of violating participants' autonomy are amplified when they are impoverished. This is especially possible in cases where participants are financially compensated for their participation or physical, mental health, or educational services are provided at a discounted rate. LIEM populations may feel less able to withdraw from a study when experiencing discomfort and in some cases may even hide important information from researchers for fear of losing financial compensation (Ripley, 2006). Psychologists who strive for ethical and cultural competence with LIEM populations concerning research must pay great heed to the potential for economic exploitation in research.

## Intersectionality and LIEM

These guidelines recognize the importance of the intersection of LIEM with other identities such as race, ethnicity, country of origin, immigration status, sexual orientation, gender, religion and spirituality, ability, language, age, and other areas of identity (e.g., Cole, 2009). Intersectionality (Crenshaw, 1989) refers to the cumulative impact on marginalized individuals of overlapping and interrelated sources of discrimination and oppression. Consistent with the guidance provided by the APA Multicultural Guidelines (APA, 2017; http://www.apa.org/about/policy/multicultural-guidelines.pdf), effective work with intersectionality and LIEM supports and is supported by cultural competence and cultural humility.

There is a large correlation between economic marginalization and holding other marginalized identities. For instance, people at both ends of the age spectrum are more likely to experience poverty. Children or persons under 18 years of age, of any background, are more likely to experience poverty than adults (Bruner, 2017). Approximately 15% of older persons live below poverty thresholds in the United States (DeNavas-Walt & Proctor, 2014). Additional resources on the intersection of age and LIEM are available in two extant APA documents: the APA *Aging & Socioeconomic Status* fact sheet (https://www.apa.org/pi/ses/resources/publications/age) and the APA *Guidelines for*

*Psychological Practice with Older Adults* (https://www.apa.org/practice/guidelines/older-adults). Among adults, women are more likely than men to have a higher average poverty rate (Mohanty, 2019), perhaps due to the sustained gender gap in pay and wages (Graf, Brown, & Patten, 2018). Further, the gender gap in global poverty (based on a study of 89 countries) emerges during early childhood and continues through middle adulthood, with girls and women consistently demonstrating higher rates of poverty than boys and men (Munoz et al., 2018). The APA *Guidelines for Psychological Practice with Girls and Women* (https://www.apa.org/about/policy/girls-and-women-archived.pdf) provides readers with additional resources for understanding the differential impact of poverty on women and girls.

People of color are disproportionally affected by economic stress (Bruner, 2017), and people of color are more likely to also identify as being lower SES (APA, 2017). Native/First Americans, for example, are almost two times as likely to live in poverty as the total national average (Wilson & Mokhiber, 2017) and unemployment in some reservation communities is as high as 21%, compared to the national unemployment rate of 4.1% (Hagan, 2018). Further, skin color can increase these disparities, with darker skin being associated with lower socioeconomic resources (Hochschild & Weaver, 2007). In a recent report, *Stress and Health Disparities* (APA, 2017), the APA Working Group on Stress and Health Disparities highlighted the complex interplay between race and social class in stress exposure. The APA highlighted that the existence of higher levels of threat to safety and achievement, combined with gaps in economic resources, contributes to higher levels of stress that further exacerbate health disparities for individuals who are both economically marginalized and members of minority groups (APA, 2017).

Sexual orientation also intersects with social class such that individuals who are lesbian, gay, and bisexual (LGB) are more likely to live in poverty (Badgett, Durso, & Schneebaum, 2013) and may feel increased pressures to accumulate capital in order to be connected to the larger LGB community (Whitcomb & Walinsky, 2013). LGB individuals who are from LIEM backgrounds may be more likely to reside in communities in the United States that are more hostile toward LGB identity (Burnes & Singh, 2016). Lesbian, gay, bisexual, and transgender (LGBT) youth also commonly experience economic difficulty, particularly homelessness, and become homeless more often than heterosexual persons, often due to familial discrimination (Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). Socially, LGBT persons often experience workplace discrimination, which contributes to socioeconomic difficulty (McGarrity, 2014). Transgender adults are four times more likely to live below the federal poverty line than the general population (Grant et al., 2011). Regarding immigration status, immigrant Latinx children are more likely to live below the federal poverty line than White children, although, immigrant status has sometimes been found, paradoxically, to be a protective factor for adverse childhood experiences (Loria & Caughy, 2018). Adult undocumented immigrants are known to experience economic difficulty related to their decreased abilities to gain employment and use government benefits without citizenship (Passel & Cohn, 2009).

Finally, persons with disabilities also experience poverty more than persons who do not have disabilities (Palmer, 2011). This relationship is related to an increased prevalence of unemployment, stigma, and discrimination (Hughes & Avoke, 2010). In addition, healthcare disparities and exposure to environmental and other hazards have contributed to a relationship between poverty and intellectual disabilities (Emerson, 2007). This relationship is intensified by the exclusion of individuals with intellectual disabilities from employment opportunities (Emerson, 2007). For example, in 2016 only 35.9% of people with disabilities were employed, compared to 76.6% of people without disabilities, and the median earnings of people with disabilities was approximately two-thirds of those without disabilities (Kraus, Lauer, Coleman, & Houtenville, 2018). Ironically, systems of assistance (such as Social Security disability benefits) are only available to people who earn very little money ($1,220/month in 2019; Social Security Benefits Planner, n.d.), perpetuating the relationship between poverty and disability.

Importantly, disparities in wealth across groups are even more pronounced than income disparities. Wealth is generally identified as the level of net worth or accumulated assets (Piketty & Zucman, 2014), and may therefore indicate a more stable indicator of SES or social class than income. For example, Killewald and Bryan (2018) found that the median White household wealth is 13 times greater than the median Black household wealth. Wealth disparities have also been found to be associated with differences in health status across racial/ethnic groups (Pollack et al, 2013). Ultimately, when psychologists are working with LIEM populations, it is important to understand how social class, income, SES, and wealth may intersect with multiple other socially marginalized identities, and how detriment arising from membership in one or both groups may be exacerbated. The APA OSES has multiple publications on the intersection of SES and multiple areas of identity; see its fact sheets for further information (https://www.apa.org/pi/ses/resources/publications).

## Purpose

The purpose of the *Guidelines for Psychological Practice with Low-Income or Economically Marginalized (LIEM) Individuals* (guidelines) is to assist psychologists in the provision of culturally competent care for those whose economic position has negatively impacted or constrained their health and well-being. Culturally informed care for individuals who are LIEM attends to and accounts for the financial barriers, social marginalization, and differentiated developmental trajectory of those who have been impacted by economic constraints. These constraints are not purely monetary and can include variables such as access to quality school districts, childcare, access to adequate insurance, family size, cultural capital, and a range of other indicators of one's social class identity. Psychologists who wish to provide culturally appropriate care are encouraged to design services and interventions that consider these types of barriers in how they facilitate access to care and administer services.

## Documentation of Need

The APA Council of Representatives adopted the *Resolution on Poverty and Socioeconomic Status* (2000; 2010) and commissioned the APA Task Force on Socioeconomic Status to study the impacts and consequences of poverty and low SES. This action culminated in

the establishment of an APA OSES and a permanent Committee on Socioeconomic Status (CSES) in 2011. The OSES provides advocacy and input on federal policies and legislation, focused on reducing inequality and disparity related to income and SES (APA, n.d.).

The work of OSES and CSES subsequently identified the need to develop guidelines to help clinicians, trainees, and researchers more effectively address poverty and economic marginalization in their psychological work. Therefore, the CSES initiated the work of a new task force in 2016, the Task Force on Developing Guidelines for Psychological Practice for Persons with Low-Income and Economic Marginalization. That task force, which authored the current guidelines, has relied heavily on the resources of the OSES and the goals of the CSES.

The current task force has also drawn from the critically important *Report of the APA Task Force on Socioeconomic Status* (APA, 2007), which offered several recommendations that have served to guide the development of the proposed guidelines. The Task Force on Socioeconomic Status recommended that APA "work to expand support for psychological research, education, practice, and public policy addressing SES and social class," and "work to strengthen clinical practice through the integration of SES/social class" (p. 27), as well as "encourage an increase in training and education in psychology related to socioeconomic status and social class" (p. 28). The role of social class and income disparity has become even more critical in the decade since the Task Force on Socioeconomic Status made its recommendations, as psychologists in the United States are working with clients and trainees who live in an increasingly bifurcated economic reality that has substantial influence on health and well-being. This guidelines document therefore builds on the original report of the task force by providing recommendations for education, research, and clinical practice based on contemporary empirical support. The specific steps taken by the guidelines task force are described in the following guidelines development process section.

## Users of the Guidelines

The intended audience for these guidelines includes psychologists and psychology trainees. The guidelines are intended to be used for guidance in the provision of clinical care, the supervision and education of trainees, and the performance of research. Given that SES is relevant to all persons in a society, it is expected that psychologists and psychology trainees can encounter issues related to income and poverty in any setting and while participating in any aspect of their roles as a professional. In addition to current and future psychologists, these guidelines are likely to be useful to other healthcare providers, including counselors, social workers, physicians, nurses, and public health officials. Given the importance of interprofessional services in the contemporary healthcare market, the information in these guidelines is relevant to all professionals who are working with individuals, training students, or conducting research.

## Beneficiaries of the Guidelines

Although financial conditions contribute to shaping the identity of those from all ends of the economic spectrum (e.g., working class, middle class, upper class, top one percent), these guidelines are focused specifically on those at the lower end of the continuum. The guidelines are designed to benefit adults, children, and families who have previously experienced, or are currently experiencing, economic marginalization. Most psychologists, and even most psychologists-in-training, are not themselves living in LIEM situations. Therefore, sensitivity to the issues presented in these guidelines must be developed in order to provide culturally competent psychological services and conduct culturally informed research. The APA *Resolution on Poverty and Socioeconomic Status* (2000) identifies the following populations to be at a higher risk of facing economic marginalization: racial and ethnic minorities, refugees, documented and undocumented immigrants, older adults, veterans, persons with disabilities, those affected by mental illness, individuals who identify as LGBTQI, single mothers, youth, foster children, and families.

## Distinction Between Standards and Guidelines

As stated by APA (2015), "The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists. *Guidelines* differ from standards. *Standards* are mandatory and, thus, may be accompanied by an enforcement mechanism; *guidelines* are not mandatory, definitive, or exhaustive. *Guidelines* are aspirational in intent. They aim to facilitate the continued systematic development of the profession and to promote a high level of professional practice by psychologists. A particular set of *guidelines* may not apply to every professional and clinical situation with the scope of that set of guidelines. As a result, *guidelines* are not intended to take precedence over the professional judgments of psychologists that are based on the scientific and professional knowledge of the field (Ethics Code, Std. 2.04)" (p. 824). Practice guidelines are intended to be consistent with ethical practice, as defined in the *Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association* (APA, 2010). In the event of a conflict with the Ethics Code, adherence to ethical conduct takes priority. In addition, federal or state laws may supersede these guidelines.

## Guidelines Development Process

### INITIAL STAGES WITHIN CSES

Initial action steps for the guidelines began in 2013 and continued until 2016 within CSES. During this time CSES made several key decisions pertaining to the goals for the guidelines, including the title of the guidelines and the decision to focus on LIEM populations. At this time, CSES also made the decision to include domains of key areas within SES research. Additionally, the committee also decided to include key definitions of SES terminology within the document. CSES also consulted with several experts within APA

pertaining to guideline development including representatives from the Board of the Advancement of Psychology in the Public Interest (BAPPI), Board of Professional Affairs, and the Committee on Professional Practice and Standards (COPPS). CSES also reviewed established professional practice guidelines, including the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* and *Professional Practice Guidelines for Integrating the Role of Work and Career Into Psychological Practice,* as these were the most recent professional practice guidelines approved by the APA.

In addition, several keys tasks were accomplished during this time pertaining to the production of the document. Rough drafts were produced of the introduction, definitions, guidelines headings, and several of the domains. Contributing writers outside of CSES at this stage of development included Laura Smith, PhD, Columbia University and Cindy Juntunen, PhD, the University of North Dakota. An extensive reference list covering most of the major SES studies produced within the field over the past 40 years was also created.

## DEVELOPMENT OF APA TASK FORCE

In 2016 CSES made the decision to move the guideline process to a task force for several reasons. First, the rotating nature of the CSES committee made it difficult for any members to consistently stay committed to the project over time. Second, the committee was balancing multiple projects at once, and felt the guidelines needed specific focus and a dedicated team. Third, the committee had concerns related to the timeline and believed that the guidelines could be developed more expediently with a dedicated task force. An open call for task force members was sent out. CSES reviewed task force members and eventually submitted potential members to BAPPI for approval. The following members were appointed to the committee: Cindy Juntunen, PhD, Astrea Greig, PsyD, Jameson Hirsch, PhD, Amy Peterman, PhD, Denise Ross, PhD, and Mindi Thompson, PhD, In addition, Kipp Pietrantonio, PhD, who had been leading the project over the past several years as a member of CSES, elected to join the task force and Darren Bernal, PhD, joined as a current liaison for CSES. Cindy Juntunen, PhD, was appointed as task force chair.

## DEVELOPMENT PROCESS

The task force began meeting in spring of 2017 and continued meeting on a monthly to biweekly basis. CSES transferred all rough draft materials created to the task force. The task force reviewed established drafts and determined that due to overlap issues the original eight domain areas could be broken into four areas. After developing and writing the final working draft of the four domains, the task force invited three psychologists with expertise in social class measurement and SES and well-being to review the document. Two of those invited, Matthew Diemer, PhD, and Melanie Lantz, PhD, provided extensive feedback, which was integrated into the document prior to its initial submission for review by BAPPI, CSES, COPPS, and APA Office of General Counsel. Feedback and suggested revisions were provided by BAPPI and CSES, and those comments were all addressed prior to submission of the document for review by all boards and committees on the APA cross-cutting agenda in spring 2019.

## BOUNDARIES OF APPLICABILITY

These guidelines are limited in several important ways that are worthy of note. First, the guidelines are grounded in providing culturally competent care and not in changing or modifying one's social class position. Although it is excellent to provide care that aids individuals in raising their social class position, these guidelines are not designed specifically for this purpose. Second, the guidelines are not intended to stereotype or pathologize people who live in poverty. These guidelines speak to general themes pertaining to individuals living in LIEM conditions, but these themes are not universal and may or may not be applicable to all individuals. Finally, it is important to attend to intersectionality with other cultural identities when using these guidelines. Although the APA *Resolution on Poverty and Socioeconomic Status* identifies specific economically at-risk populations, it should be noted that each of these groups face unique challenges.

# Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization

# THE GUIDELINES

Nine guidelines are presented in four major domains: training and education, health disparities, treatment considerations, and career concerns and unemployment. Each guideline is presented with a rationale supporting the value or need for the guideline and an application section. The applications are organized by individual, community, and structural/policy applications. This multilevel approach is used to demonstrate the importance of attending to social context and policy, as well as individual concerns, when working with clinical, training, and research situations that are impacted by LIEM.

## Overview of the Guidelines

### DOMAIN 1: TRAINING AND EDUCATION

- Guideline 1: Psychologists strive to gain awareness of how their biases related to social class may impact the training and education they provide.
- Guideline 2: Psychologists are encouraged to increase their knowledge and understanding of social class issues, including poverty and wealth, through continuing education, training, supervision, and consultation.

### DOMAIN 2: LIEM AND HEALTH DISPARITIES

- Guideline 3: Psychologists strive to understand the contribution of economic and social marginalization to the substantial health disparities in our society.
- Guideline 4: Psychologists strive to promote equity in the access to, and the quality of, healthcare available for people from LIEM backgrounds.

### DOMAIN 3: TREATMENT CONSIDERATIONS

- Guideline 5: Psychologists acknowledge the presence of social class as a variable that is present in mental health treatment settings. Psychologists are encouraged to seek to a) understand how social class influences psychotherapists' ability to effectively engage clients in treatment, and b) attend to ways that social class differences manifest and impact the experience of mental health treatment for clients.
- Guideline 6: Psychologists aim to understand the barriers that prevent persons with low SES from better accessing mental health care and make efforts to alleviate these barriers when providing psychological interventions and/or creating mental health care delivery systems.
- Guideline 7: Psychologists strive to understand the common clinical presentations that may be more likely to occur among persons who are from LIEM populations and how best to address these in treatment settings.

