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

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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 a poverty level income (U.S. Census Bureau, 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. Census Bureau (Fontenot, Semega, & Kollar, 2018) and the Supplemental Poverty Measure identified 13.9% of U.S. citizens living in poverty (Fox, 2018).

Although global poverty has decreased by 50% in the last 20 years (World Bank Group, 2015), the U.S. Census Bureau reports that the percentage of people living in poverty, as defined by federal policy, has consistently remained between 10 and 16% since 1965 (U.S. Census Bureau, 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).

As our introduction indicates, economic marginalization is a complex and multifaceted social issue that can be examined in many ways. One of the ongoing difficulties that this

24 complexity presents is a lack of common terminology, constructs, or measures. In one review of
25 the literature, Liu, Soleck, Hopps, Dunston, and Pickett (2004) discovered that there were over
26 400 different terms being utilized to describe social class and related constructs. Because such a
27 variety of language is used in the literature as well as in public policy and the media, these
28 Guidelines have adopted an encompassing term – low-income and economic marginalization
29 (LIEM) – that is intended to cut across the common characteristics of current language. In order
30 to further explicate the definitional issues of this area of study, we have provided a set of
31 definitions of common LIEM-relevant language. The definitions (Appendix A) are designed to
32 serve two purposes. The first purpose is to provide a common language for which to discuss
33 social class concerns within the field. The current differentiation within the language contributes
34 to confusion and inefficiency in reviewing literature, which stifles the acquisition and growth of
35 knowledge. The second purpose of the definitions is to better inform psychologists of culturally
36 sensitive language that can be utilized when describing economically disenfranchised people and
37 the societal constructs that contribute to marginalization.

38 We propose that developing a common language, such as LIEM, will particularly help to
39 foster effective research and applied work in psychology. This is intended to be an umbrella
40 term that incorporates many aspects of what it means to be economically oppressed, including
41 both limited financial resources and marginalization related to social class. However, we
42 recognize that the existing literature is saturated with a wide variation in terminology in current
43 use. Further, the conclusions and implications drawn by researchers may have been influenced
44 by the words they used in formulating questions and measuring variables. Therefore, the
45 language in these Guidelines is consistent with the original works that are cited, in an effort to
46 maintain accuracy. The extant variation in language will be apparent throughout the Guidelines,

47 as “social class”, “SES,” “working poor”, and “lower income” and similar terms are used
48 throughout all of the supporting evidence relevant to the Guidelines and the application. When
49 more inclusive observations were available in the literature, we utilized LIEM to include all
50 aspects of income and economic marginalization. We also use LIEM to identify the
51 recommendations and contributions specific to the Guidelines. We encourage others to try to
52 utilize the common language established in these guidelines in future research.

53 The implications of economic marginalization are apparent across multiple aspects of life
54 in contemporary society. The economic and social status into which one is born is a powerful
55 factor in determining one’s access to resources and supports and, therefore, access to available
56 opportunities (Blustein, 2006; Evans, 2004). Such limited access has important implications for
57 areas of relevance to psychologists, such as employment, education, achievement, and physical
58 and mental health. Indeed, the associations between socioeconomic status and indicators of
59 health, including behavioral, mental, and physical health, are well-documented (APA, 2006;
60 Belle & Dodson, 2006; Gallow & Mathews, 2003; Jackson & Williams, 2006; Kaplan, Siefert,
61 Ranjit, Raghunathan, Young, Tran, et al., 2005; Lorant, Deliege, Eaton, Robert, Philippot &
62 Anssearu, 2003; Siefert, Heflin, Corcoran & Williams, 2004; APA, 2010; Smith, 2010; Smith,
63 2015; Sweet, 2011), and poverty has been identified as the most pervasive risk to the health of
64 children in America (Schickedanz, Dreyer, & Haffon, 2015).

65 The needs and desires of LIEM populations are often neglected or even ignored. There
66 are a multitude of reasons for this. One possibility refers to a process called distancing, which
67 can contribute to classism. Lott (2002) defines classism as cognitive and behavioral distancing
68 from people who are poor. In simpler terms, this means that classism is often perpetuated by
69 making poor people invisible to those in other social class groups. In politics, leaders primarily

70 speak to and focus their agendas on the middle-class, and poor people are forgotten or degraded
71 (Lott & Bullock, 2007). Furthermore, people living in LIEM circumstances are often without
72 representation in the government as positions of power are not afforded to poor people (Smith,
73 2013). Further, neighborhood segregation often keeps middle and upper class people from
74 interacting with low-income individuals, which can contribute to distancing from and
75 unawareness of the experiences of low-income individuals (Smith, 2013). Representation in the
76 media further contributes by a disproportionate absence or negative characterization of low-
77 income individuals in the media (Bullock, Wyche, & Williams, 2001). In the realm of the
78 workplace, when low-income and working-class people organize to voice concerns during
79 decision-making and negotiation processes, they are silenced by negative public outcries and
80 absent or negative media coverage (Smith, 2010).

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

93 justification for the inequities in education, healthcare, the justice system, the environment, and
94 the ability to access a vocation that provides a living wage.