### DOMAIN 4: INTERSECTION OF LIEM WITH CAREER CONCERNS AND UNEMPLOYMENT

- Guideline 8: Psychologists seek to understand the impact of social class on academic success, career aspirations, and career development throughout the lifespan.
- Guideline 9: Psychologists seek to understand the interaction among economic insecurity, unemployment, and underemployment and attempt to contribute to re-employment processes for individuals.

DOMAIN 1

# TRAINING AND EDUCATION

GUIDELINE 1

**Psychologists strive to gain awareness of how their biases related to social class may impact the training and education they provide.**

### Rationale

Psychologists often reside within a higher SES than the students they teach, clients with whom they work, and those who participate in research (Appio, Chambers, & Mao, 2013; Lott, 2002; Smith, 2005). The cultural mismatch between psychologists and those they teach has great potential for biases when interacting with students from low-income backgrounds (Liu, 2012; Smith, Foley, & Chaney, 2008). In addition, much of psychological theory has been developed and normed on middle- and upper-class populations (Liu, Pickett, & Ivey, 2007). The result is that the lived experiences of many psychologists may not reflect the lives of students from LIEM backgrounds nor the material being taught (APA, 2017). As psychologists engaged in training and education tend to inhabit jobs within universities and clinical training sites, they may be inherently distanced from people who are economically marginalized. This lack of exposure may perpetuate biases that are unbeknownst to even the most thoughtful psychologists (Smith et al., 2008). In this section of the guidelines, we discuss some of the biases that psychologists may hold pertaining to their own social class and the social class of their students.

#### OMISSIONS OF SOCIAL CLASS FROM PSYCHOLOGICAL EDUCATION

The first way that social class bias may present itself is simply through a lack of mention of the subject matter within the classroom or at a training site. The lack of discussion around social class differences, economic inequality, or poverty is a long-standing and deeply-rooted concern within the field (APA, 2017; Smith et al., 2008; Liu, 2010; Liu et al., 2004; Lott & Bullock, 2007). The effect is that students do not develop knowledge, or a critical lens, related to SES and social class issues. In addition, within clinical training sites, the lack of education related to multicultural competency with low-income people could result in less effective treatment, or even harmful effects for clients (APA, 2017; Appio et al., 2013; Kim & Cardemil, 2012; Liu et al., 2007). Psychologists who intend to increase their multicultural competence and cultural humility pertaining to SES are encouraged to be mindful of how the absence of these concerns within their teaching materials or supervision may reflect their own bias or lack of knowledge pertaining to the subject matter.

#### SYSTEMIC BIAS

Beyond omissions of social class material and consideration, there may also be systemic class bias built into educational environments. Some research indicates that low-income/first-generation college students tend to face more barriers than their more affluent counterparts. (Terenzini, Springer, Yaeger, Pascarella, & Nora, 1996; Thayer, 2000; Bui, 2002; Goldrick-Rab 2006; Ramos-Sánchez & Nichols, 2007). Within graduate psychology training, class-based discrimination may also exist. Unexpected or miscellaneous costs tend to add up and have a greater impact on those from LIEM backgrounds. Textbooks costs, assistantship funding, costs related to practicum sites, dissertation credit hours while on internship, costs of applying and moving for clinical internships, and costs of assessment materials are just a few examples of these unexpected costs that many low-income students may not be aware of when beginning their training (Doran, Kraha, Marks, Ameen, & El-Ghoroury, 2016; Pietrantonio & Garriott, 2017, Lantz & Davis, 2017).

#### INTERPERSONAL BIAS

In addition to systemic biases, many low-income students may face interpersonal classism and microaggressions within the student-teacher/supervisor-supervisee interaction. The first and most straightforward bias is that of an overt classist attitude. This attitude consists of the belief that students from low-income backgrounds are somehow less equipped, ill prepared for learning, or simply are not as invested in education compared to their more affluent counterparts. This can create a self-fulfilling bias with educators who may not invest as much time and energy into low-income students (Hauser-Cram, Sirin, & Stipek, 2003). In addition, students who face classism endorse feelings of not belonging, worse psychosocial outcomes, and an increased desire to leave the university (Langhout, Drake, & Rosselli, 2009).

Instructors may also engage in this bias when evaluating the work of low-income students. For example, a university student may not complete an online assignment due to having low technology literacy because they attended a low-income high school or never owned a personal computer. The instructor who falls prey to this bias may falsely attribute this incomplete assignment to irresponsibility or a lack of investment in the class. This bias not only sheds a negative light on the individual but, also, does not allow the instructor to meet the real educational needs of the student. Lott and Bullock (2007) report that psychologists who come from low-income backgrounds themselves may be more susceptible to this type of bias due to their own successful experiences of transcending poverty; that is, there may be an *I did it, so why can't you?* attitude that contributes to this bias. These psychologists may be less likely to attribute their own success to luck or systemic factors and more likely to attribute this to their own work ethic or innate abilities.

### UPWARD MOBILITY BIAS

Another bias is the upward mobility bias (Liu et al., 2004), which is defined as the belief that all people are interested in raising their social class or adopting middle/upper class values. Psychologists are especially susceptible to this bias due to the educational attainment needed within the field (e.g., doctoral degree). This bias can best be presented as a belief system positing that if one is not pursuing upward social class mobility within society, they must be lazy, incompetent, or a poor decision maker.

In addition to a classroom setting, upward mobility bias can also impact supervision and training within practicums, while on doctoral internship, or at the post-doctoral level of training. For instance, a supervisor may over-emphasize the importance of a client staying in school or holding a high-status job even when it may go against the client's value system. They may also assume concepts such as upwards mobility, the want for a higher salary, or the desire to secure a higher social status as motivators for clients when they are not. Supervisors might strive to attend to upward mobility bias and how it may contribute to a misinformed conceptualization of a client during supervision.

### IDEALIZATION BIAS

Another bias is the idealization of individuals who are poor (Liu et al., 2007) as hard-working underdogs pursuing the American dream. Although this stereotype is positive, it can also paint students from LIEM backgrounds in a false light, which may undermine their needs. The first issue is the assumption that poverty, somehow, has value in society and provides low income people with a can-do work ethic. Similar to the just world belief (see Appendix B), this assumption asserts that life provides a trade-off to those unfairly born into poverty (Lerner, 1980; Smith, Mao, Perkins, & Ampuero, 2011), perhaps manifesting as the thought, *You may have been born poor, but you learned to be a hard worker, so life is fair.* Second, this bias portrays poverty as something that can be transcended through pure will power and ignores systemic constraints that keep people in poverty. This romanticizing is often displayed in American media and falsely portrays poverty as something of value. Underlying this assumption is the false belief that those in poverty do not work hard and those who do work hard are not impoverished. Although work ethic can often play a role in economic success, this ignores situations such as inherited wealth or poverty as a result of vocations being outsourced or replaced by technology. The belief that poverty is a choice in this manner disregards significant systemic factors. Third, this bias puts an expectation on poor people to work harder than those not in poverty and instills an (often false) insistence that this work will result in the transcendence of economic conditions (Kraus & Tan, 2015).

### CLASS BLINDNESS BIAS TOWARD STUDENT FINANCIAL CONCERNS

Another potential bias may occur when instructors and supervisors are not aware of some of the daily financial difficulties faced by students from LIEM backgrounds. As examples, class fees, parking costs, on-campus healthcare costs, required unpaid teaching assistant, research assistant, and practicum positions, the need to take continued dissertation credits while on internship, and dissuading students from working outside of their graduate program may have a greater impact on students from low-income families (Doran et al., 2016; Pietrantonio & Garriott, 2017; Lantz & Davis, 2017). In addition, what may be considered relatively minor problems for affluent students, may be devastating for students from LIEM backgrounds. Issues such as car repair, rising tuition costs, delayed receipt of financial aid, or the loss of a part-time job may be enough to put a low-income student's educational future in jeopardy. Recognition of, and familiarity with, this discrepancy of impact is an area worthy of examination for those psychologists wanting to decrease their social class bias.

In the United States, cumulative student debt has now surpassed $1.3 trillion and the cost of post-secondary education has increased by 250% in the past 30 years (Johnson, Van Ostern, & White, 2012). Within graduate education in psychology, the average student loan debt incurred by students is now over $100,000 although the average starting salary has remained stable at slightly over $60,000 (Doran et al., 2016). Some research has shown that training programs and professors tend to avoid discussing student debt concerns with their students (Olson-Garriott, Garriott, Rigali-Oiler, & Chao, 2015). This aversion to discussing student debt can be damaging, as those from low-income backgrounds tend to have lower financial literacy (Chen & Volpe, 2002; Xu & Zia, 2012; Pietrantonio & Garriott, 2017). Faculty must be cautious about discussing the specific financial concerns of students, in order to avoid dual relationships or violation of privacy. However, the aversion to discussing financial and debt concerns more generally with students, or even the failure to recognize this as a salient professional issue, can have a negative effect, potentially allowing students to make financial choices that could negatively affect them across their lifespan (Lantz & Davis, 2017).

#### Individual Application

In order to address the bias of omission, psychologists may want to perform a content analysis of their teaching materials, examining them for appropriate inclusion of LIEM issues. This can include both focusing on examining potential biases within material being presented and looking for space in which omitted materials focused on social class could be introduced. The types of educational experiences and class work provided can also be examined. As research has indicated that students from low-income backgrounds tend to struggle with classrooms that value independence over interdependence, creating assignments and in-class activities that emphasize interdependence can be valuable (Terenzini et al., 1996), including in-class discussions, group assignments, group research projects, and in-class group exercises, which incorporate inclusive psychological principles. Psychologists may also want to be aware of how classroom assignments may unintentionally advantage wealthy students while disadvantaging low-income students. As examples, giving assignments that require attending an event that costs money, homework that can be more effectively or efficiently completed with expensive software and technology, use of a graphing calculator in a statistics class, choice of an expensive textbook, or assignments that require color printing may all differentially impact

low-income students. In addition, psychologists can implement social class issues in supervision discussions with relative ease, alongside other cultural variables. Asking supervisees to assess for social class variables and to examine differences between themselves and their clients pertaining to SES may raise class awareness for both the supervisor and supervisee. For additional resources, a curriculum of social class related teaching materials and exercises can be found on the Office of the Committee on Socioeconomic Status' webpage at https://www.apa.org/pi/ses/resources/publications/classroom-exercises.

Psychologists who strive for increased social class competence are encouraged to first look inward, examining, honestly and earnestly, their own biases related to social class. An excellent place to begin this work is by having discussions with colleagues and in peer supervision groups. Engaging in cultural dialogues that focus on one's own social class, and hearing the experiences of others' social class stories, can be very helpful in providing a baseline level of awareness related to social class privilege and identity development. These approaches can directly counteract the impact of interpersonal biases. In addition, self-education regarding social class issues can be valuable in reducing sources of bias related to upward mobility and idealization bias. Books such as *Psychology and Economic Injustice: Personal, Professional, and Political* (Lott & Bullock, 2007) and *Social Class and Classism in the Helping Professions: Research, Theory, and Practice* (Liu, 2012) provide an excellent introduction to social class in psychology. It can also be helpful to examine literature from other fields such as sociology, social work, anthropology, and economics, which have done extensive work on class differences and economic marginalization. In addition, volunteer work with organizations that serve low-income populations can help reduce distance between psychologists and the economically disenfranchised within their communities. Volunteer work with LIEM populations has been shown to be more effective in eliminating biases when volunteers adopt a reflective stance about the impacts of social class and how it (and other intersecting social forces) shaped those communities (Mitchell, 2008).

**Community/Structural Applications**

Pursuing continuing education opportunities that focus on social class issues within the field can help psychologists address community-level applications. These opportunities allow psychologists to form networking relationships with other psychologists and to learn more about community resources. For example, each year, a range of trainings with both individual and community level relevance are offered at the APA convention through OSES. Similarly, APA Division 9: Society for the Psychological Study of Social Issues; APA Division 17: Society of Counseling Psychology; and APA Division 45: Society for the Psychological Study of Culture, Ethnicity and Race, regularly provide programing related to working with LIEM populations.

In terms of inclusivity of social class in research, raising students' awareness of SES concerns in research can be very valuable, and might involve reading relevant literature or integrating such issues existing in multicultural inclusivity materials presented in a research methods course. Teaching students how to effectively measure SES variables can also be valuable. Diemer and colleagues (2013) provide an excellent starting point in their article, *Best Practices in Conceptualizing and Measuring Social Class in Psychological Research*. One skill is to teach students to have their measurement choice informed by the type of social class information they are attempting to collect (e.g., subjective experience of social class compared to others, objective data points that indicate social class, relative social class variable for a specific community). Finally, students might strive to be aware of cultural sensitivity and the potential for exploitation in studying economically marginalized populations. Specifically, that financial incentives and power differentials may be more likely to have an adverse impact on the economically marginalized.

As noted previously, reducing the cognitive distance between the lives of psychologists and the lives of low-income students can be helpful in reducing class bias. This can start with simple curiosity and affirmation pertaining to the lives of students from low-income backgrounds (Pietrantonio & Garriott, 2017). Being open and affirming when students raise social class concerns can create an environment in which economically marginalized students can succeed. In addition, becoming involved with first-generation college student organizations and higher education programs designed to help students from marginalized backgrounds can be helpful in identifying common themes that students from LIEM backgrounds struggle with at the institution (e.g., Upward Bound, Young Scholars, McNair Scholars).

It can be valuable for psychologists to familiarize themselves with the costs of education and financial aid resources, both on campus and on a national level. Specifically, in a psychology department, normalizing the behavior of professors familiar with financial aid procedures and policies can be helpful for low-income students. Having financial aid officers speak to departmental staff and faculty about options and resources available to students can be a valuable systemic intervention (Lantz & Davis, 2017; Pietrantonio & Garriott, 2017). There are also opportunities to engage in the national student debt conversations, through avenues promoted by groups such as the American Psychological Association of Graduate Students. Doctoral, internship, and postdoctoral training programs can also examine practices that contribute to financial strain and replace them with more affordable practices. For example, onsite interviews may be replaced with high quality videoconferencing meetings at a relatively low cost for programs, dramatically reducing travel and application costs for applicants.

GUIDELINE 2

**Psychologists are encouraged to increase their knowledge and understanding of social class issues, including poverty and wealth, through continuing education, training, supervision, and consultation.**

### Rationale

Providing training, supervision, and consultation that supports the continuing education of practicing and future psychologists in issues related to LIEM communities may help address the need for mental health services (APA, 2000). Further, formal training in social class issues is important for psychologists because research suggests that while there is a demand for mental health services in low-income communities, social class bias from psychologists may negatively affect their access to treatment. For instance, Smith Mao, Perkins, and Ampuero (2011) found that graduate psychology majors had negative impressions of lower-income clients when compared to higher-income clients that were described in vignettes. Relatedly, Thompson, Cole, and Nitzarim (2012) found that lower-income clients thought that their therapists could not identify with their problems or stressors because of social class differences.

Thus, when future and practicing psychologists are not aware of the impact of poverty on clients' lives, they may inadvertently demonstrate social class bias in the form of withholding access to effective treatments and/or services, which can inhibit effective treatment outcomes for clients who are already placed at a greater risk for depression and other mental health conditions associated with poverty. To address the issue of systemic barriers and social class bias for lower-income clients, APA (2000) resolved in its *Resolution on Poverty and Socioeconomic Status* to, "...encourage in psychological graduate and postgraduate education and training curricula more attention to the causes and impact of poverty, to the psychological needs of poor individuals and families, and to the importance of developing cultural competence and sensitivity to diversity around issues of poverty in order to be able to help prevent and reduce the prevalence of poverty and to treat and address the needs of low-income clients."

### Individual Applications

In terms of individual applications, the authors recommend working with trainees to incorporate a worldview that recognizes the difficulties that LIEM populations face. The Social Class Worldview Model (Liu, 2012) provides a model to help professors and consultants teach psychologists about social class. In this model, trainers teach trainees to explore their own social class bias by engaging them in increasingly more complex discussions of classism, the trainees' own social class values and experiences, socialization messages they have received related to social class, and, finally, their own worldview of social class.

In addition to dialogues related to social class, there are several training activities that can help raise social class awareness. Assigning readings that focus on social class issues and engaging in classroom activities that raise awareness of social class differences can be powerful experiences for developing psychologists. A large list of resources, suggested course content, and classroom activities is available in the *Report of the APA Task Force on Resources for the Inclusion of Social Class in Psychology Curricula* (APA, 2017).

### Community/Structural Application

Educational programs and environment can also be shaped to better train clinicians in terms of SES competency. In terms of curriculum, there are several recommended competencies to prepare psychology professionals for practice with LIEM populations. These include: a) developing a professional identity that includes social class awareness; b) engaging relationship skills, including affective expression and conflict management, with clients from LIEM backgrounds; c) increasing and maintaining knowledge of social and economic issues experienced by clients from LIEM backgrounds; d) measuring social class in research; e) adapting evidence-based practices; f) incorporating practical experiences in training settings; and g) administering and advocating at the systems level (Stabb & Reimers, 2013). Additionally, training programs can help trainees become aware of factors that produce stress for lower-income clients, rates of poverty over time, the intergenerational nature of poverty, and the relationship of poverty to national trends in their communities.

Liu (2012) suggests that trainees receive supervision in settings with clients who have varying social class backgrounds. In these settings, trainees can learn clinical practice with different populations while also learning about their own values related to social class. By supporting psychologists through this process, trainers can help them identify and respond appropriately to negative social class stereotypes in practice while providing a context for them to develop a worldview that includes clinical practices that do not contain social bias. Further recommendations for treatment can be found in Domain 3: Treatment Considerations.

In addition, psychologists are encouraged to take SES issues into account when teaching research methods, especially concerning sampling. Teachers should encourage students to be thoughtful of whether their samples are inclusive of LIEM populations and the potential impacts of either including or not including this group on the results of research. Students should also be thoughtful of the impact of their research on communities. Students should be encouraged to use their research to support economically marginalized communities when possible and to mitigate against economic exploitation and harm that could be by-products of research. Finally, training programs are strongly encouraged to be intentional about the way that they introduce SES as a multicultural topic to students. Due to the historical neglect of this topic within the field, being thoughtful of how and when this topic is introduced to students is of critical importance. The authors recommend that SES issues be discussed early in multicultural training and as a unique component of identity that has been disentangled from other cultural variables.

DOMAIN 2

# LIEM AND HEALTH DISPARITIES

GUIDELINE 3

**Psychologists strive to understand the contribution of economic and social marginalization to the substantial health disparities in our society.**

### Rationale

Beginning with the landmark Whitehall studies (Marmot et al., 1991), strong evidence has developed for a graded-inverse relation between economic status and health. That is, the impact of SES on health does not follow a threshold model that would indicate SES only contributes to poor health in people with the fewest economic resources (e.g., those living below the federal poverty guidelines). Rather, the association between SES and health is an inverse gradient (Adler & Ostrove, 1999; Evans, Wolfe & Adler, 2012) that can be visualized as a ladder, with those on a higher step tending to have better health than those on a lower step, regardless of where in the ladder they are. Thus, psychologists are advised to consider the potential negative impact of SES on the health of all patients, not only those who are living in poverty.

Modern research and theory posit lower SES as a causal and/or exacerbating factor for the spectrum of mental and physical disease, ranging from stress to psychopathology, and from communicable diseases to chronic illnesses, such as HIV, cancer, and cardiac disease, to early mortality (APA, 2016; Adler & Stewart, 2010; Denning & DiNenno, 2010; Evans et al., 2012; Ruiz, Prather, & Steffen, 2012). As a broad example, the poorest states in the United States have lower life expectancies and higher rates of morbidity and mortality than the richest states; in fact, more than half of the countries in the world have a longer life expectancy than the poorest U.S. state (Egen, Beatty, Blackley, Brown, & Wykoff, 2016). Evidence specific to mental health similarly demonstrates an inverse relationship between socioeconomic position and the prevalence or incidence of a broad array of mental health disorders among adults (Sareen, Afifi, McMillan, & Asmundson, 2011), as well as children and adolescents (Reiss, 2013).

Multidisciplinary efforts have demonstrated that LIEM status contributes to health disparities through a variety of mechanisms. These generally fall into four basic categories: 1) substantially greater acute and chronic stress, with concomitant negative psychological and physiological (e.g., neuroendocrine, immune) consequences (e.g., Grunewald, et al., 2012; Matthews & Gallo, 2011); 2) greater exposure to unhealthy environmental factors including pollution in its various forms, damaged infrastructure (e.g., the built environment), social tension, crime, and other violence (Schüle & Bolte, 2015); 3) poorer health behaviors, including fewer opportunities to engage in health promoting behaviors such as affordable healthy food options and safe, accessible places to exercise (Nandi, Glymour, & Subramanian, 2014); and 4) lower levels of access to quality healthcare including prevention programs, medication, quality care, specialty services, and tertiary care options (Allen, Wright, Harding, & Broffman, 2014; Arpey, Gaglioti, & Rosenbaum, 2017), the lack of which may also contribute to downstream effects on health literacy, another known contributor to health disparities (Mantwill et al., 2015).

The impact of these mechanisms can be quite pervasive, as growing up in a LIEM household can contribute to lifelong negative health consequences, regardless of a person's SES in adulthood (Evans, 2004; Johnson, Riis, & Noble, 2016). Indeed, the negative impact of these factors is likely cumulative over time (Crystal, Shea, & Reyes, 2017) and, as a result, older adults who have been exposed to these factors over decades would be at particularly high risk for physical and mental disease (Kwon & Park, 2017). Psychologists can strive to recognize how a marginalized social environment can be developmentally damaging (Shonkoff et al., 2012), leading to difficulties in interpersonal functioning (e.g., thwarted belongingness; Ruscio, et al.,), cognitive-emotional processing and regulation (e.g., distress, hopelessness; Fry, Langley, & Shelton, 2017), and cognitive-intellectual ability (Johnson et al., 2016).

A potentially explanatory, conceptual model has been advanced by psychologists Miller and Chen (2013; Miller, Chen & Parker, 2011). It posits that exposure to SES disadvantage in childhood may result in: a) social (e.g., poor nurturance) and physical (e.g., toxin exposure, violence) risk factors during sensitive periods in childhood; and b) consistent behavioral responses (e.g., threat sensitivity, unhealthy lifestyle factors) that can continue into adulthood. These disadvantages interact with epigenetic factors to produce a stable, pro-inflammatory phenotype that predisposes children to greater burden of chronic mental and physical disease in adulthood. Importantly, their model also investigates sources of resilience that may buffer the negative consequences of a low SES environment during childhood. These include maternal nurturance (Chen, Miller, Kobor, & Cole, 2011) and a positive family emotional climate (Miller & Chen, 2010). Unfortunately, although a healthy family environment can ameliorate the effects of poverty on children, poverty exerts significant stress on families (Jackson et al, 2016). As a result of the higher levels of external stressors that come in this context, low-income individuals experience significantly higher rates of relationship distress, family instability, and Intimate Partner Violence (Cunradi, Caetano, & Schafer, 2002; Bramlett & Mosher, 2002; Lundquist et al., 2013). These challenges make it difficult to establish the necessary positive and stable family environment. This is a cumulative, intergenerational problem that necessitates recognition, more research, preventative work, and direct intervention. Such research is highly significant, as it helps to avoid over-pathologizing all low-SES families and acknowledges the importance

of psychosocial resources for buffering SES-related challenges.

It is important to recognize that the burden of having a LIEM status includes not only the strain of limited resources, but also the associated stigma and the internalization of marginalization. Indeed, a recent meta-analysis demonstrated that measures of subjective social status have incremental predictive validity for physical health over and above the variance that is explained by objective measures such as income and education (Cundiff & Matthews, 2017).

In summary, a plethora of previous research indicates that a LIEM background is a substantial risk factor for an array of physical and mental health problems, including earlier mortality, over and above the effects of other contributing factors. Psychologists are encouraged to increase their awareness of the many barriers to health promotion and maintenance related to the mechanisms identified above.

### Individual Application

Psychologists strive to respect the client's priorities, including as they occur within the context of SES and barriers, and to gain an understanding of the role of sociocultural determinants in the development and maintenance of mental and physical illness. When appropriate, through psycho-education and therapeutic exploration, psychologists can help the client understand: a) how historical, socially-constructed, and intergenerational forces can impact health; b) how psychological and physical health are intertwined; and c) how mental health care can facilitate better interpersonal and role functioning, general well-being, and health-related quality of life. In addition, psychologists can acknowledge the client's individual needs and the barriers that may interfere with successful engagement with treatment and strive for consistent, yet flexible, treatment within the context of the client's life parameters (e.g., scheduling, childcare, and transportation challenges; sliding scale fees; and stigma reduction). In this respect, the psychologist may collaborate in an interdisciplinary and integrated fashion with social work, nursing, public health, and medical colleagues to optimize access to, and receipt of, quality care, including recommended psychological intervention.

There are several excellent resources for enhancing one's ability to implement these recommendations to specifically address SES an social class, including *Social Class and Classism in the Helping Professions: Research, Theory, and Practice* (Liu, 2012) and *Psychology, Poverty and the End of Social Exclusion: Putting Our Practice to Work* (Smith, 2013). Other texts, such as *Addressing Cultural Complexities in Practice* (Hays, 2016) and *Cultural Humility: Engaging Diverse Identities in Therapy* (Hook, Davis, Owen, & DeBlaere, 2017), provide information and guidance for considering LIEM status in intersection with other marginalized identities.

### Community/Structural Application

Psychologists who want to help reduce health disparities can be thoughtful regarding how they can improve their work environment to better meet the needs of LIEM populations. Psychologists are encouraged to share their knowledge of the barriers faced by individuals from LIEM backgrounds (e.g., unreliable transportation, difficulty leaving work for medical appointments) with other healthcare providers. This knowledge can increase empathy and understanding for the difficult choices (e.g., not seeking care due to lack of transportation or lack of money for a co-pay) that low-income people must often make due to insufficient resources and limited alternative options for care. In turn, such knowledge and empathy may help to minimize the potential for providers to stigmatize patients because of the providers' own frustration and lack of understanding of the challenging contexts within which their patients live.

The movement within the field toward integrated healthcare produces unique opportunities to provide competent care for LIEM populations (Farber, Ali, van Sickle, & Kaslow, 2017; Hodgkinson, Godoy, Beers & Lewin, 2017). Although receipt of primary care can also be a challenge for individuals who are LIEM, the availability of safety-net medical clinics and federally-qualified health centers, as well as expanded insurance options resulting from the Affordable Care Act (ACA), provide some enhanced opportunity for medical care. In addition to allowing greater accessibility for a wider range of patients, such integration helps to decrease the stigma associated with seeking help from a psychologist or other mental health provider (Shim & Rust, 2013). Indeed, decreased stigma is a primary principle of integrated care: that is, physicians provide a warm handoff of the patient to a psychologist with a clear, biopsychosocial explanation for the role played by that provider in enhancing health and well-being. Yet, it is important to recognize current legislative limitations that might preclude patients from LIEM populations from receiving adequate care. For example, for older adults, low reimbursement rates may dissuade providers, particularly mental health providers, from treating patients with Medicare (Boccuti, 2016) and, further, Medicare does not provide coverage for all services often needed by older adults such as dental care and hearing aids (U.S. Centers for Medicare & Medicaid Services, 2019). Such systematic, policy-level factors restrict older adults' access to necessary services, particularly in those patients who cannot afford supplemental insurance coverage.

Psychologists who work in educational, service, or policy settings can dedicate effort to increasing their students' and the public's knowledge about the potential health risks related to growing up in, or living in, LIEM areas and circumstances. The United States spends a far greater proportion of its gross domestic product on health care than other countries, even though we rank 31st in life expectancy behind almost all other economically developed nations in the world (Papanicolas, Woskie, & Jha, 2018). Psychologists can play an important educational and advocacy role by promoting understanding of, and facilitating change to reduce, the negative health consequences of income-related structural and environmental factors in health.

GUIDELINE 4

## Psychologists strive to promote equity in the access to, and the quality of, healthcare available for people from LIEM backgrounds.

### Rationale

Access to quality health care for physical and mental illness is inextricably woven with socioeconomic status. Much of this

association is the result of being underinsured or lacking insurance coverage, as well as spiraling costs of co-pays and deductibles. Although insurance coverage was improved by such efforts as the ACA, near-poor (23.9%) and poor (26.2%) members of the U.S. population were more likely to be uninsured than those who are not poor (7.7%; Martinez & Ward, 2016). Data are similar for children in the United States; in 2017, among children 0–17 years old, non-poor children (3.7%) were less likely to be uninsured than nearly-poor (7.2%) and poor (6%) children and adolescents (Cohen et al., 2018). Regarding mental health, some states did not comply with the ACA guidelines to expand Medicaid coverage as part of the ACA, and subsequently have penalized those with mental health needs. For instance, low-income, uninsured persons are 30% less likely to obtain mental health treatment than their Medicaid-insured counterparts (Han, Nguyen, Drope, & Jemel, 2015), which may particularly disadvantage young adults, who fall into a gap between parental coverage and excessive premiums (Palmer, 2016).

Although poverty-based lack of insurance coverage is an important, direct contributor to lack of access, LIEM also contributes indirectly to poor health care. For instance, results from the National Health Insurance Survey (Martinez et al., 2018) indicate that poor and nearly-poor persons are less likely than non-poor persons to have either a regular source of health care provision or opportunities for preventive care or early detection.

The difference between health care available to people with higher- vs. lower-SES includes not only access to early screening and detection opportunities, but also differences in the range and quality of care received. For example, people of color, who are typically more economically disadvantaged than white people, receive fewer medical procedures and poorer quality medical care than whites (Williams & Wyatt, 2015). Other research has demonstrated that impoverished persons, as well as African American and Hispanic persons in the lowest-quintile SES group, receive less nephrological care for kidney disease (Nee et al., 2017), and poorer children with cancer receive fewer medical screenings and less care during their treatment regimen (Caplan et al., 2016).

There is often a lack of consensus on how to address mental health care needs in economically-marginalized groups given the frequent presence of poor health literacy and stigmatized beliefs regarding mental illness. In addition, disparities arising from low education and lack of employment resulting from gender and/or race and ethnicity disparities, or due to disadvantageous location (e.g., rural areas), also deleteriously impact knowledge and understanding of health care resources (Adler et al., 2016).

Overall, in contrast to those in higher-SES conditions, socioeconomically marginalized persons may not have access to appropriate care, may have limited choices of care options, may not have adequate personal or public transportation, may require longer waits, and may receive lower quality care (James, 2017). Additionally, persons from LIEM backgrounds may be unable to afford required copays and deductibles (Adler et al., 2016). Such patterns of disparity are critical to recognize, as evidence demonstrates that access to, and quality of, care contribute to disparities in disease severity at diagnosis, quality of condition management, and subsequent morbidity, recovery, and mortality (Adler et al., 2016; AHRQ, 2018; Moscelli, Siciliani, Gutacker, & Cookson, 2018).

### Individual Application

Prevention and intervention efforts may need to be altered for persons from LIEM backgrounds. Intervention efforts, including flexible scheduling (e.g., nights and weekends), brief interventions within integrated health care settings, and alternative delivery methods (e.g., telehealth) that may make mental health treatment more accessible are described in the treatment domain of these guidelines (see Domain 3). Short-term, trans-diagnostic treatments have been shown to be effective in primary care settings (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010), which may be more accessible to LIEM persons needing treatment for substance abuse, anxiety, and depression. In addition, prevention efforts are needed to better understand population-level and individual-level barriers to health care. For example, the development of multi-method assessments to identify barriers can be useful to highlight problematic access issues, including income, that stand in the way of service seeking and delivery. Combinations of qualitative inquiries with quantitative surveys across diverse groups of consumers and potential consumers of psychological service would provide valuable insight into the factors that facilitate and limit usage. Assessment methods may be modified for use with low literacy populations and using localized idioms of distress may help ensure reliability and validity (Kohrt, Luitel, Acharya, & Jordans, 2016). Yet, it is important to recognize that assessment and treatment can be deleteriously impacted by LIEM status and its correlates, including educational disparities. For example, comprehension of, and responses to, diagnostic questionnaires and assessments and treatment paradigms may be predicated on the duration and quality of education, which is often limited for persons from LIEM backgrounds (Newell & Coffee, 2012).