95 Biased and negative views toward people living in poverty are reinforced by the Western
96 value of meritocracy (Kluegel & Smith, 1986), a belief structure that purports that hard work and
97 individual merit will result in commensurate status and rewards. Often framed as the "myth of
98 meritocracy" (McNamee & Miller, 2004), endorsement of this worldview can contribute to
99 greater distancing or discrimination of people who are poor and working class. Amidst vast
100 disparities, many people from low-income backgrounds espouse a belief that the social systems
101 that affect them are fair and legitimate, that equal opportunities characterize the society in which
102 they live, and that everyone receives what they deserve (Frank, 2004; Hochschild, 1981; Jost &
103 Banaji, 1994; Kluegel & Smith, 1986; Lerner 1980; McCoy & Major, 2007). These beliefs can
104 be conceptualized as reflecting System-Justification Ideologies and can lead to internalized self-
105 blame among the very people who are targets of classism. Interested readers can find additional
106 discussion of system-justifying ideologies in Appendix B.

107 **Lack of Representation of Socioeconomic Status in Research**

108 Socioeconomic status (SES) has long been neglected in the psychological literature, both
109 theoretically and methodologically (Buboltz, Miller, & Williams, 1999; Lee, Rosen, & Burns,
110 2013; Riemers & Stabb, 2015). The limitation in research pertaining to LIEM populations is
111 reflected both in measurement difficulties, and a paucity of research in which LIEM populations
112 or issues are the primary focus. Attending to these variables within research is critical in building
113 multicultural competency with LIEM populations.

114 Measurement of SES includes a range of difficulties, such as invisibility of identity,
115 multiple operational definitions, a combination of objective and subjective variables, and the

116 unique challenge of multiple fields studying the subject (e.g., Economics, Sociology,
117 Anthropology, Political Science; Diemer et al., 2012). Currently, the APA Publication Manual
118 does not require or recommend any measures of SES variables. As a result, SES has often been
119 omitted from research (Lee, Rosen, & Burns, 2013; Reimers & Stabb, 2015) and, when
120 measured, has been assessed in an unstandardized manner. Even the common "triumvirate"
121 measures of income, occupational prestige, and educational attainment have challenges. For
122 example, challenges include combining these variables into a singular variable, which obscures
123 the unique impacts of income, prestige and education; participants finding income questions to
124 be invasive (despite strategies that reduce this feeling have been developed, see Diemer et al.
125 2013); and the impact of technology or new jobs on occupational prestige measures. Raising
126 these measurement concerns to students can be important for creating competence and criticality
127 when reading and understanding research methods pertaining to SES. Further, variables such as
128 assets, debt, social class of origin, access to loans/banking, family size, documented status,
129 affordable childcare, and other factors representing social class may be of greater saliency
130 depending on the research question or population. Some inroads and clear best practices in
131 measuring social class have emerged; see Diemer et al. (2013) and Roosa et al. (2005) for
132 instructive primers (which include sample questions for a variety of measures) on the
133 measurement of social class.

134 Because of omissions and measurement inconsistency, there is a critical concern that the
135 full spectrum of SES is not represented in the psychological literature. This lack of
136 representation creates significant issues in accurate reporting. For instance, the APA's Stress in
137 America research has consistently shown that finances, work, and access to healthcare, all
138 defined as SES-related variables, are the top stressors Americans report year after year (APA,

139 2017). Although the APA, and psychology as a field, has become more class conscious in the
140 last decade, there remains considerable work to adequately represent economically marginalized
141 individuals and communities in research (Reimers & Stabb, 2015).

142 This lack of attention has been attributed to numerous explanations including, the desire
143 of professionals to distance themselves from poor and low-income individuals (Lott, 2002), the
144 difficulties inherent in accurately measuring and reporting socioeconomic status (Diemer,
145 Mistry, Wadsworth, López, & Reimers, 2013), and pervasive stereotypes and negative attitudes
146 toward poor and low-income families by individuals in the dominant culture (Kunstman, Plant,
147 & Deska, 2016).

148 Eventually, the “invisibility of low-income persons” (Lott, 2002, p. 100) in the literature
149 and theories of psychology was challenged with an affirmative statement by the American
150 Psychological Association (APA) in 2000. Specifically, the APA resolved to advocate for and
151 support research and public policy efforts that address poverty and socioeconomic status (APA,
152 2000). The APA Socioeconomic Status Office, established in 2007, develops and disseminates
153 relevant fact sheets and reports highlighting the impact of SES and poverty on psychological and
154 social well-being (see http://www.apa.org/pi/ses/index.aspx).

155 Given the pervasive influence of socioeconomic factors on multiple life domains, it is
156 imperative that psychologists understand the influence of income and economic marginalization
157 on help-seeking behaviors and treatment effectiveness. This understanding will expand the realm
158 of psychological practice to become more welcoming and inclusive of individuals with LIEM
159 circumstances, and help to ensure that people, regardless of wealth, come to view psychological
160 interventions as relevant tools rather than luxuries solely intended for the wealthy. Further, it is
161 important to train future and current psychologists to recognize the impact of income inequalities

162 on individual clients and on the organizational structures that either facilitate or restrict their
163 access to services. Finally, to maintain a lasting effect on practice and training, psychological
164 researchers need to be adequately prepared to attend to and appropriate measure economic
165 factors, and to produce research that can inform effective practice.