### Community/Structural Application

Psychologists are encouraged to attempt to improve equity in access to physical and mental health care across settings, including within their practice and institutions, and advocate for policies that promote equity for all, regardless of socioeconomic conditions. At the practice and institutional levels, practitioners are encouraged to support pro-equity economic procedures such as sliding scales and pro bono work, when feasible, and advocate for within-institution policies to support equity in both access to and quality of care. Such actions are challenging to implement, but psychologists are encouraged to consider how they can work within the boundaries of third-party payer regulations and requirements to increase access to uninsured and under-insured individuals through flexible pay scale options. Identifying a manageable proportion of low-cost and pro bono services can be developed as part of an agency or practice business plan, and services can be made more accessible through telepsychology or remote service delivery. Psychologists are also encouraged to educate fellow practitioners, educators, and policy makers within their institution on the rationale for

pursuing equity, including the link between socioeconomic status, access, and health disparities, and the societal benefits of a healthier population.

At the broader regional and political levels, psychologists may want to use their knowledge of these issues to raise awareness and advocate for change in systemic mechanisms that would not only mitigate the effects of poverty on health, but also eradicate poverty altogether (Brenes & Wessells, 2001). For example, efforts may include raising public awareness via psycho-education, public messaging, and community outreach; supporting research to identify key factors that moderate and mediate the effects of poverty on health-care access; engaging in the development and validation of interventions that are affordable, sustainable, and flexible in their delivery; and advocating for policies that advance the goal of economic and health care equity.

Given that persons from LIEM backgrounds, who are often most in need of mental health care, also have the most difficult time accessing such services, community strategies to increase access can be critically important. One suggestion, which is applicable for both rural and urban impoverished persons, is to utilize primary care services, including pediatric primary care, as a line of first defense against mental illness, given that medical settings are the largest catchment area for those with psychiatric needs (Hodgkinson et al., 2017), particularly for African Americans (Hudson, Kaphingst, Croston, Blanchard, & Goodman, 2016).

DOMAIN 3

# TREATMENT CONSIDERATIONS

Though empirical evidence resoundingly demonstrates that psychotherapy is beneficial for most clients (Wampold & Imel, 2015), documented disparities in treatment utilization and outcomes exist for clients from lower-income groups as opposed to higher-income groups (e.g., Nadeem, Lange, & Miranda, 2009; Siefert et al., 2001). Until relatively recently, much of the limited psychotherapy literature related to client income focused on treatment dropout. Results suggested that psychotherapy clients from LIEM backgrounds have higher attrition rates relative to their middle- to upper-class counterparts (Miranda, Azocar, Komaromy, & Golding, 1998; Siefert et al., 2001). Additionally, research using secondary analyses of data from randomized clinical trials (RCTs) has demonstrated that patients from lower, as opposed to upper, social class backgrounds have decreased treatment gains from psychotherapy (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Organista, Munoz, & Gonzalez, 1994). For example, results from one study (Cohen et al., 2006) demonstrated that older adults who occupied low-income census tracts responded less to treatment and reported greater incidences of suicidality at its conclusion than their counterparts who occupied higher-income census tracts. Interested readers can find additional studies in Appendix B. The prevailing pattern of findings indicate that SES and financial difficulties impact the delivery and efficacy of psychological treatment, often resulting in difficulties accessing and remaining in care, receiving appropriate care, and manifesting expected benefits from psychological services. As such, psychologists are strongly encouraged to address these areas in their treatment endeavors.

GUIDELINE 5

**Psychologists acknowledge the presence of social class as a variable that is present in mental health treatment settings. Psychologists are encouraged to seek to a) understand how social class influences psychotherapists' ability to effectively engage clients in treatment, and b) attend to ways that social class differences manifest and impact the experience of mental health treatment for clients.**

### Rationale

Results from quantitative (e.g., Falconnier & Elkin, 2008; Smith et al., 2011; Thompson et al., 2014) and qualitative (e.g., Balmforth, 2009; Chalifoux, 1996; Thompson et al., 2012) investigations have demonstrated that both clients and therapists notice markers of income and social class within the context of psychotherapy. Indeed, one explanation for disparities in treatment outcomes, purported by some (e.g., Appio et al., 2013; Ballinger & Wright, 2007; Bullock, 2004; Lott, 2002; Smith, 2005), is that psychologists hold biases toward individuals who are from LIEM backgrounds. There is some historical evidence to support this assertion, including expressions that clients from LIEM backgrounds are less introspective (Gould, 1967) and have "lower estimated intelligence" (Brill & Storrow, 1960, p. 343) and more severe symptoms (e.g., Abramowitz & Dokecki, 1977; Trachtman, 1971) than their counterparts from higher incomes. In 1996, Schnitzer suggested that psychotherapists pass along stories about clients from low-income backgrounds that reveal unexamined classist assumptions, including: "they don't come in" (p. 572), "they're so disorganized" (p. 574), and, "they don't care" (p. 575). Although limited empirical evidence to support the assertion exists, scholars have argued that clients who hold multiple minority identities (e.g., a client who is from a LIEM background and is a lesbian woman or woman of color) may face double or triple jeopardy (Cole & Omari, 2003; Thompson, Chin, & Kring, 2019).

More recent results from a series of vignette-based quasi-experimental studies (Dougall & Schwartz, 2011; Smith et al., 2011; Thompson et al., 2014; Thompson et al., 2019) with therapists or therapists-in-training, however, reveals a mixed pattern of findings regarding the presence of therapist biases. Taken together, this research demonstrated that mental health practitioners notice social class differences in hypothetical clients and vary in the extent to which such perceived social class differences impact their overall perceptions of clients.

Current or former psychotherapy clients who identify as low-income or working-class report being aware of class-related characteristics of their therapists (e.g., Balmforth, 2009; Chalifoux, 1996; Thompson et al., 2012). Most of these clients perceived their therapists to be middle class due to their education level and occupation, as well as environmental cues such as their dress, office decor, and vocabulary (Appio et al., 2013; Baker, 1996). For some clients, these evident differences in social class contributed to their beliefs that their therapist could not adequately understand and empathize with them (Balmforth, 2009; Chalifoux, 1996), but other participants have reported forming effective relationships in the face of perceived differences in social class (Thompson et al., 2012).

### Individual Application

Given that social class differences can introduce conscious and unconscious bias into a psychotherapist's clinical judgment (Sue & Lam, 2002; Liu et al., 2004), psychologists are encouraged to examine how such biases may negatively affect treatment (Gelso & Mohr, 2001; Ward, 2005). Qualitative interviews with licensed mental health practitioners highlighted the presence of a variety of emotional reactions that therapists have to client social class and social class-related conversations in therapy, including feelings of guilt, anger, sadness, and fear (Thompson et al., 2015). Psychologists are, therefore, encouraged to be attuned to their own reactions that emerge in psychotherapy. Specifically, psychologists should reconsider how their own beliefs about LIEM may be negatively affecting their ability to form an effective therapeutic relationship with a client. This includes awareness of their own social class beliefs, assumptions, and worldview (e.g., Liu et al., 2004; Thompson et al., 2015). Case consultation, supervision, and team approaches to treatment are three mechanisms that may facilitate opportunities for psychologists to examine their experience of countertransference toward their clients that may otherwise negatively impact treatment (e.g., Holmes, 2006; Ward, 2005).

The ability of the therapist to form an effective working alliance is key to addressing disparities in psychotherapy outcomes with clients from varying social class backgrounds. The role of the therapeutic relationship in contributing to treatment outcomes has been well-documented in the psychotherapy literature (e.g., Frei & Peters, 2012; Holdsworth, Bowen, Brown, & Howat, 2014; Horvath, Del Re, Flűckiger, & Symonds, 2011). Some evidence (e.g., Falconnier & Elkin, 2008; Thompson et al., 2012) also suggests that fostering a strong working alliance may be a critical component to engaging clients from LIEM backgrounds in treatment. Psychologists are encouraged to attend to social class-related cues and indicators from clients and to address social class-related topics in treatment.

### Community/Structural Application

Psychotherapy researchers focus on characteristics of the psychotherapist as a contributor to client treatment outcomes. Baldwin and Imel (2013) defined therapist effects as "the effect of a given therapist on patient outcomes as compared to another therapist" (p. 260) and meta-analytic evidence has demonstrated that therapist effects explain significant variance in treatment outcomes. For examples, therapist effects have implications for outcomes for individuals from diverse racial/ethnic groups (Imel et al., 2011) and for clients who reported greater levels of financial distress (Thompson, et al., 2018). Specifically, in a naturalistic study the risk of early attrition for clients with higher baseline financial distress was attenuated (or amplified) depending on the therapist (Thompson et al., 2018).

Psychologists are encouraged to actively address social class as a cultural variable in psychotherapy training (e.g., Bullock, 2004; Lott, 2002; Smith, 2005; Smith et al., 2011; Thompson et al., 2014). Indeed, themes from qualitative interviews with clinicians (i.e., Smith, Li, Dykema, Hamlet, & Shellman, 2013) indicated that practitioners had limited training specific to working with clients who are living in poverty, and that they recognized their own previously-held stereotypes toward individuals who are poor.

## GUIDELINE 6

**Psychologists aim to understand the barriers that prevent persons with low SES from better accessing mental health care and make efforts to alleviate these barriers when providing psychological interventions and/or creating mental health care delivery systems.**

### Rationale

Low SES is related to poor access to and utilization of mental health care, likely due to logistical and system-level barriers, and negative perceptions of mental health care. Yet, there is evidence that this population also has an increased need for mental health care and benefits from evidence-based treatments (Santiago, Kaltman, & Miranda, 2013).

In the United States, persons living in low-income counties have higher levels of unmet mental health needs and, as per capita income increases, these unmet needs decrease (Thomas, et al., 2009). For example, in a study examining geographic access to mental health treatment in a large national database of over 30,000 communities based on zip code, low-income areas have fewer mental health practices and providers, but are more likely to have safety-net treatment facilities such as community health centers. As such, community health centers are often the main infrastructure of mental health services in low-income areas, perhaps because these facilities are more likely to accept Medicaid for services (Cummings et al., 2017).

Children, adolescents, and adults with low-income status are often first connected to mental health care through primary care

(Benson, Nierkens, Willemsen, & Stronks, 2015; Hodgkinson, 2016) or emergency services. In a study of over 100,000 persons who sought emergency treatment for a mental health reason, more than half had no prior outpatient mental health care, did not have an outpatient primary care provider, and were more likely to have low income, have immigrant or refugee status, and a rural residence (Gill et al., 2017). Such findings confirm a growing body of research indicating the importance of partnering with primary care providers and settings to encounter low-income persons with mental health needs.

Clients who are from low-income backgrounds may also have unique needs and may experience a variety of barriers that make accessing and engaging in traditional mental health treatment challenging. Prior evidence suggests that individuals with social class-related concerns and stressors are less likely to access treatment because of a variety of environmental barriers (Nadeem et al., 2009). For example, logistical difficulties (e.g., lack of or low access to transportation; difficulty attending appointments during work hours; poor access to phones or other forms of communication with treatment providers) may make accessing and engaging in mental health treatment difficult (Johnson & Zlotnick, 2009; Lenze & Potts, 2017; O'Mahen, Himles, Fedock, Henshaw, & Flynn, 2013).

When engaging clients from LIEM backgrounds in psychological assessment, it is important for psychologists to take into account particular considerations, including selecting psychological assessments that are valid for particular clients in specific circumstances, managing clients' potential skepticism and hesitations surrounding participation in psychological assessment, and providing psychoeducation to clients about their results and addressing potential fears regarding how results will be used and potentially misused. For example, given that persons from LIEM backgrounds are less likely to have a college-level education (Han et al., 2015), they may be differently able to understand and respond to items included in particular assessment inventories based upon reading ability and have increased anxiety regarding their efficacy to understand health information and communicate with service providers (Mantwill, Monestel-Umaña, & Schulz, 2015). It is important for psychologists to carefully attend to the appropriateness of using particular assessment inventories with clients from LIEM backgrounds in terms of the assessment's psychometric properties (e.g., norm groups and cultural validity) that may affect interpretations to be made from the results of the assessments. Similarly, language may pose an additional challenge for clients from LIEM backgrounds, regarding psychological assessment and treatment. In a study examining referral of Latinx low-income persons to community mental health services, about one third successfully received care. However, this rate is higher than found in previous literature and is possibly attributable to the staff being bilingual and bicultural, and that mental health care was integrated into a primary care setting (Hochhausen, Le, & Perry, 2011). Older adults from LIEM backgrounds also may experience difficulties accessing competent treatment that meets their unique needs (Hamp, Stamm, Lin, & Christdis, 2015) and may be less likely to seek mental health treatment due to the high rates of stigma toward mental health treatment in older adult populations (Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014).

In addition, clients from LIEM backgrounds may be confronted with systemic barriers related to oppression and stigma that further decrease their likelihood of seeking mental health treatment. Community and familial perceptions of psychotherapy within certain communities may further decrease individuals' likelihood of seeking treatment (e.g., Santiago et al., 2013). Additionally, individuals from lower-income backgrounds may face challenges that relate to basic survival needs including food security, stable living conditions, and the ability to provide a safe environment for their children (e.g., Fass & Cauthen, 2008; Foss, 2012). Such needs may contribute to their belief that psychotherapy will not be helpful and/or may pose additional obstacles to treatment engagement (e.g., lack of childcare to attend sessions; allocation of limited financial resources).

Perhaps not surprisingly, some authors (e.g., Goodman et al., 2010; Goodman, Pugach, & Smith, 2012) have asserted that traditional mental health interventions do not sufficiently address the complex needs of LIEM individuals, given the prevalence of an array of poverty-related characteristics (i.e., social isolation, stress, and powerlessness) in their lives. Others (e.g., Chalifoux, 1996; Hillerbrand, 1988; Kim & Cardemil, 2012; McCarthy, Reese, Schueneman, & Reese, 1991; Parnell & Vanderkloot, 1994; Smith, 2005; Sue & Lam, 2002) have gone further to critique the historical grounding of traditional psychotherapy in middle-to-upper class values, experiences, and assumptions as contributing to its limited ability to meet the needs of LIEM clients. Moreover, available evidence suggests that mental health care providers often feel inadequate in their ability to address clients' basic needs (e.g., Kim & Cardemil, 2012; Smith et al., 2011; Thompson et al., 2015).

### Individual Application

Psychologists are encouraged to consider acts of advocacy that may contribute to client treatment engagement, retention, and outcomes. Small advocacy-based steps can improve the therapeutic alliance and act as psychological intervention (Goodman et al., 2010). Goodman and colleagues (2012) made the case for therapists to engage in acts of advocacy on behalf of clients from lower-income backgrounds, which may entail working beyond the 50-minute hour. Several authors (e.g., Goodman et al., 2010; Santiago et al., 2013) have further suggested that psychologists working with LIEM persons be called upon to extend or be flexible within their roles. In one investigation, self-identified LIEM clients highlighted such acts as enhancing psychotherapy experiences (Thompson et al., 2012). For example, as appropriate to the situation and in accordance with the APA code of ethics, psychologists may consider activities such as writing letters of support regarding clients' access to particular benefits (e.g., housing subsidies, Social Security disability income, scholarship opportunities for education or training), providing flexibility in fees (e.g., utilizing sliding scale fee structures, making provisions for gaps in insurance coverage), and facilitating the coordination of a client's mental health care (e.g., communicating directly with the client's prescriber or assisting with insurance concerns). Clients who identified as LIEM

highlighted the importance of the small yet meaningful acts of advocacy undertaken by their therapists, which were perceived as contributing to their positive treatment experiences (Thompson et al., 2012).

Psychologists also are encouraged to consider the many external factors that prevent individuals from low-income backgrounds from accessing care. Barriers to treatment can include transportation concerns, long waiting lists, or complex intake processes that require access to a permanent phone or mailing address or access to a computer (Santiago et al., 2013). Psychologists might consider taking steps when creating and providing services to reduce these barriers. For example, to help reach participants in a recent study examining the efficacy of psychotherapy with low-income women experiencing depression during pregnancy, they were provided with public transportation vouchers for appointments, flexible visit times, reminder calls, and activities for children during appointments (Lenze & Potts, 2017). This research highlights the need to make services available at non-standard hours, including evenings and weekends. Given that many individuals from LIEM backgrounds are working in situations where they may be unable to take time off for appointments, access to treatment is dependent on having a broad range of service hours.