166 **Intersectionality and LIEM**

167 The intersection of low income and economic marginalization with other identities such
168 as race, ethnicity, country of origin, immigration status, sexual orientation, gender, religion,
169 ability, language, age, and other areas of identity (e.g., Cole, 2009) is important and recognized
170 by these guidelines. Intersectionality (Crenshaw, 1989) refers to the cumulative impact on
171 marginalized individuals of overlapping and interrelated sources of discrimination and
172 oppression.

173 There is a large correlation between economic marginalization and holding other
174 marginalized identities; for instance, children or persons under 18 years of age, of any
175 background, are more likely to experience poverty than adults (Bruner, 2017). Among adults,
176 women are more likely to live 200% below the poverty line than men (National Center for
177 Health Statistics, 2017), perhaps due to the sustained gender gap in pay and wages (Graf, Brown,
178 & Patten, 2018). Additionally, people of color are disproportionally affected by economic stress
179 (Bruner, 2017), and people of color are also more likely to identify as having a lower
180 socioeconomic status (APA, 2017). American Indians, for example, are almost two times as
181 likely to live in poverty as the total national average (Wilson & Mokhiber, 2017) and
182 unemployment in some reservation communities is as high as 21%, compared to the national
183 unemployment rate of 4.1% (Hagan, 2018). Further, skin color can further increase these
184 disparities, with darker skin being associated with lower socioeconomic resources (Hochschild &

185 Weaver, 2007). In a recent report, *Stress and Health Disparities* (APA, 2017), the APA Working
186 Group on Stress and Health Disparities highlighted the complex interplay between race and
187 social class in stress exposure. The APA highlighted that the existence of higher levels of threat
188 to safety and achievement, combined with gaps in economic resources, contributes to higher
189 levels of stress that further exacerbate health disparities for individuals who are both
190 economically marginalized and members of minority groups (APA, 2017). Lesbian, gay,
191 bisexual, and trans (LGBT) youth also commonly experience economic difficulty, particularly
192 homelessness, and become homeless more often than heterosexual persons, often due to familial
193 discrimination (Whitebeck, Chen, Hoyt, Tyler, & Johnson, 2004). Regarding immigration status,
194 immigrant Latinx children are more likely to live below the federal poverty line than White
195 children, although, immigrant status has sometimes been found, paradoxically, to be a protective
196 factor for adverse childhood experiences (Loria & Caughy, 2018). Adult undocumented
197 immigrants are known to experience economic difficulty related to their decreased abilities to
198 gain employment and use government benefits without citizenship (Passel & Cohn, 2009).
199 Finally, persons with disabilities also experience poverty more than persons who do not have
200 disabilities (Palmer, 2011). This relationship is related to an increased prevalence of
201 unemployment, stigma and discrimination (Hughes & Avoke, 2010; Stevens et al., 2016). In
202 addition, health care disparities and exposure to environmental and other hazards have
203 contributed to a relationship between poverty and intellectual disabilities (Emerson, 2007). This
204 relationship is intensified by the exclusion of individuals with intellectual disabilities from
205 employment opportunities (Emerson, 2007). For example, in 2016 only 35.9% of people with
206 disabilities were employed, compared to 76.6% of people without disabilities, and the median
207 earnings of people with disabilities was approximately two-thirds of those without disabilities

208 (Kraus, Lauer, Coleman & Houtenville, 2018). Ironically, systems of assistance (such as Social
209 Security Disability benefits) are only available to people who earn very little money
210 ($1,220/month in 2019; Social Security Benefits Planner, n.d.), perpetuating the relationship
211 between poverty and disability.

212 Importantly, disparities in wealth across groups are even more pronounced than income
213 disparities. Wealth is generally identified as the level of net worth or accumulated assets (Piketty,
214 2014), and may therefore indicate a more stable indicator of SES or social class than income.
215 For example, Killewald and Bryan (2018) found that the median White household wealth is 13
216 times greater than the median Black household wealth. Wealth disparities have also been found
217 to be associated with differences in health status across racial/ethnic groups (Pollack, Cubbin,
218 Sania, Hayward, Ballone, Flaherty & Braverman 2013). Ultimately, when psychologists are
219 working with LIEM populations, it is important to understand how social class, income, SES,
220 and wealth may intersect with multiple other socially marginalized identities, and how detriment
221 arising from membership in one or both groups may be exacerbated.

222 **Purpose**

223 The purpose of the Guidelines for Psychological Practice with Low-Income or
224 Economically Marginalized (LIEM) individuals (hereafter Guidelines) is to assist psychologists
225 in the provision of culturally competent care for those whose economic position has negatively
226 impacted or constrained their health and well-being. Culturally-informed care for individuals
227 who are LIEM both attends to and accounts for the financial barriers, social marginalization and
228 differentiated developmental trajectory of those who have been impacted by economic
229 constraints. These constraints are not purely monetary and can include variables such as access
230 to quality school districts, childcare, access to adequate insurance, family size, cultural capital,

231 and a range of other indicators of one's social class identity. Psychologists who wish to provide
232 culturally-appropriate care are encouraged to design services and interventions that consider
233 these types of barriers both in how they facilitate access to care and administer services.

234 **Documentation of Need**

235 The APA Council of Representatives adopted the *Resolution on Poverty and*
236 *Socioeconomic Status (SES)* (2000; 2010) and commissioned the APA Task Force on
237 Socioeconomic Status to study the impacts and consequences of poverty and low SES. This
238 action culminated in the establishment of an APA Socioeconomic Status Office (OSES) and a
239 permanent Committee on Socioeconomic Status (CSES) in 2011. The OSES provides advocacy
240 and input on federal policies and legislation, focused on reducing inequality and disparity related
241 to income and socioeconomic status (APA SES Office, n.d.).

242 The work of the SES Office and CSES subsequently identified the need to develop
243 guidelines to help clinicians, trainees, and researchers more effectively address poverty and
244 economic marginalization in their psychological work. Therefore, the CSES initiated the work
245 of a new Task Force in 2016, the Task Force on Developing Guidelines for Psychological
246 Practice for Persons with Low-Income and Economic Marginalization. This Task Force, which
247 authored the current Guidelines, has relied heavily on the resources of the APA SES Office and
248 the goals of the CSES.

249 The current Task Force has also drawn from the critically important *Report of the APA*
250 *Task Force on Socioeconomic Status* (APA, 2007), which offered several recommendations that
251 have served to guide the development of the proposed guidelines. The Task Force on
252 Socioeconomic Status recommended that APA "work to expand support for psychological
253 research, education, practice, and public policy addressing SES and social class," and "work to

254 strengthen clinical practice through the integration of SES/social class (p. 27)," as well as
255 "encourage an increase in training and education in psychology related to socioeconomic status
256 and social class (p. 28)." The role of social class and income disparity has become even more
257 critical in the decade since the Task Force on Socioeconomic Status recommendations were
258 made, as psychologists in the United States are working with clients and trainees who live in an
259 increasingly bifurcated economic reality that has substantial influence on health and well-being.
260 This Guidelines document therefore builds on the original report of the Task Force by providing
261 recommendations for education, research and clinical practice based on contemporary empirical
262 support. The specific steps taken by the Guidelines Task Force are described in the following
263 Guidelines Development Process section.

264 **Users of the Guidelines**

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

276 **Beneficiaries of the Guidelines**

277 Although financial conditions contribute to shaping the identity of those from all ends of
278 the economic spectrum (e.g., working class, middle class, upper class, top 1%), these guidelines
279 are focused specifically on those at the lower end of the continuum. The guidelines are designed
280 to benefit adults, children, and families who have previously experienced, or are currently
281 experiencing, economic marginalization. It is critical to note that most psychologists, and even
282 most psychologists-in-training, are not themselves living in LIEM situations. Therefore,
283 sensitivity to the issues presented in these Guidelines must be developed in order to provide
284 culturally competent psychological services and conduct culturally informed research. The APA
285 Resolution on Poverty and Socioeconomic Status (2010) identifies the following populations to
286 be at a higher risk of facing economic marginalization: racial and ethnic minorities, refugees,
287 documented and undocumented immigrants, elderly individuals, veterans, persons with
288 disabilities, those affected by mental illness, individuals who identify as LGBTIQ, single
289 mothers, youth, foster children, and families.

290 **Distinction between standards and guidelines**

291 As stated by APA (2015), “The term *guidelines* refers to statements that suggest or
292 recommend specific professional behavior, endeavor, or conduct for psychologists. *Guidelines*
293 differ from standards. *Standards* are mandatory and, thus, may be accompanied by an
294 enforcement mechanism; *guidelines* are not mandatory, definitive, or exhaustive. *Guidelines* are
295 aspirational in intent. They aim to facilitate the continued systematic development of the
296 profession and to promote a high level of professional practice by psychologists. A particular set
297 of *guidelines* may not apply to every professional and clinical situation with the scope of that set
298 of guidelines. As a result, *guidelines* are not intended to take precedence over the professional
299 judgments of psychologists that are based on the scientific and professional knowledge of the

300 field (Ethics Code, Std. 2.04)" (p. 824). Practice guidelines are intended to be consistent with
301 ethical practice, as defined in the *Ethical Principles of Psychologists and Code of Conduct of the*
302 *American Psychological Association* (APA, 2010). In the event of a conflict with the Ethics
303 Code, adherence to ethical conduct takes priority. In addition, federal or state laws may
304 supersede these Guidelines,

305 **Guidelines Development Process**

306 *Initial stages within CSES*

307 Initial action steps for the guidelines began in 2013 and continued until 2016 within
308 CSES. During this time several key decisions were made by CSES pertaining to the goals for the
309 guidelines. The title of the guidelines was decided and area of focus being LIEM populations
310 was determined. The decision to include "domains" of key areas within SES research was also
311 made at this time. In addition, the decision to include key definitions of SES terminology within
312 the document was made by the committee. CSES also consulted with several experts within APA
313 pertaining to guideline development including representatives from BAPPI, BEA, and COPPS.
314 CSES also reviewed established professional practice guidelines including the *Guidelines for*
315 *Psychological Practice With Transgender and Gender Nonconforming People* and *Professional*
316 *Practice Guidelines for Integrating the Role of Work and Career Into Psychological Practice*.
317 These were the most recent professional practice guidelines approved by the APA.