Using technology is a helpful, often inexpensive, way to provide psychological intervention. Telephone calls and mailings (Fu et al., 2016), cell phone messages and texts (McInnes, Li, & Hogan, 2013), and telepsychology treatment of depression (Sheeber et al., 2017) have all demonstrated effectiveness with clients from LIEM backgrounds. In sum, alternative forms of therapeutic outreach may provide psychologists with additional means to provide needed services to individuals from LIEM populations.

Psychologists will likely benefit from being mindful of language and client literacy level. Psychologists may accomplish this by ensuring that therapeutic approaches and materials are educationally-appropriate, given that persons with low SES may be more likely to have lower levels of education and health literacy. For instance, recent adaption of group cognitive behavioral treatment to adjust for literacy levels has shown efficacy (Thorn et al., 2018).

### Community/Structural Application

At a systemic level, psychologists are encouraged to examine their assumptions about traditional definitions of mental health treatment. Some scholars and practitioners (e.g., Appio et al., 2013; Ballinger & Wright, 2007; Bullock, 2004; Goodman et al., 2010; Lott, 2002; Smith et al., 2012) have noted that sentiments passed among psychotherapy training programs speak to a general lack of appreciation for engaging in nontraditional work activities. Indeed, some therapists in Thompson's (2015) qualitative investigation noted their "frustration toward their colleagues who scoff at them when they engage in this 'extra' work or who argue that case management or advocacy is 'not a therapist's job.'"

The mechanisms through which psychologists deliver psychological interventions to persons with LIEM also may be broadened. This can include outreach work in nontraditional settings such as conducting in-home psychotherapy and visiting community sites and homeless shelters. Given the difficulty in making community appointments, in-home psychotherapy is an option to reach this population, and may be more cost effective than standard care (Ammerman, Mallow, Rizzo, Putnam, & Van Ginkel, 2017). Psychotherapy provided in shelters can be beneficial to treat post-traumatic stress disorder (PTSD) symptomatology and improve psychosocial functioning. Importantly, shelter-based interventions can be strengthened by including collaboration with shelter staff to better facilitate client success across life domains (Johnson & Zlotnick, 2009).

Given the disparities in health status and high psychosocial need among persons from LIEM backgrounds, a multidisciplinary approach can be particularly useful when working with this population, as interprofessional collaboration can enhance service provision (APA, 2017). For example, in an analysis of recruitment channels for persons from LIEM backgrounds participating in behavioral therapy for smoking cessation, the most common referral channel was through a person's primary care provider (Benson, Nierkens, Willemsen, & Stronks, 2015). Psychologists striving to work with individuals from LIEM communities may therefore strive to provide education to primary care and other health service providers and attempt to change public perceptions of mental health care delivery to be more encompassing of integrated care (Hodgkinson, 2016), as health care settings are a main catchment area for people from LIEM backgrounds in need of mental health services. Further, being diagnosed and perceiving a need for treatment may decrease barriers to accessing care or may prompt increased necessity to overcome barriers. In a longitudinal study among low-income women who experienced intimate personal violence and were without insurance, having a diagnosis and wanting treatment were found to increase treatment seeking in general (Cheng & Lo, 2014). In this way, psychologists can increase health care utilization by helping to ensure that persons from LIEM backgrounds have access to initial assessment and diagnostic services.

Persons with mental health disorders and low-income status benefit from being connected to affordable insurances such as Medicaid and Medicare. When examining Medicaid expansion efforts among low-income persons with serious mental illness, persons who can benefit from Medicaid expansion efforts will likely have higher usage of mental health treatment than those who remain uninsured. It is estimated that use of mental health services will increase by 30% in states that expand Medicaid coverage (Han et al., 2015). Psychologists are encouraged to help persons with mental health needs to connect with support services to obtain affordable insurance and advocate for policy change to improve low-income persons' access to mental health care (APA, 2017).

GUIDELINE 7

**Psychologists strive to understand the common clinical presentations that may be more likely to occur among persons who are from LIEM situations and how best to address these in treatment settings.**

### Rationale

As described earlier in this document, persons with LIEM often have higher levels of mental health symptoms (Hudson, 2005; Javanbakt et al., 2015; Sareen et al., 2011; Stansfeld, Clark, Rodgers, Caldwell, & Power, 2011). Yet, psychologists are also encouraged to be mindful to not over-pathologize clients living in LIEM circumstances simply due to assumptions about potential psychopathology associated with low SES. It is important to understand how social determinants of health, such as poverty, contribute to the frequent experience of stressors that underlie the risk for, and development of, mental health symptoms (Evans, 2004). Societal systemic disadvantage also limits the external resources that a person has available to manage their stress, including familial, social, financial, and time resources (APA, 2017).

Developmentally, the effects of experiencing childhood low SES are often long lasting, with multiple studies revealing childhood low SES as a risk factor for adult psychopathology (Hudson, 2005; Javanbakt et al., 2015; Stansfeld et al., 2011). Conversely, mental health disorders may also contribute to the experience of poverty, via social drift. This theory posits that persons with mental health disorders are more likely to have difficulty maintaining employment and housing, thereby affecting their quality of life and socioeconomic status. Social drift theory has been mildly supported in a longitudinal study where childhood mental health disorder correlated with low SES as an adult, based on employment and housing, even when accounting for childhood SES (Stansfeld et al., 2011). Likely, a bidirectional association exists where mental illness contributes to poverty, which, in turn, makes it more difficult for the person to improve their SES, thereby furthering their level of poverty (Stansfeld et al., 2011).

Common presenting clinical concerns that may arise for psychologists working with this population are anxiety disorders, mood disorders, substance use, serious mental illness, and cognitive difficulties (Chow, Jaffee, & Snowden, 2003; Sareen et al., 2011; Stansfeld et al., 2011). The experience of stress, hyperarousal and increased stress reactivity is common among socioeconomically disadvantaged persons (APA, 2017; Bender et al., 2015; Javanbakt et al., 2015; Riley et al., 2014). Hyperarousal and increased stress reactivity are commonly found in persons with PTSD (American Psychiatric Association, 2013), suggesting that perhaps the experience of poverty is related to trauma. In general, increased experiences of trauma are also correlated with having an increased amount of additional mental health disorders (Riley et al., 2014).

Low SES is also considered to be a risk factor for depression (Pratt, & Brody, 2014) and for developing depressive disorders later in life (Lorant et al., 2003; Sareen et al., 2011; Stansfeld et al., 2011). Moreover it is correlated with suicidal ideation (Wetherall, Daly, Robb, Wood, & O'Connor, 2015) especially in specific groups such as older adult men (Kiosses, Szanto, & Alexopoulos, 2014). Substance use is a common concern among persons from LIEM backgrounds. Stress, in the form of a decrease in income, is related to the onset of substance use behaviors (Sareen et al., 2011). There are also fewer resources for persons with low SES to manage stress, making it difficult to avoid or reduce substance use behavior (APA, 2017). Of note, substance use is also particularly high among persons experiencing housing instability; for example, in a sample of over 3,000 persons experiencing homelessness or housing instability, 60% had a substance use disorder (Bharel et al., 2013).

As for serious mental illness, persons diagnosed with schizophrenia who have Medicaid are more likely to reside in high-poverty neighborhoods than low-poverty neighborhoods (Chow et al., 2003). Some studies have shown that while poverty does not cause psychosis, it likely contributes to the development of psychosis when combined with other life stressors (Gallagher & Jones, 2017). Similarly, persons diagnosed with paranoid, schizoid, schizotypal, and borderline personality disorders are more likely to have low SES (Sareen et al., 2011). This may reflect a relationship between symptom severity and difficulty managing employment and housing.

Lastly, poverty is correlated with decreased cognitive capabilities (Pluck et al., 2011). This relationship is particularly noted in executive functioning and working memory. Such deficits may be found even if someone is experiencing poverty temporarily (e.g., financial crisis), likely due to the excess cognitive load exacerbated by poverty-related stress (Mani, Mullainathan, Shafir, & Zhao, 2013; Hackman, Gallop, Evans & Farah, 2015).

### Individual Application

Among persons with low SES and mental health symptoms or disorders, psychological intervention at the individual level are important and effective (Santiago et al., 2013). Though persons experiencing low SES are at increased risk for psychopathology, they also respond well to psychological intervention. Preliminary data also suggests that the effects of long-term chronic stress related to low SES and social marginalization are reversible, yet further research is warranted (APA, 2017). A variety of interventions have shown promise for their effectiveness in contributing to positive treatment outcomes for individuals from LIEM backgrounds. Cognitive behavioral therapy (CBT) is the treatment approach that has received the most empirical attention for its effectiveness with LIEM populations (Organista et al., 1994; Sheeber et al., 2017; Thorn et al., 2018), including in treating persons (including adolescents) experiencing homelessness and/or housing instability (Shein-Szydlo et al., 2016). In addition, behavior therapy and dialectical behavior therapy (DBT) have demonstrated efficacy in treating substance use among individuals who are LIEM (Slesnick, Guo, Brakenhoff, & Bantchevsha, 2015; (Shein-Szydlo et al., 2016), including preliminary evidence to support the use of DBT, combined with specific cultural and spiritual practices in the treatment of American Indian and Alaska Native adolescents who were diagnosed with substance use disorders (Beckstead, Lambert, DuBose, & Linehan, 2015). Other recent evidence highlights the effectiveness of just a few encounters of motivational interviewing or motivational enhance-

ment interventions with people from LIEM populations (Fu et al., 2016; Slesnick et al., 2015). Specific interventions such as eye movement desensitization and reprocessing have revealed preliminary effectiveness with individuals from LIEM backgrounds (Czyz & Muhlbauer, 2015). This summary of findings is not exhaustive, and numerous other psychotherapies and interventions are likely effective with the LIEM population based on various needs and presentations of persons or groups.

In addition, a number of specific interventions or adjunctive treatments have shown promise in treatment outcomes for individuals from LIEM backgrounds. For example, teaching the practice of specific coping strategies to manage the chronic stresses can be beneficial given the impairment in executive function that is correlated with chronic social marginalization through poverty. Specifically, interventions aimed at strengthening skills such as attentiveness, cognitive control, problem solving, affect regulation, and stress management can be beneficial (APA, 2017; Troy, Ford, McRae, Zarolia, & Mauss, 2017; Wadsworth, Raviv, De Carlo Santiago, & Etter, 2011Nitz). In addition, a trauma informed treatment perspective is important given the high prevalence of trauma and stress among this population. Trauma-informed care aims to prevent re-traumatization and improve health outcomes through awareness and education at individual and organizational levels of care (U.S. Department of Health and Human Services, 2014). Finally, interventions designed to bolster individuals' ability to cope with poverty-based stress offer important opportunities for treatment. For example, social cognitive interventions to bolster self-efficacy beliefs for coping with stereotype threat and identity concerns (APA, 2017) and mindfulness-based stress reduction interventions aimed to assist individuals in increasing their awareness of internal responses as they arise without judgement and learn methods for self-regulation of emotional responses (Dutton, Bermudez, Matas, Majid, & Myers, 2013) may be beneficial.

Taken together, evidence suggests that high-quality, evidence-based, and culturally-informed psychological interventions with persons from LIEM backgrounds can be effective (e.g., Santiago et al., 2013). Yet, there continues to be a dearth of knowledge in this area. Psychologists are encouraged to further examine and research effective and applicable individual interventions for persons who are economically disadvantaged.

### Community/Structural Application

Psychologists attempt to recognize that socially marginalized persons often experience legitimate feelings of powerlessness and lack of control over their environment (Troy et al., 2017). For example, one's perception of their social class is associated with suicidal ideation and presence of mental health disorders (McLaughlin, Costello, Leblanc, Sampson, & Kessler, 2012; Wetherall et al., 2015). This suggests the strong deleterious impact that one's view of oneself and perhaps stigma and discrimination can have on a person's emotional well-being. Psychologists, therefore, can help to mitigate psychopathology by addressing clients' individual perceptions of their social status and related experiences of stress, stigma, and discrimination.

The extant literature espouses the need to intervene across multiple systemic levels, including individual, community, and policy levels, to combat social determinants of mental health disorders, with poverty as the main contributor (Wahlbeck, Cresswell-Smith, Haaramo, & Parkkonen, 2017; World Health Organization & Calouste Gulbenkian Foundation, 2014). Yet, in some recent meta-analyses of international interventions to lessen poverty's effect on mental health, individual and family-level interventions are found to be more robust than some community or policy-level interventions (e.g., economic development projects, debt relief programs). Meanwhile, other meta-analytic findings suggest that community interventions have mixed results in alleviating mental health symptoms. Though all levels of intervention are important, this perhaps suggests the importance of including individual psychological interventions in community and systemic approaches to mitigate the effect of poverty on psychological functioning (Lund et al., 2011; Wahlbeck et al., 2017). There are several important complementary frameworks from which to better deliver care in community and organizational settings, including person-centered care, trauma-informed care, and delivery of programming from an understanding of social determinants of health and systemic and institutional discrimination. When consistent with professional judgment, psychologists may consider the value of focusing on prevention at the systemic and community levels and are well equipped to engage in such work.

DOMAIN 4

# INTERSECTION OF LIEM WITH CAREER CONCERNS AND UNEMPLOYMENT

Work is seen as a pathway to power and economic well-being, thereby increasing access to resources (Blustein, 2006). Although work does increase access for many, it also is important to acknowledge that work does not necessarily alleviate poverty. For the year 2016, the 22.8 million U.S. citizens living below the poverty line included 2.5 million who were working full time and another 6.3 million who were working part-time, as well as many people who were unable to find suitable work or had given up trying to find employment (U.S. Department of Cmmerce, 2017). Even among those living in poverty, however, access to work is critical, as individuals who work 30 weeks per year are one third less likely to return to poverty than those who work 20 weeks of the year (Stevens, 2012).

Guided by a framework that acknowledges barriers that limit work opportunity and career development, psychologists are encouraged to take specific actions that aim to reduce social barriers while increasing access to resources known to affect career and work opportunities, such as equitable education and training, available and attainable quality child care, living wages, equitable healthcare, and an equitable living environment (Smith, 2010; Blustein, 2006).

GUIDELINE 8

**Psychologists seek to understand the impact of social class on academic success, career aspirations, and career development throughout the lifespan.**

### Rationale

Social class is inherently interwoven with work, career aspirations, and success, in part because educational and vocational outcomes are often used as indicators of SES (Diemer & Ali, 2009). Beyond that tautology, however, social class also has demonstrable predictive impacts on future academic and career achievement and is therefore an important consideration in any efforts to support academic, career, and economic success. LIEM individuals face social and logistical barriers that limit access to resources and opportunities to realize academic and career goals (Blustein, 2006; Flores, Navarro, & Ali, 2017; Lott & Bullock, 2007; Smith, 2010).

#### ACADEMIC SUCCESS

The impact of social class on academic achievement starts at a very early age and continues through multiple academic and career milestones. For example, vocabulary at 24 months was greater among those from higher SES and a larger vocabulary predicted later success in kindergarten (Morgan, Farkas, Hillemeier, Hammer & Maczuga, 2015). Students are likely to have poorer social and academic outcomes when they are socioeconomically marginalized (Benner & Wang, 2014); specifically, students from lower SES in middle- or upper-SES schools are likely to have greater levels of loneliness and lower levels of school engagement and educational attainment (Benner & Wang).

The continuing impact of family SES on students in the United States has been demonstrated through associations of lower SES with high school dropout (Parr & Bonitz, 2015), successful transitions from school to work (Blustein et al., 2002), and SAT college admission test scores (Sackett, Kuncel, Arneson, Cooper, & Waters, 2009). Sirin (2005), in a meta-analysis of 58 studies, including 75 independent samples, concluded that familial social class was a strong predictor of individual student success and was even more strongly associated with school-level achievement.

#### CAREER DEVELOPMENT

The impact of social class continues into adulthood and career preparation activities in a variety of ways. Using the multi-wave National Longitudinal Study of Adolescent Health, Lui, Chung, Wallace, and Aneshensel (2014) found that family social class tended to be persistent for those at the extreme ends of the continuum and more flexible for middle-class youth. Specifically, youth from low SES backgrounds, as compared to those from higher SES backgrounds, were less likely to complete high school or go to college, more likely to have children at a younger age, more likely to live with parents as young adults, and more likely to either never marry or marry during young adulthood and to divorce. Youth from lower SES backgrounds were also less likely than other youth to work full-time and they had less personal income and accumulated assets by adulthood (ages 25-31), as compared to their peers from higher SES backgrounds.