318 In addition, several keys tasks were accomplished during this time pertaining to the
319 production of the document. Rough drafts were produced of the introduction, definitions,
320 guidelines headings, and several of the domains. An extensive reference list was produced
321 covering most of the major SES studies produced within the field over the past 40 years.

322 *Development of APA Task Force*

323 In 2016 CSES made the decision to move the guideline process to a task force. This
324 decision was made for several reasons. First, the rotating nature of the CSES committee made it
325 difficult for any members to consistently stay committed to the project over time. Second, the
326 committee was balancing multiple projects at once, and felt the guidelines needed specific focus
327 and a dedicated team. Third, the committee had concerns related to the timeline and believed that
328 the guidelines could be developed more expediently with a dedicated task force. An open call
329 for task force members was sent out. CSES reviewed task force members and eventually
330 submitted these to BAPPI. The following members were elected to the committee: Cindy
331 Juntunen, Ph.D., Astrea Greig, Psy.D., Jameson Hirsch, Ph.D., Amy Peterman, Ph.D., Denise
332 Ross, Ph.D., and Mindi Thompson, Ph.D. In addition, Kipp Pietrantonio, Ph.D., who had been
333 leading the project over the past several years as a member of CSES, elected to join the task
334 force and Darren Barnal, Ph.D. joined as a current liaison for CSES. Cindy Juntunen was chosen
335 as chair of the task force.

336 *Development process*

337 The task force began meeting in spring of 2017 and continued meeting on a monthly to
338 biweekly basis. All rough draft materials created were transferred from CSES to the task force.
339 The task force reviewed established drafts and determined that, due to overlap, the original eight
340 domain areas could be categorized into four areas.

341 **Boundaries of Applicability**

342 These guidelines are limited in several important noteworthy ways. First, these guidelines
343 are grounded in providing culturally competent care and not in changing or modifying one's
344 social class position. Although it is excellent to provide care that aids individuals in raising their
345 social class position, these guidelines are not designed specifically for this purpose. Second, the

346 guidelines are not intended to stereotype or pathologize people who live in poverty. These
347 guidelines speak to general themes pertaining to individuals living in LIEM conditions, but these
348 themes are not universal and may or may not be applicable to all individuals. Finally, it is
349 important to attend to intersectionality with other cultural identities when utilizing these
350 guidelines. Although the APA Resolution on Poverty and Socioeconomic Status identifies
351 specific economically at-risk populations, it should be noted that each of these groups face
352 unique challenges.

353 **The Guidelines**

354 Nine guidelines are presented in four major domains: Training and education, Health
355 disparities, Treatment considerations, and Career concerns and unemployment. Each guideline is
356 presented with a Rationale supporting the value or need for the Guideline and an Application
357 section. The applications are organized by individual, community, and structural/policy
358 applications. This multilevel approach is used to demonstrate the importance of attending to
359 social context and policy, as well as individual concerns, when working with clinical, training,
360 and research situations that are impacted by LIEM.

361 **Overview of the Guidelines**

362 Domain 1: Training and Education

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

368 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 LIEM people.

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 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 LIEM and how to best 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 socioeconomic status than the students they teach, clients with whom they work, and those who participate in research (Appio, Chambers, and Mao, 2013; Lott, 2002; NORC Scores, 2012; Smith, 2005; U.S. Department of Labor, 2014). The cultural mismatch between psychologists and those they teach has great potential for biases and "blind spots," when interacting with students from low-income backgrounds (Liu, 2010, p. 5; 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 of this is that the lived experiences of many psychologists may not reflect the lives of LIEM students, nor the material being taught (APA, 2008). 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, Foley, & Chaney, 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, 2008; Foley & Chaney, 2008; Liu, 2010; Liu, Soleck, Hopps,

415 Dunston, & Pickett, 2004; Smith, Lott & Bullock, 2007). The effect of this is that students do not
416 develop knowledge, or a critical lens, related to socioeconomic status and social class issues. In
417 addition, within clinical training sites, the lack of education related to multicultural competency
418 with low-income people could result in less effective treatment, or even harmful effects for
419 clients (APA, 2017; Appio, Chambers & Mao, 2013; Kim & Cardemil, 2012; Liu et al, 2007).
420 Psychologists who intend to increase their multicultural competence pertaining to SES are
421 encouraged to be mindful of how the absence of SES concerns within their teaching materials or
422 supervision may reflect their own bias or lack of knowledge pertaining to the subject matter.

423 *Systemic Bias*

424 Beyond omissions of social class material and consideration, there may also be systemic
425 class bias built into educational environments. Some research indicates that low-income/first-
426 generation college students tend to face more barriers than their more affluent counterparts.
427 (Terenzini, Springer, Yaeger, Pascarella, & Nora, 1996; Thayer, 2000; Bui, 2002; Goldrick-Rab
428 2006; Ramos-Sánchez, & Nichols, 2007). Within graduate psychology training, class-based
429 discrimination may also exist. Unexpected or miscellaneous costs tend to add up and have a
430 greater impact on those from LIEM backgrounds. Textbooks costs, assistantship funding, costs
431 related to practicum sites, dissertation credit hours while on internship, costs of applying and
432 moving for clinical internships, and costs of assessment materials, are just a few examples of
433 these unexpected costs that many low-income students may not be aware of when beginning
434 their training (Doran et al, 2016; Pietrantonio & Garriott, 2017)

435 *Interpersonal Bias*

436 In addition to systemic biases, many low-income students may face interpersonal
437 classism and microaggressions within the student-teacher/supervisor/supervisee interaction. The

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

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

457 *Upward mobility bias*

458 Another bias is the upward mobility bias (Liu, Soleck, Hopps, Dunston, & Pickett, 2004),
459 which is defined as the belief that all people are interested in raising their social class or adopting
460 middle/upper class values. Psychologists are especially susceptible to this bias due to educational

461 attainment needed within the field (e.g., doctoral degree). This bias can best be presented as a
462 belief system positing that if one is not pursuing upward social class mobility within society,
463 they must be lazy, incompetent, or a poor decision maker.