SES generally relates positively to vocational aspirations (Schoon & Parsons, 2002) and is likely to have an influence on vocational preferences (Fouad et al., 2012). In addition to the academic preparation and achievement factors leading to career success, individuals of lower SES, such as those receiving Temporary Assistance for Needy Families, are likely to encounter numerous barriers in the realms of job search and employment attainment (Juntunen, Ali, & Pietrantonio, 2013). These include factors such as lack of educational requirements, higher levels of depression and other mental health concerns, higher rates of physical health limitations, caring for young children or other family members, being in an abusive relationship, and having no employment history (Dworsky & Courtney, 2007). In addition, practical barriers such as lack of childcare and lack of transportation services can be formidable barriers to job-seeking or steady job attendance (Juntunen et al., 2013).

### Individual Application

When working with adolescents of lower social class, it may be useful to focus on increasing their sociopolitical development (Diemer et al., 2010), which is defined by Diemer and colleagues as "consciousness of, and motivation to reduce, sociopolitical inequality" (p. 619). In multiple samples of African American, Asian American, and Latina/o American adolescents in the 10th and 12th grades, the authors found that sociopolitical development was associated with increased work salience and, to a slightly lesser degree, vocational expectations. They concluded that increasing sociopolitical development may increase social mobility and access to existing resource infrastructure for youth from LIEM backgrounds. Interventions psychologists can use to increase sociopolitical development include those that increase awareness of inequality, help students link inequality to their own experience, and engage students in supporting community engagement and social action (Diemer et al., 2010; Morsillo & Prilleltensky, 2007). These can be demonstrated in class discussions and in-service learning projects geared toward community needs and equity issues, including job shadowing activities.

Vocational assessments can be directly helpful for youth and adults who are seeking employment. A wide range of cost-effective and psychometrically sound vocational assessments are available, including several that are available at low or no charge in online form. The U.S. Department of Labor, Employment and Training Administration's *Vocational Assessments Guide* (https://youthbuild.workforcegps.org/resources/2014/08/21/10/11/vocational-assessments-guide) is easily accessible to potential clients and can serve as an excellent focus of vocational interventions.

Psychologists also can help clients identify both the reasons they engage in work and the values they attribute to work, supporting client self-determination. In a qualitative study of adult women facing major financial barriers, Clark and Bower (2016) identified the important role providers can play in supporting the intrinsic motivation and determination of clients seeking work. They identified, in interviews with 10 women, three major reasons to engage in work: survival, social connection, and support for children and family members. Although the participants identified numerous barriers to gaining employment, they also highlighted that self-determination and resilience were keys to overcoming those barriers. The authors further suggested that peer support groups may also be a valuable supplement to individual vocational psychology interventions. Further strategies for working with employment and career concerns are also available in APA's *Professional Practice Guidelines for Integrating the Role of Work and Career Into Psychological Practice* (https://www.apa.org/practice/guidelines/role-work-career.pdf).

### Community/Structural Application

Psychologists working with adolescent individuals or groups may consider exploring role models and leaders in various careers as part of career counseling interventions. Among African American 10th graders from a low SES community, researchers found that attitudes toward health science and future health careers were highly influenced by respected leaders or mentors in health science (Boekeloo, Randolph, Timinons-Brown, & Wang, 2014). The authors suggested that exposure to respected leaders, particularly those identifying as African American, may help support career decision-making among youth from lower-income backgrounds. It may also be useful to help youth explore how their own career goals or achievement may contribute to their community, as a way of supporting their connection to their culture (including social class), as well as their goals for the future (Ali & Saunders, 2006).

Psychologists are also encouraged to learn about resources that have been developed specifically to support individuals seeking self-sufficiency through employment. For example, several interventions around the United States are being evaluated through the Pathways for Advancing Career and Education project of the Administration for Children and Families within the Department of Health and Human Services (see http://www.career-pathways.org/acf-sponsored-studies/pace/).

GUIDELINE 9

## Psychologists seek to understand the interaction among economic insecurity, unemployment, and underemployment and attempt to contribute to re-employment processes for individuals.

### Rationale

Individuals without decent work may be in a variety of different employment circumstances, but all share the potential threat of poverty (Thompson & Dahling, in press). At one end of the spectrum, individuals may have a job, yet be underemployed. Underemployment occurs when a person holds a job that is inadequate relative to their financial needs or desires (McKee-Ryan & Harvey, 2011). At the other end, people who are unemployed are unable to utilize their skills and abilities until they successfully complete a job search and become employed or re-employed. In addition, the number of individuals who are non-employed, or who have been unemployed for so long that they have exited the workforce is growing (Bureau of Labor Statistics [BLS], 2017a). Given the large numbers of involuntarily underemployed individuals, the numbers of part-time workers, and the high rates of individuals who are employed in jobs for which they are overqualified (BLS, 2017b), it is difficult to quantify the number of individuals within these employment statuses. Rates of individuals who are underemployed, unemployed, and non-employed are likely underestimated given that many may not be actively searching for work or receiving government benefits. In addition, those who are experiencing housing insecurity and homelessness are often not included in these estimates (Thompson & Dahling, in press).

Individuals who are unemployed, underemployed, and non-employed experience a number of challenges related to their employment status, including financial insecurity, increased social isolation and stigma, decreased social status, loss of daily routine, and lowered self-esteem (Ali, Fall, & Hoffman, 2013; Blustein, 2006). Such stressors contribute to individuals' susceptibility to mental and physical health concerns, including heightened distress,

depression, anxiety, and psychosomatic symptoms (e.g., Paul & Moser, 2009; Price, Choi, & Vinokur, 2002). Family members of individuals who are unemployed, underemployed, and non-employed also experience challenges related to these job statuses (e.g., Schliebner & Peregoy, 1994). This experience, known as vicarious unemployment (VU), can contribute to increased financial insecurity and strain, increased rates of abuse, and relational conflict (e.g., Kalil, 2013; McLoyd, 1989). Over time, stress can accumulate and contribute to heightened susceptibility to mental health symptomatology among family members (e.g., Christofferson, 1994; Sleskova et al., 2006; Sund, Larsson, & Wichstrom, 2003). Broad macroeconomic changes, including large-scale job loss or political instability within a community also can have trickle-down implications for individuals and families. For example, reduced access to community and educational resources may contribute to more individuals moving out of communities and to increased stress in teacher-to-student interactions (Yoshikawa, Aber, & Beardslee, 2012). Lowered employment rates also may lead to increased substance use and crime rates within communities and can contribute to a reduction in the number of employed adults who are available to serve as role models for children and adolescents (e.g., Dahling, Melloy, & Thompson, 2013; Wilson, 1996).

Being a member of a stigmatized or underrepresented group may further thwart employment and re-employment processes for LIEM individuals (Thompson & Dahling, in press). For example, individuals who are members of underrepresented racial and ethnic groups face additional barriers to employment and re-employment as compared to their majority White counterparts, due, in part, to factors that are often exacerbated by poverty such as insufficient local job opportunities, documented disparities in post-secondary educational attainment, prior work history, and employment discrimination (e.g., Bertrand & Mullainathan, 2004; Holzer, Offner, & Sorensen, 2005; Schaffer & Taylor, 2012). In addition, job seekers who are older, job seekers with disabilities, and job seekers who are immigrants or refugees may experience increased challenges to employment and re-employment (e.g., Wanberg, Watt, & Rumsey, 1996). Older workers are also often contending with medical concerns (Cahill, Giandrea, & Quinn, 2013), which can serve as an exponential barrier. Sexual and gender minorities also are likely to face barriers to both obtaining and maintaining employment, with LGBT employees who are out at work being more likely to experience discrimination (Sears & Mallory, 2014). Finally, individuals who are transitioning out of the criminal justice system and those with a criminal record may struggle to gain and maintain stable employment, the lack of which is related to increased rates of recidivism (e.g., Thompson & Cummings, 2010).

### Individual Applications

Psychologists are encouraged to assist individuals with securing and maintaining decent work, as a mechanism that may allow individuals to avoid poverty and longer-term income insecurity (Thompson & Dahling, in press). Re-employment refers to the process by which individuals who are underemployed, unemployed, or non-employed regain access to decent work (Kalleberg, 2008). Successful re-employment has been documented to have positive implications for individuals and families in that it contributes to increased wellness and financial security to meet basic needs (e.g., Gowan, 2012; Park, Chan, & Williams, 2016).

At the individual level, psychologists are encouraged to use interventions that increase agency and hopefulness among unemployed individuals, such as those that are successful in combating stigma directed at people who are LIEM (Hall, Zhao, & Shafir, 2014). According to meta-analytic results, interventions that emphasize mastery experiences and behavioral modeling are likely to be particularly effective in enhancing job search self-efficacy, proactivity, and goal-setting (Liu, Huang, & Wang, 2014). For example, one of the most well-documented re-employment interventions is the JOBS program developed by Caplan et al. (1989). The JOBS program was developed to support individuals to secure a job via four program components: active learning, augmenting coping self-efficacy, enhancing social support, and positive feedback. The JOBS program has been demonstrated to have successful outcomes among individuals who were unemployed in the United States (e.g., Caplan et al., 1989; Vinokur et al., 1991; Vuori et al., 2002) and individuals who were long-term unemployed in the Netherlands (e.g., Brenninkmeijer & Blonk, 2011). Another intervention with empirical support for its effectiveness in assisting individuals who were long-term unemployed is vocationally-oriented cognitive-behavioral training (VO-CBT), which focus on bolstering motivation, challenging negative thinking, and focusing on goals to improve personal agency (Rose, Perez, & Harris, 2012). Like the JOBS program, components of the VO-CBT program include a focus on mastery experiences through increased learning opportunities (i.e., hands-on activities, peer learning) and strategies to self-regulate cognitions and behaviors. These programs, in combination, offer potential interventions that psychologists may use to contribute to client re-employment via individual career counseling and group intervention programming.

### Community/Structural Application

Unexpected work transitions, including the moves from employment to unemployment and subsequent loss of financial security, are increasingly common in the contemporary workplace (Fouad & Bynner, 2008). Perhaps not surprisingly, adult workers with fewer financial and asset resources are more likely to anticipate negative employment decisions and feel that the future is uncontrollable (Atkinson, 2010). Given the high rates of unemployment and underemployment and the negative long-term outcomes associated with VU, psychologists are encouraged to contribute to primary prevention interventions to bolster resilience, increase coping efficacy, and build relevant world-of-work skills and knowledge to protect against the potential negative implications of VU experiences (e.g., Afifi, Hutchinson, & Krouse, 2006; Nitzarim & Thompson, 2019).

At a social level, psychologists are encouraged to work with local and regional employers, and to address potential sources of discrimination and stigma that may prevent them from pursuing or hiring employees who are unemployed, underemployed, and financially under-resourced (Juntunen & Bailey, 2014; Juntunen et al., 2013). Finally, psychologists can also have an important influence by advocating for improved policies and programs that support living wages for all workers (Juntunen et al., 2013).

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APPENDIX A

# DEFINITIONS

### Class privilege

Class privilege encompasses the unearned advantages, protections, immunities, and access experienced by a small class of people who typically carry special status or power within a society or culture (Class Action, n.d.). This status and privilege are typically conferred based on wealth and financial status, occupational prestige (e.g., the perceived societal valuation of an occupational class or job title), title/leadership within a culture, or fame/recognition. These advantages are typically granted to the disadvantage of others and contribute to the establishment of perceived and concrete hierarchies within a community, culture, and/or society.

### Classism

Classism is the assignment of characteristics of worth and ability based on actual or perceived social class; and the attitudes, policies, and practices that maintain unequal valuing based on class (Collins & Yeskel, 2005). Classism can be expressed via prejudiced or discriminatory attitudes, language, or behaviors directed toward individuals based on perceived or actual social class. This can occur in interpersonal interactions, education, housing, healthcare, legal assistance, politics, public policy, and more (Lott & Bullock, 2007).

### Cultural capital

Cultural capital is forms of knowledge, skills, education, and advantages that a person has, which afford them a higher status in society. Individuals and systems in one's life provide them with cultural capital by transmitting the attitudes and knowledge needed to succeed in specific societal settings (Bourdieu, 1986). This can include the ability to navigate etiquette, manners, verbal code switching, fashion choices, and understanding of decorum.

### Educational attainment

Educational attainment refers to the highest level of education that an individual has completed. This can be operationalized by a number of years of education completed but is also indexed by specific educational milestones such as degree or certificate completion (e.g., high school diploma or its equivalency, technical certificate, college or professional degree). Educational attainment typically does not address educational quality and, as such, may sometimes serve as a poor or inaccurate estimate for individuals who are attending underfunded or under-supported school districts or educational programs.

### Income inequality

The term income inequality refers to the degree to which income is unevenly distributed within a population. Income includes revenue from wages, salaries, accrued interest, and other forms of profit. Income inequality becomes more pronounced as the cumulative percentage of income earned in a population becomes more concentrated among a smaller segment of households (Deininger & Squire, 1996), as has happened in the United States. Although income inequality may be operationalized and measured in numerous ways (see Kawachi & Berkman [2001] for a review), all methods of assessment generally reflect equality of distribution of income.

### Income levels

Income levels are measures of relative income compared to national median size-adjusted household income (Pew Research Center, 2015). Income levels are dependent upon household size as well as geographic location when adjusting for cost of living and relative income of those living in the same area. While calculations of income levels may vary, prior research has used ratios (e.g., less than two-thirds, two-thirds to double, and double) of median size-adjusted household income to calculate income levels.

### Occupational prestige

Occupational prestige indexes the social and cultural esteem and desirability given to an occupation or field of employment, as well as the degree of deference granted to individuals holding that occupation (Diemer et al., 2013; Siegel, 1974). Occupational prestige rankings are derived from ratings of goodness, worth, status, and power (Kraus, Schild, & Hodge, 1978). Occupational prestige is not necessarily linked to corresponding economic indicators such as income, though typically occupations of higher prestige are accompanied by higher income levels.

### Poverty

Most commonly, official definitions of poverty are based on comparing a total household's income with the federal poverty threshold, an absolute dollar amount that is set annually by the Department of Health and Human Services and varies with family size and inflation. In 2018, poverty was defined as an annual income of less than $12,140 for an individual and $25,100 for a family of four living in the contiguous 48 states of the United States (U.S. Department of Health and Human Services, 2018). The official threshold has been criticized as outdated in its reliance on the cost of food as the primary household expense, as well as being geographically insensitive and generally too low to account for contemporary costs of living (Roosa

et al., 2005). A more comprehensive measure, the Supplemental Poverty Measure (SPM), was developed by the U.S. Census Bureau in 2011. The SPM includes a broader definition of family, address costs of clothing, shelter and utilities in addition to food, adjusts on a five-year rolling average of expenditures, and includes multiple aspects of resources available to families beyond gross income (Fox, 2018). Many psychologists broadly conceptualize poverty as being associated with a conglomeration of economic, familial, social and environmental inequities (Evans, 2004; McLoyd, 1998). Poverty is not synonymous with unemployment, as many families living in poverty include adults who are working. Though some families experience chronic, long-lasting poverty, other individuals and families may move in and out of the experience of poverty.

### Social capital

Social capital is the collective value of social networks that is determined by specific benefits flowing from the trust, reciprocity, information, and cooperation associated with connected individuals (Sander & Lowney, 2006). Access to, control of, and utilization of social networks is greatly influenced by socieconomic indicators such as education level, income, geographic region, occupation, and access to leisure time activities.

### Social class

Class is a relative social rank based on income, wealth, education, status and/or power (Class Action, n.d.), and can be both objective and subjective.

#### OBJECTIVE SOCIAL CLASS

One approach to operationalizing social class is to define it as access to material resources. Objective social class can be identified as the access or chances people have in life based on their income, occupation, skills and other measurable assets (Giddens, 1973). The objective method of measuring social class assesses variables that are external to the individual such as educational attainment, income, assets, occupational prestige scores, and family size, among others. Any of these variables can be utilized as an indicator of social class, and they can be evaluated individually or collectively.