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

472 *"Idealization" Bias*

473 Another bias is the "idealization" of individuals who are poor (Liu, Pickett, & Ivey,
474 2007) as hard working underdogs pursuing the American dream. Although this stereotype is
475 positive, it can also paint students from LIEM backgrounds in a false light, which may
476 undermine their needs. The first issue is the assumption that poverty, somehow, has value in
477 society and provides low income people with a "can do" work ethic. Similar to the just world
478 belief (See Appendix B), this assumption asserts that life provides a "trade off" to those unfairly
479 born into poverty (Lerner, 1980, Smith, Mao, Perkins, & Ampuero, 2011), perhaps manifesting
480 as the thought "*You may have been born poor, but you learned to be a hard worker, so life is*
481 *fair.*" Second, this bias portrays poverty as something that can be transcended through pure will
482 power and ignores systemic constraints that keep people in poverty. This romanticizing is often
483 displayed in American media and falsely portrays poverty as something of value. Third, this bias

484 puts an expectation on poor people to work harder than those not in poverty and instills an (often
485 false) insistence that this work will result in the transcendence of economic conditions (Kraus &
486 Tan, 2015).

487 *Class Blindness Bias Toward Student Financial Concerns*

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

499 In the United States, cumulative student debt has now surpassed 1.3 trillion dollars and
500 the cost of post-secondary education has increased by 250% in the past 30 years (Johnson,
501 VanOstern, & White, 2012). Within graduate education in psychology, the average student loan
502 debt incurred by students is now over $100,000 although the average starting salary has
503 remained stable at slightly over $60,00 $63,260 (Doran et al, 2016). Some research has shown
504 that training programs and professors tend to avoid discussing student debt concerns with their
505 students (Olsen-Garriot, 2015). This aversion to discussing student debt can be damaging, as
506 those from low income backgrounds tend to have lower financial literacy (Chen and Volpe,

507 1998; Chen & Volpe, 2002; Xu & Zia, 2012; Pietrantonio & Garriott, 2017). Faculty must be
508 cautious about discussing the specific financial concerns of students, in order to avoid dual
509 relationships or violation of privacy. However, the aversion to discussing financial/debt
510 concerns more generally with students, or even the failure to recognize this as a salient
511 professional issue, can have a negative effect, potentially allowing students to make financial
512 choices that could negatively affect them across their lifespan (Lantz & Davis, 2017),

513 **Application**

514 *Individual Application*

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

530 students. In addition, social class issues can be implemented in supervision discussions with
531 relative ease, alongside other cultural variables. Asking supervisees to assess for social class
532 variables and to examine differences between themselves and their client's pertaining to SES
533 may raise class awareness for both the supervisor and supervisee. For additional resources, a
534 curriculum of social class related teaching materials and exercises can be found on the Office of
535 the Committee on Socioeconomic Status' webpage (APA, 2008).

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

553 reflective stance about the impacts of social class and how it (and other intersecting social
554 forces) shaped those communities is adopted (Mitchell, 2008).

555 *Community/Structural Applications*

556 Pursuing continuing education opportunities that focus on social class issues within the
557 field can help psychologists address community-level applications. These opportunities provide
558 opportunities to form networking relationships with other psychologists and to learn more about
559 community resources. For example, each year, a range of trainings with both individual and
560 community level relevance are offered at the APA Convention through the Office on
561 Socioeconomic Status. Similarly, The Society for the Psychological Study of Social Issues
562 (SPSSI), Division 17: Society of Counseling Psychology, Division 45: Society for the
563 Psychological Study of Culture, Ethnicity and Race regularly provide programing related to
564 working with LIEM populations.

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

576 Specifically, financial incentives and power differentials may be more likely to have an adverse
577 impact on the economically marginalized.

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

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

598 relatively low cost for programs, dramatically reducing travel and application costs for
599 applicants.

600 ***Guideline 2: Psychologists are encouraged to increase their knowledge and understanding of***
601 ***social class issues, including poverty and wealth, through continuing education, training,***
602 ***supervision and consultation.***

603 **Rationale**

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

614 Thus, when future and practicing psychologists are not aware of the impact of poverty on
615 clients' lives, they may inadvertently demonstrate social class bias in the form of withholding
616 access to effective treatments and/or services, which can inhibit effective treatment outcomes for
617 clients who are already placed at a greater risk for depression and other mental health conditions
618 associated with poverty. To address the issue of systemic barriers and social class bias for
619 lower-income clients, the APA (2000) resolved in its "Resolution on Poverty and SES" to:

620 encourage in psychological graduate and postgraduate education and training curricula more
621 attention to the causes and impact of poverty, to the psychological needs of poor individuals and
622 families, and to the importance of developing "cultural competence" and sensitivity to diversity
623 around issues of poverty in order to be able to help prevent and reduce the prevalence of poverty
624 and to treat and address the needs of low-income clients.

625 **Application**

626 *Individual Applications*

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

634 In addition to dialogues related to social class, there are several training activities that can
635 help raise social class awareness. Assigning readings that focus on social class issues and
636 engaging in classroom activities which raise awareness of social class differences can be
637 powerful experiences for developing psychologist. A large list of resources, suggested course
638 content, and classroom activities is available in the *Report of the APA Task Force on Resources*
639 *for the Inclusion of Social Class in Psychology Curricula (APA, 2006)*

640 *Community/Structural Application*

641 Educational programs and environment can also be shaped to better train clinicians in
642 terms of SES competency. In terms of curriculum, there are several recommended competencies

643 to prepare psychology professionals for practice with LIEM populations. These include : 1)
644 Developing a professional identity that includes social class awareness, 2) appropriate
645 interpersonal relations to LIEM clients, 3) knowledge of social and economic issues experienced
646 by LIEM clients, 4) measuring social class in research, 5) adapting evidence-based practices, 6)
647 incorporating practical experiences in training settings, and 7) administration and advocacy
648 (Stabb & Reimers, 2013). Additionally, training programs can help trainees become aware of
649 factors that produce stress for lower-income clients, rates of poverty over time, the
650 intergenerational nature of poverty, and the relationship of poverty to national trends in their
651 communities. Additionally, training programs can help trainees become aware of factors that
652 produce stress for lower-income clients, rates of poverty over time, the intergenerational nature
653 of poverty, and the relationship of poverty to national trends in work and education.

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

662 In addition, we encourage psychologists to take SES issues into account when teaching
663 research methods, especially concerning sampling. Teachers should encourage students to be
664 thoughtful of whether their samples are inclusive of LIEM populations and the potential impacts
665 of either including or not including this group on the results of research. Students should also be

666 thoughtful of the impact of their research on communities. Students should be encouraged to use
667 their research to support economically marginalized communities when possible and to mitigate
668 against economic exploitation and harm that could be by products of research. Finally, we
669 strongly encourage training programs to be intentional about the way that they introduce SES as
670 a multicultural topic to students. Due to the historical neglect of this topic within the field, being
671 thoughtful of how and when this topic is introduced to students is of critical importance. The
672 authors recommend that SES issues to be discussed early in multicultural training and discussed
673 as a unique component of identity that has been disentangled from other cultural variables.

674 **Domain 2: LIEM and Health Disparities**

675 ***Guideline 3: Psychologists strive to understand the contribution of economic and social***
676 ***marginalization to the substantial health disparities in our society.***

677 **Rationale**

678 Beginning with the landmark Whitehall studies (Marmot et al., 1991), strong evidence
679 has developed for a graded-inverse relation between economic status and health. That is, the
680 impact of SES on health does not follow a threshold model that would indicate SES only
681 contributes to poor health in people with the fewest economic resources (e.g., those living below
682 the federal poverty guidelines; Adler & Stewart, 2010). Rather, the association between SES and
683 health is an inverse gradient (Adler & Ostrove, 1999; Evans, Wolfe & Adler, 2012) that can be
684 visualized as a ladder, with those on a higher step tending to have better health than those on a
685 lower step, regardless of where in the ladder they are. Thus, psychologists are advised to
686 consider the potential negative impact of SES on the health of all patients, not only those who are
687 living in poverty.

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

699 Multidisciplinary efforts have demonstrated that LIEM status contributes to health
700 disparities through a variety of mechanisms. These generally fall into four basic categories: 1)
701 substantially greater acute and chronic stress, with concomitant negative psychological and
702 physiological (e.g., neuroendocrine, immune) consequences (e.g., Grunewald, et al., 2012;
703 Matthews & Gallo, 2010); 2) greater exposure to unhealthy environmental factors including
704 pollution in its various forms, damaged infrastructure (e.g., the built environment), social
705 tension, crime, and other violence (Schüle & Bolte, 2015); 3) poorer health behaviors, including
706 fewer opportunities to engage in health promoting behaviors such as affordable healthy food
707 options and safe, accessible places to exercise (Nandi, Glymour & Subramanian, 2014); and 4)
708 lower levels of access to quality healthcare including prevention programs, medication, quality
709 care, specialty services, and tertiary care options (Allen, Wright, Harding & Broffman, 2014;
710 Arpey, Gaglioti & Rosenbaum, 2017).