#### SUBJECTIVE SOCIAL CLASS

Social class can also be defined subjectively based on not only an individuals' perception of their own social class position, but also their perception of how their position relates to others in the hierarchy, such as when they choose how they identify their own class as lower, middle or upper (Jackman, 1979; Liu et al., 2004). Despite being rooted in individual perceptions, such subjective estimations have predictive utility. The subjective method of assessing social class is concerned with an individual's personal understanding of their own social class in comparison to others. This can include an employed behavior and attitude, and an expected consequence, as the individual attempts to navigate within and between classes.

#### SOCIAL STRATIFICATION

A third approach to defining social class adds an analysis of power to the experience of subjective social class. In this approach, social class includes examining the structure in which groups are located. Therefore, social class includes not only access to resources but also the hierarchical structure that reifies the connections between privilege, power, and wealth (Weber, 1922). This sociological perspective highlights the persistence of societal characteristics over generations. Its relevance to psychology becomes apparent in discussion of the impacts of such patterns on psychological health and well-being, described in greater detail in the guidelines below.

### Socioeconomic status

Socioeconomic status (SES) is the social standing or class of a group or individual, often measured as a combination of education, income, and occupation (American Psychological Association, n.d.). SES is commonly conceptualized in terms of access to resources (e.g., income, education, neighborhood). Although some define SES using single indicators, others use a combination of these factors or complex formulas to calculate an individual's level of material resources. Another complementary approach is to measure an individual's cultural capital as an indicator of socioeconomic status. This approach defines SES as access to resources through one's social networks. What these definitions have in common is a focus on the attainment of goods, services, or information to define one's SES.

### Wealth

Wealth refers to a person's entire financial resources, and not simply to income. People who are wealthy are those who are privileged and advantaged in financial resources relative to society's average standards of income and assets (Scott et al, 2014). Wealth is commonly conceived of as net worth, or a household's assets (e.g., financial holdings, real estate, savings accounts) less debts (e.g., mortgage, student loan debt). Wealth disparities, historically, internationally, and domestically, are generally more inequitable than income disparities (Piketty & Zucman, 2014). Wealth plays an important role in fostering social mobility and inequality, for example, by the capacity to take out home equity loans to pay for children's postsecondary education (Killewald & Bryan, 2018). The highest levels of wealth refer to people possessing the greatest levels of net worth.

# APPENDIX B

## System-Justifying Ideologies

System-justifying ideologies are defined as the general motivation to defend, bolster, and justify the status quo, current institutions, and societal arrangements (Jost et al., 2004). There are several constructs used to describe system-justification ideologies (e.g., Protestant work ethic, meritocratic ideology, fair market ideology, belief in a just world; Jost, Blount, Pfeffer, & Hunyady, 2003; Jost & Burgess, 2000; Jost, Glaser, Kruglanski, & Sulloway, 2003; Jost & Thompson, 2000). The common theme among these constructs is an underlying assumption that hard work, merit, and subsequent achievement is based on an individual's ability and that this ability is rewarded by a system that is fair and just. These ideological viewpoints are predicated on the belief that the world is an unbiased and predictable system in which hard work is rewarded by success and failure and hardship is the result of lack of merit and perseverance. There is evidence that even subtle priming messages of meritocracy can contribute to individual cognitive justification of social inequalities (McCoy & Major, 2007).

## Example Questions for Clinical Assessment of LIEM Identity

Early assessment of those who may hold LIEM identities is important in the therapeutic relationship. Asking clinically appropriate questions to assess this identity can be a critical skill that few clinicians may have adequate training regarding. Below is a list of questions, which can be asked during an intake to further assess one's identity as part of the LIEM population (Pietrantonio, 2019).

- How are you doing financially?
- What's your highest level of education?
- How would you identify in terms of your social class?
- How does/did your family compare to other families in your neighborhood?
- Did your family ever struggle financially?
- What do/did your parent(s) do for a living?
- Have there ever been any significant changes in you or your family's finances?
- Do you ever feel stressed related to money?
- Are you able to talk with others about your stress related to money?
- Are you proud of the work you do?
- Do you feel good about going to work?
- Do you feel confident in your ability to provide for your family?

## Supplemental Supporting Literature, Provided by Guideline

### GUIDELINE 1

Low-income students and first-generation college students are less likely to feel prepared for college, endorse lower self-efficacy concerning their adjustment to college, are more likely to have to have outside employment, have increased financial stress, feel more distress concerning balance between home life/academic life, and are less likely to engage with support programs on campus. (Terenzini et al., 1996; Thayer, 2000; Bui, 2002; Goldrick-Rab, 2006; Ramos-Sánchez, & Nichols, 2007). In addition, the cultural mismatch between low-income students and universities is well documented and has a negative impact on retention (Terenzini et al., 1996; Pascarella, Pierson, Wolniak, & Terenzini, 2004; Pike & Kuh, 2005). One possibility is that this is connected to an independence bias within higher education and an emphasis on middle class norms. Often, low-income students come from families and communities that are interdependent. Having classroom norms, rules, and assignments that encourage independence over interdependence has shown to decrease retention for low-income/first generation college students (Terenzini et al., 1996). It may be helpful for psychologists to be mindful of how their syllabus, classroom design, assignments, and classroom activities may perpetuate this independence bias or perpetuate a cultural mismatch for students from low-income families.

### GUIDELINE 3

Sareen and colleagues demonstrated substantial negative impact of low income (and a decrease in income) on the incidence of most mental disorders using a structured interview to confirm diagnosis (e.g., Sareen et al., 2011). Similarly, a study of 56,000 people across 18 countries documented a substantially higher risk of 16 different mental disorders for people reporting low subjective social status, after controlling for variance due to more objective measures such as income and education (Scott, et al., 2014).

Research studies focused on specific disorders have found SES to be a predictor of attention-deficit hyperactivity disorder (Russell, Ford, Williams, & Russell, 2016); panic disorder, generalized anxiety disorder, and phobias (Muntaner, Eaton, Miech, & O'Campo, 2004); and schizophrenia (Agerbo et al., 2015). The inverse association between SES and major depression has been demonstrated repeatedly over the years (e.g., Brown & Harris, 1978; Lorant et al., 2003; Mezuk, Myers, & Kendler, 2013), and a recent community study of major depression incidence and trajectory over 13 years provides strong support for the effect of SES on the persistence of depression over time (Melchior et al., 2013). As a caution, though, mixed results have been found in studies in the United States, when only considering African Americans (Hudson, Neighbors, Geronimus, & Jackson, 2012; Willams, Priest, & Anderson, 2016). Such subgroup differ-

ences highlight the importance of considering the multiple pathways and processes by which socioeconomic factors can influence health.

Several barriers to upward economic mobility should be acknowledged, including poor educational opportunities; challenges to safety, housing permanency, and food security; as well as the potential for long-term impairment of self-efficacious and volitional processes (e.g., goal-setting, hope; Egmond, Berges, Omarshah, & Benton, 2017). In addition, the presence of mental and physical health challenges may be compounded by poverty (Cohen & Zammitti, 2016). The cost of care, in the context of a lack of expendable income, can increase individual stress and family/network strain, thereby further damaging health (Cundiff & Smith, 2017). As a result, many persons of low-SES status will engage in minimal levels of healthcare, only when necessary, and often at the point where they are in a compromised physical/mental state and unable to fulfill the responsibilities of daily life, including interpersonal relationships. This compromised engagement can exacerbate health conditions, lead to accidents, further burden the social network to compensate, and contribute to a worsening of health.

## GUIDELINE 4

Many Americans can be classified as being underinsured, which is defined as having insurance coverage over the last 12 months, but also having out-of-pocket expenses that are greater than 10% of household income, or 5% of household income if below 200% of the poverty level, and deductibles exceeding 5% of annual income (Collins, 2015). In 2014, 23% of the U.S. population (31 million people), ages 19-64, were uninsured, representing an 11% increase since 2003 (Schoen, Hayes, Collins, Lippa, & Radley, 2014). As with the uninsured, health outcomes for the underinsured are poor; for example, in 2014, compared to adequately-insured persons, the underinsured were 39% more likely to report fair or poor health, and were 38% more likely to report frequent mental distress (Zhao, Okoro, Hsiah, & Town, 2018).

It is critical to recognize the impact of intersectionality; for instance, low-income, ethnic-minority persons, low-SES females, or rural immigrant young adults, among other vulnerable groups, must often endure multiple stressors. As an example, among women, obtaining a mammogram screening occurred more frequently (68%) for those with insurance, than those without (31%) (ACS, 2017b). Among ethnic minorities, Blacks and Hispanics had a more difficult time paying their medical bills, than did Whites and Asians (Cohen & Zammitti, 2017), and were also more likely to be uninsured. Gender minorities also experience disparities; for example, transgender persons are less likely to have insurance than heterosexual or LGB persons (Ranji, Beamesderfer, Kates, & Salganicoff, 2014). Finally, rural individuals in impoverished areas experience greater rates of chronic physical and mental illness, including current patterns of opioid abuse, and historically greater rates of psychopathology and death by suicide (Hirsch & Cukrowicz, 2014). In addition, rural communities are often federally designated health profession shortage areas, further limiting their access to psychological services or any healthcare. Such patterns illustrate measurable disparities in basic healthcare and disease prevention opportunities, across and between vulnerable groups, in the context of low socioeconomic status. These patterns of disparity extend to mental health as well. For example, there are sex differences in perceived need for mental health care, with White and African American low-income males less likely to perceive a need for care (Villatoro, Mays, Ponce, & Aneshensel, 2018). Low-income, homeless women also have great difficulty accessing mental health care, and peer support, flexible service delivery, and gender-sensitive services are suggested as potential methods of intervention (David, Rowe, Lawless, & Ponce, 2015).

## GUIDELINE 5

In one set of studies, Falconnier (2009; 2010) analyzed data from the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program to better understand the impact of social class on treatment outcomes across three treatment modalities (CBT, interpersonal processing therapy [IPT], and pharmacotherapy). Results demonstrated that lower SES (as measured by Hollingshead's Four-Factor ISP (Hollingshead, 1975) was associated with less improvement in depressive symptoms (2009) and that individuals from lower class backgrounds reported lower improvement ratings for work functioning (2010) than their middle-class counterparts.

More recently, using a large, naturalistic dataset of college students in psychotherapy ($n$ = 5,078 patients, $n$ = 238 therapists), Thompson, Goldberg, and Nielsen (2018) examined the impact of client self-reported financial distress on psychotherapy outcomes using the Outcome Questionnaire-45. Although overall clients showed treatment effects in the moderate to large range ($d$ = 0.73), those clients with higher financial distress at baseline were more likely to drop out of treatment after one session. In addition, when controlling for baseline severity, clients with higher self-reported financial distress had worse outcomes at the end of treatment. Though the effects were small, results remained significant when controlling for age, sex, and treatment length.

Racial and ethnic differences also exist in the use of mental health services among persons with low SES. For example, Asian and Latinx persons in high poverty areas are less likely to be hospitalized for mental health needs than Whites and are more likely to use emergency services, suggesting that individuals from these groups may only attempt to access care when conditions have greatly worsened; of note, for some groups, this could be due to immigration status, insurance status, cultural mistrust, and/or stigma regarding care. Related to this notion, Asians in high poverty areas are less likely to have Medicaid than Whites. Interestingly, Black, Latinx, and Asian youth under 18 years old are more likely to use mental health services than Whites in high poverty neighborhoods but not in low poverty neighborhoods (Chow et al., 2003). This perhaps is related to greater psychological distress due to a cumulative effect of poverty and discrimination as stressors (APA, 2017).

Results from one vignette-based study, in which therapists-in-training evaluated a hypothetical client presented across four conditions (low income, working class, middle class, and wealthy), indicated that therapists-in-training who reviewed a client portrayed as working class had significantly less favorable impressions regarding future work with this client than therapists-in-training who evaluated the three other conditions, including the client portrayed as low income (Smith et al., 2011). In another study, counselors and counselor-trainees responded to a hypothetical cli-

ent presented via a written case vignette and four-minute video of the client presenting to an intake session. Results demonstrated no differences in cognitive attributions about the client but did demonstrate that the therapists were significantly more likely to ascribe milder issues to the client portrayed as having a high-SES as compared to the client portrayed to have a low-SES (Dougall & Schwartz, 2011). Another vignette-based study with 188 licensed mental health practitioners (Thompson et al., 2014) demonstrated that the practitioners detected social class differences based upon cues written into one of two descriptions of a hypothetical client that varied only on social class-related descriptors. These perceived differences, however, did not impact practitioners' attributions toward the client for solving or causing her problems, level of Global Assessment of Functioning score assigned to the client, or the therapists' willingness to work with the client.

Most clients perceive their therapists to be middle class due to their education level and occupation, as well as environmental cues such as their dress, office decor, and vocabulary (Appio et al., 2013). For some clients, these evident differences in social class contributed to their beliefs that their therapist cannot adequately understand and empathize with them, which increased their tendency to withhold information in session and to doubt the ability of psychotherapy to meet their needs (Balmforth, 2009; Chalifoux, 1996), but other participants have reported forming effective relationships even with perceived differences in social class (Thompson et al., 2012).

Findings from a grounded theory investigation with a racially diverse group of 16 clients who self-identified as low income or poor indicated that all clients recognized the dynamic process by which they experienced social class within the context of psychotherapy (Thompson et al., 2012). Yet, these clients reported an ability to form effective working relationships with their therapist even though they perceived differences in social class. In other words, these participants cited the ability and willingness of their therapist(s) to address social class within the room as contributing to perceptions of working alliance, depth within session, and overall positive experiences in treatment. On the other hand, therapists' failure to address and incorporate social class-related content, interventions, and conversations within treatment was perceived to negatively impact clients' experience of psychotherapy.

This finding is consistent with those from Falconnier and Elkin's (2008) investigation of therapists' attention to economic stress topics during the first two sessions of psychotherapy with patients who were depressed in the NIMH Treatment of Depression Collaborative Research Program. Their analyses revealed that 86% of clients across all client SES groups introduced problems in at least one of three economic stress topics (financial, work, and unemployment) and that the ability of the therapists to approach these conversations with clients contributed to better outcomes across all SES groups, regardless of treatment modality (i.e., IPT or CBT).

Similarly, Thompson et al. (2015) found that the mental health practitioners in their qualitative interviews highlighted the lack of systematic attention to issues of social class in training programs and in clinical treatment settings. These therapists attributed their feelings of inadequacy in talking about social class with clients, feeling unprepared to assess for and deliver specific treatments that meet the individualized needs of clients who are low-income, and limited exposure to theoretical approaches to psychotherapy that integrate social class as a cultural variable that impacts clients' lives, to a lack of training.

Several studies focusing on low-income populations and the use of case management and/or outreach strategies such as reminder calls and letters, in addition psychotherapy or psychological intervention, have shown effectiveness (Johnson & Zlotnick, 2009; Lenze & Potts, 2017; O'Mahen et al., 2013).

A randomized control trial using outreach methodology by telephone and mailings to increase persons with low SES use of smoking cessation treatment was found more successful than treatment as usual, suggesting that phone-based therapy may be an effective intervention for clients from LIEM backgrounds who are otherwise hard to connect with care (Fu et al., 2016). Recent research also supports using cell phones to engage low SES homeless clients and to deliver mental health interventions (McInnes, Li, & Hogan, 2013). Finally, when examining low-income mothers with symptoms of major depressive disorder, significant improvements were found after telemental health intervention in both self-report and clinician administered measures of depressive symptoms (Sheeber et al., 2017).

In addition, it is important to note that the utilization of brief therapies offer an effective mechanism for treatment given that some low SES persons may have limitations to their time that preclude them from accessing longer-term care and research evidence to support the notion that high-quality care can be delivered in shorter timeframes. For example, recent studies have shown that just a few encounters of motivational interviewing or motivational enhancement interventions are effective with a low-income population (Fu et al., 2016; Slesnick et al., 2015). Furthermore, motivational interviewing for smoking cessation with low-income clients was more effective, in a multisite randomized control trial, than treatment as usual, with an average of just four therapy encounters. Clients in this study also started at all stages of change, regarding smoking behavior, revealing increased applicability to potential clients (Fu et al., 2016). These studies show that short-term interventions can be effective for this population that may not be able to obtain longer-term services. Likewise, a randomized control trial examining the use of a shortened duration of psychotherapy, comprising six individual DBT visits and six group DBT visits, was more effective than treatment as usual for reducing substance use (Nyamathi et al., 2017). Additionally, a randomized control trial examining interpersonal psychotherapy revealed that most low-income participants were able to complete four sessions, which was also seen as the minimum necessary for therapeutic intervention (Lenze & Potts, 2017).

## GUIDELINE 7

Recently, in a large study with over 34,000 participants, using standardized diagnostic interviews at two time points, the lifetime occurrence of mood, anxiety, substance use, and personality disorders was associated with having low SES (Sareen et al., 2011). Moreover, a strong negative correlation was found between SES, mental illness severity, and likelihood of a mental health diagnosis, when examining six years of statewide psychiatric hospitalization data with over 100,000 individuals (Hudson, 2005).

The stressors that occur when persons from LIEM circumstances experience frequent systemic disadvantage can affect neu-

ral structures and processes that help regulate emotional states and manage stress. Poverty may also contribute to the experience of a blunting to stress or, conversely, a heightened and easily activated response to stressors (APA, 2017; Hofmann, Schmeichel, Baddeley, 2012; Javanbakt et al., 2015). Aside from such physiological and structural changes, frequent stress from social marginalization may change a person's social cognition which, in turn, may deleteriously impact mood and motivation (APA, 2017; Brondolo, Ng, Pierre, & Lane, 2016).

Studies involving brain imaging reveal that neural structures involved in the perception of, and response to, stress are structurally changed in persons with low SES. In a longitudinal fMRI study, children who experienced poverty were later found, as adults, to have increased emotional responses to stressors and negative social cues, as well as decreased connectivity between the amygdala and medial prefrontal cortex, resulting in long-term changes in a person's ability to manage social threats (Javanbakt et al., 2015). Thus, due to the stress of poverty, people more easily perceive stress and have greater difficulty managing it (APA, 2017; Javanbakt et al., 2015). Such hyperarousal and increased stress reactivity are commonly found in persons with posttraumatic stress disorder (American Psychiatric Association, 2013), suggesting that perhaps the experience of poverty is related to trauma.

Researchers conducting longitudinal studies with large sample sizes reported that persons with an income of less than $20,000 who are experiencing poverty had higher odds of having a mood disorder when assessed again years later (Sareen et al., 2011; Stansfeld et al., 2011). Interestingly, suicide risk is related to perceived social class rather than absolute income (in other words, a person's perceptions of themselves as low-income matters more than actual income level; Wetherall et al., 2015). Additionally among adolescents, perceived social status is more strongly associated with the existence of mental health disorders than objective identifiers of socioeconomic status as well (McLaughlin, Costello, Leblanc, Sampson, & Kessler, 2012).

In randomized control trials, cognitive behavioral therapies are effective for low-income populations experiencing depression, anxiety, posttraumatic stress, and chronic pain (O'Mahen et al., 2013; Sheeber et al., 2017; Shein-Szydlo et al., 2016; Thorn et al., 2018). CBT has, furthermore, been found effective with low-income persons experiencing homelessness and/or housing instability, including adolescents (Shein-Szydlo et al., 2016). Moreover, there is efficacy in using behavioral therapies and dialectical behavioral therapy for substance use in this population (Slesnick et al., 2015; Nyamathi et al., 2017), and efficacy for interpersonal psychotherapy, for the LIEM persons experiencing PTSD, both in individual and group formats (Krupnick & Green; Lenze & Potts, 2017). Likewise, some research suggests that motivational interviewing or motivational enhancement approaches for substance use are effective among this population (Benson, Nierkens, Willemsen, & Stronks, 2015; Slesnick et al., 2015).

Findings from psychotherapy studies show that, despite poverty and housing instability, psychological intervention with persons from LIEM populations are effective, and the teaching and practice of specific coping strategies to manage the chronic stresses of low SES may be particularly beneficial. For example, given the impairment in executive function that is correlated with chronic social marginalization, interventions aimed at strengthening skills such as attentiveness, cognitive control, problem solving, affect regulation, and stress management, are beneficial (APA, 2017; Wadsworth et al., 2011). An additional therapeutic intervention of importance includes cognitive restructuring (Troy et al., 2017; Wadsworth et al., 2011). Interestingly, cognitive reappraisal has recently been found to be an intervention that is particularly effective in the emotional regulation of low-income persons. Using a hybrid interview and experimental study, cognitive reappraisal was more effective at managing depression symptoms for persons living at or below the poverty level than persons with high incomes (Troy et al., 2017).

Additional treatment recommendations, emerging from a review of the literature focused on poverty-based stress, include mindfulness and social cognitive interventions for stereotype threat and identity concerns. As poverty-related stress is highly correlated with negative changes to social cognition, psychologists are equipped to create appropriate interventions (APA, 2017). Overall, evidence suggests that persons experiencing poverty benefit from high-quality, evidence-based psychological intervention (Santiago et al., 2013); yet, there continues to be a dearth of knowledge in this area and, so, psychologists are encouraged to further examine and research effective and applicable individual interventions for persons who are economically disadvantaged.

Given the high prevalence of stress among LIEM populations, a trauma informed care perspective may be particularly useful and appropriate. Trauma informed care aims to prevent re-traumatization and improve health outcomes through awareness and education at individual and organizational levels of care (U.S. Department of Health and Human Services, 2014). When providing trauma informed care, clinicians recognize the prevalence of trauma among persons with low SES and strive to provide services that address, but do not exacerbate, existing experiences with social marginalization, powerlessness, hopelessness, and difficulty navigating stressors. An extensive literature review on services geared towards persons experiencing homelessness show that trauma informed service delivery helps improve individual outcomes and even program cost-effectiveness (Hopper, Bassuk, & Olivet, 2010). Shared decision making is a helpful approach in health care systems to help ensure clients experience positive outcomes when accessing care (Schauer, Everett, & del Vecchio, 2007)

## GUIDELINE 8

For the year 2016, the 22.8 million U.S. citizens living below the poverty line included 2.5 million who were working full time and another 6.3 million who were working part-time, as well as many people who were unable to find suitable work or had given up trying to find employment (U.S. Department of Commerce, 2017). The U.S. Bureau of Labor Statistics defines as working poor those adults of working age who spend at least 27 weeks of the year either working or looking for work and whose incomes are at or below the poverty level. Importantly, these numbers are considered by most to be underestimates of actual poverty rates as they fail to account for individuals not included in Census data (e.g., undocumented individuals, individuals lacking a stable address) as well as failing to account for a substantial portion of individuals who were unable to find decent work or who have given up trying to find employment. These numbers do not include unemployed adults, children, or older

adults who are also represented in overall poverty statistics. The difference between working and working poor can be abrupt, as one-fourth of all experiences of poverty are due to the single life change of a head of household becoming unemployed, and another quarter of poverty-related experiences result from divorce or other major family structure changes (Stevens, 2012). Further, families in which an individual experiences major health concerns are more likely to file for bankruptcy from mounting healthcare debt. Even among those living in poverty, however, access to work is critical, as individuals who work 30 weeks per year are one third less likely to return to poverty than those who work 20 weeks of the year (Stevens, 2012).

Students from lower SES families have lower reading skills at both entrance to school and the end of third grade and are subsequently more likely to drop out of high school (Anne E. Casey Foundation, 2010). This early impact also has an important indirect affect via health outcomes. Family SES moderates birth weight and several adolescent health factors, and subsequently influences multiple aspects of academic performance in high school (Shaw, Gomes, Polotskaia, & Jankowska, 2015). Family SES also serves as a strong predictor of enrollment in higher education (Brekke, 2015).

Sirin (2005), in a meta-analysis of 58 studies, including 75 independent samples, concluded that familial social class was a strong predictor of individual student success and was even more strongly associated with school-level achievement. Specifically, results from the meta-analysis revealed that families with lower SES was related to a lowered ability to provide individual resources to support achievement, and schools with a higher proportion of lower SES families less likely to supply sufficient in-school resources. In combination, Sirin (2005) concluded that these effects result in double jeopardy for student achievement.

Among those who attend college, students from lower SES backgrounds are more likely to have lower career decision-making self-efficacy (Hsieh & Huang, 2014). In a study of women students at an elite university, Johnson, Richeson and Finkel (2011) found that those of lower-SES backgrounds experience higher levels of, and awareness of, class-related stigma, which subsequently diverted emotional and mental energy from academic pursuits. College students also have identified shame and stigma about their identities as low income or working class, due to the perception that social class is related to personal or familial deficits and given the university context in which most peers are perceived to be from more middle- to upper- class backgrounds (Warnock & Hurst, 2016).

## GUIDELINE 9

Underemployment and unemployment rates also vary considerably across demographic characteristics and geography, making the work-poverty link highly subject to contextual variables. For example, in the United States, Black and Latino workers face higher rates of job loss than their White counterparts (e.g., Strully, 2009) and women are more likely to be underemployed than men (e.g., Villalobos, 2014).

Paul and Moser (2009), in a meta-analysis, found that people who were unemployed exhibited higher levels of distress, depression, anxiety, and psychosomatic symptoms, and lowered levels of subjective well-being and self-esteem. These mental health concerns might be exacerbated among lower-class married men who are underemployed or unemployed, perhaps because of their expectations related to their traditional role as provider for the family (Artazcoz, Benach, Borrell, & Cortes, 2004); and for both men and women who are struggling financially given the increased stress associated with financial insecurity (Ziersch, Baum, Woodman, Newman, & Jolley, 2014). Job loss and underemployment are also posited to predict negative outcomes, because people who are financially unstable have fewer resources to cope with stressors (McKee-Ryan & Harvey, 2011).

Children with an unemployed caregiver expressed feelings of hopelessness, confusion, anger, insecurity, blame, embarrassment, and loneliness (Morris-Vann, 1990). Vicarious unemployment also has long-term consequences for educational and career development. Parental unemployment relates to lowered school performance, increased rates of expulsion and school drop-out, and lowered likelihood of attending college (e.g., Rege, Telle, & Votruba, 2011). Longer-term implications include adolescent and young adults' lowered confidence in the economic system and disillusionment regarding the possibilities of future employment (Isralowitz & Singer, 1987), increased worry about future career prospects and the job market (Thompson et al., 2013), and lower earnings as adults (e.g., Oreopoulos, Page, & Stevens, 2008).

Individuals searching for work in communities with high levels of unemployment may be less likely to feel optimistic about job prospects. For example, in a U.S. sample of adults who were unemployed, the relation between individual financial strain and job search self-efficacy depended on objective job market characteristics, such that strain was negatively related to job search self-efficacy in regions with higher rates of unemployment, but unrelated in regions with lower unemployment rates (Dahling et al., 2013).

At the intrapersonal level, high human capital in the form of relevant skills, training, and experience helps people to maintain employment and be perceived as more attractive to prospective new employers (Fugate et al., 2004). Personality characteristics (e.g., optimism, positive affect; e.g., Côté, Saks, & Zikic, 2006) and strong mediating cognitions (e.g., self-efficacy, outcome expectations; Vansteenkiste, Lens, De Witte, De Witte, & Deci, 2004) are additional cognitive-person variables that facilitate job search behaviors and re-employment outcomes.

VO-CBT was designed to bolster motivation and challenge negative thinking among participants who were long-term unemployed (Rose et al., 2012). Components of the VO-CBT program included increased learning opportunities (i.e., hands-on activities, peer learning, peer learning) and strategies to self-regulate cognitions and behaviors. Results indicated that participants who completed the 12-week program reported increased optimism and more favorable attitudes toward working, and more than half had attained a job by the conclusion of the program. Another intervention, developed in the Netherlands, provided psychoeducation about how to establish proper learning goals to increase competence and mastery of new skills (van Hooft & Noordzij, 2009). This workshop-based program demonstrated beneficial outcomes among a group of unemployed adults; participants reported higher job search intentions, more engagement in search behaviors, and higher likelihood of reemployment, as compared to counterparts who participated in a control condition or a performance goal orientation workshop focused on demonstrating competence.

Psychologists can work with individuals to support their job stability and re-employment. For example, psychologists can bolster an individual's ability to develop and maintain access to social support (e.g., social skills training, engagement in proactive behaviors), which can act as a buffer against job loss and provide inside access to job opportunities (Thompson et al., 2017). Community-based interventions designed to bolster access to social capital and strengthen ties within social networks may be particularly useful for individuals who are from disadvantaged groups, given that homogeneous social networks comprised predominantly of people who are similarly struggling with job loss or recovery are not beneficial (Patacchini & Zenou, 2012).

At the individual level, psychologists are encouraged to use interventions that increase agency and hopefulness among unemployed individuals, like those that are successful in combating stigma directed at people who are poor (Hall et al., 2014). These authors found that self-affirmation increased participant willingness to seek out benefit programs, increased fluid intelligence, and contributed to better executive control, compared to those who did not participate in self-affirmation. Psychologists are encouraged to remain aware and mindful of the unique needs that adults with lower financial resources will have when it comes to career development and job seeking. Interventions that emphasize self-efficacy and self-concept are likely to be useful but will need to be balanced with a pragmatic understanding of the client's access to resources to meet daily living needs (Juntunen et al., 2013).

In a recent meta-analysis, older individuals had greater difficulties finding new employment and were more likely to remain unemployed than their younger counterparts (Wanberg, Kanfer, Hamann, & Zhang, 2016). These discrepancies are posited to exist because of stereotypes among potential employers that contribute to negative perceptions regarding older job seekers' presumed salary requirements, abilities, and flexibility (Lippmann, 2008). Job seekers with disabilities face similar challenges because they are assumed to have limited skills or to need accommodations that may be costly or inconvenient (e.g., Blustein, Kozan & Connors-Kellgren, 2013). Finally, many veterans experience unique challenges, including learning anew about expanded career choices that were previously nonexistent and high rates of disability and trauma from their military service (Stein-McCormick, Osborn, Hayden, & Van Hoose, 2013).

As low-income workers attempt to regain employment, they may experience important barriers related to stigma. In general, people who are poor or of lower social class are widely stigmatized (Hall et al., 2014), and frequently associated with negative attributes such as laziness, being "welfare queens," and incompetence. Given the increasing use of economic layoffs in the United States and other cultures, this stigma may now be generalized to unemployed workers (Karren & Sherman, 2012). In a conceptual paper, the authors laid out the potential detrimental effects of discrimination, selection bias, and continuing unemployment, for unemployed workers (Karren & Sherman, 2012). Such possible outcomes are consistent with research indicating that employment opportunities diminish quickly for unemployed individuals, in large part because of "nonemployment stigma" (Oberholzer-Gee, 2008, p. 30). As noted above in the section on educational attainment, this again results in a type of double-jeopardy for unemployed individuals with lower socioeconomic status.

Individuals with long-term unemployment experiences struggle with poverty-related stigma, which places them at a greater disadvantage as time passes. People who experience extended unemployment may encounter social disapproval or rejection, which can exacerbate the negative outcomes of job loss (Schliebner & Peregoy, 1994). Although it is difficult to establish clear links between length of unemployment and eventual re-employment, growing evidence suggests that individuals who have had periods of unemployment are stigmatized in ways that harm job recovery efforts. Prospective employers may stereotype individuals who are unemployed as flawed or lacking in motivation, which harms their re-employment prospects (Bonoli, 2014; Ghayad, 2013; Kroft, Lange, & Notowidigdo, 2013; Melloy & Liu, 2014). Individuals who have an extended period of unemployment also are likely to face salary losses even if they secure re-employment; as Kroft and colleagues (2013) noted, individuals without work must negotiate from a position of weakness and employers can take advantage of this by offering lower compensation packages.

The importance of providing appropriate services to adults who are involuntarily unemployed or underemployed cannot be overstated. Recent research across several countries has concluded that even short-term unemployment has a significant detrimental mental health effect (Cygan-Rehm, Kuehnle, & Oberfichtner, 2017), and warrants early intervention or prevention among those who lose employment. This becomes even more critical when considering the long-term impact of unemployment and work insecurity on economically-marginalized individuals and families (Vaalavuo, 2016; Wickrama, O'Neal, & Lorenz, 2018). Psychologists are encouraged to become familiar with local job search and employment agencies, social service assistance, and resources that support costs of transportation and childcare for job seekers.


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