711 The impact of these mechanisms can be quite pervasive, as growing up in a LIEM
712 household can contribute to lifelong negative health consequences, regardless of a person's SES
713 in adulthood (Evans, 2004; Johnson, Riis, & Noble, 2016). Psychologists can strive to recognize
714 how a marginalized social environment can be developmentally damaging (Schonkopf, et al.,
715 2012), leading to difficulties in interpersonal functioning (e.g., thwarted belongingness; Ruscio,
716 et al.,), cognitive-emotional processing and regulation (e.g., distress, hopelessness; Johnson,
717 Langley & Shelton, 2017), and cognitive-intellectual ability (Johnson, Riis, & Noble, 2016).
718 A potentially explanatory, conceptual model has been advanced by psychologists Miller
719 and Chen (2013; Miller, Chen & Parker, 2011). It posits that exposure to SES disadvantage in
720 childhood may result in: a) social (e.g., poor nurturance) and physical (e.g., toxin exposure,
721 violence) risk factors during sensitive periods in childhood; and b) consistent behavioral
722 responses (e.g., threat sensitivity, unhealthy lifestyle factors) that can continue into adulthood.
723 These disadvantages interact with epigenetic factors to produce a stable, pro-inflammatory
724 phenotype that predisposes children to greater burden of chronic mental and physical disease in
725 adulthood. Importantly, their model also investigates sources of resilience that may buffer the
726 negative consequences of a low SES environment during childhood. These include maternal
727 nurturance (Chen, Miller, Kobor & Cole, 2011) and a positive family emotional climate (Miller
728 & Chen, 2010). Such research is highly significant, as it helps to avoid over-pathologizing all
729 low-SES families and acknowledges the importance of psychosocial resources for buffering
730 SES-related challenges.
731 It is important to recognize that the burden of having a LIEM status includes not only the
732 strain of limited resources, but also the associated stigma, and the internalization of
733 marginalization. Indeed, a recent meta-analysis demonstrated that measures of subjective social

status (SSS) 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.

Application

Individual Application

Psychologists strive to respect the client's priorities, including as they occur within the context of socioeconomic status 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 to understand how historical, socially-constructed and intergenerational forces can impact health; how psychological and physical health are intertwined; and, 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, child-care, and transportation challenges; sliding scale fees; stigma reduction). In this respect, the psychologist may collaborate in an interdisciplinary and integrated fashion, with social work,

756 nursing, public health and medical colleagues, to optimize access to, and receipt of, quality care,
757 including recommended psychological intervention.

758 Readers are referred to several excellent resources for enhancing their ability to
759 implement these recommendations, including *Social Class and Classism in the Helping*
760 *Professions: Research, Theory, and Practice* (Liu, 2012) and *Psychology, poverty and the end of*
761 *social exclusion: Putting our practice to work* (Smith;2013) to specifically address
762 socioeconomic status and social class. Other texts, such as *Addressing cultural complexities in*
763 *practice* (Hays, 2016) and *Cultural humility: engaging diverse identities in therapy* (Hook,
764 Davis, Owen & DeBlaere, 2017), provide information and guidance for considering LIEM status
765 in intersection with other marginalized identities.

766 *Community/Structural Application*

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

777 The movement within the field toward integrated healthcare produces unique
778 opportunities to provide competent care for LIEM populations (Farber, Ali, van Sickle, &

779 Kaslow, 2017; Hodgkinson, Godoy, Beers & Lewin, 2016). Although receipt of primary care can
780 also be a challenge for individuals who are LIEM, the availability of safety-net medical clinics
781 and federally-qualified health centers (FQHCs), as well as expanded insurance options resulting
782 from the Affordable Care Act (ACA), provide some enhanced opportunity for medical care. In
783 addition to allowing greater accessibility for a wider range of patients, such integration helps to
784 decrease the stigma associated with seeking help from a psychologist or other mental health
785 provider (Shim & Rust, 2013). Indeed, decreased stigma is a primary principle of integrated
786 care: that is, physicians provide a "warm handoff" of the patient to a psychologist, with a clear,
787 biopsychosocial explanation for the role played by that provider in enhancing health and well-
788 being.

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

798 ***Guideline 4. Psychologists strive to promote equity in the access to, and the quality of,***
799 ***healthcare available for people living in LIEM situations.***

800 **Rationale**

801 Access to quality healthcare for physical and mental illness is inextricably woven with
802 socioeconomic status. Much of this association is the result of being underinsured or lacking
803 insurance coverage, as well as spiraling costs of co-pays and deductibles. Although insurance
804 coverage was improved by such efforts as the Affordable Care Act, near-poor (23.9%) and poor
805 (26.2%) members of the U.S. population were more likely to be uninsured than those who are
806 non-poor (7.7%; Martinez & Ward, 2016). Data are similar for children in the U.S.; in 2017,
807 among children 0-17 years old, non-poor children (3.7%) were less likely to be uninsured than
808 nearly-poor (7.2%) and poor (6%) children and adolescents (Martinez, Zammitti & Cohen, 2018;
809 NHIS, year missing). Regarding mental health, some states did not comply with the ACA
810 guidelines to expand Medicaid coverage as part of the Affordable Care Act, and subsequently
811 have penalized those with mental health needs. For instance, low-income, uninsured persons are
812 30% less likely to obtain mental health treatment than their Medicaid-insured counterparts (Han
813 et al., 2015), and this may particularly disadvantage young adults, who fall into a gap between
814 parental coverage and excessive premiums (Palmer, 2016).

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

820 The difference between healthcare available to people with higher vs lower SES includes
821 not only access to early screening and detection opportunities, but also differences in the range
822 and quality of care received. For example, people of color, who are typically more economically
823 disadvantaged than white people, receive fewer medical procedures and poorer quality medical

care than whites (Williams & Wyatt, 2015). As examples, impoverished persons, as well as African American and Hispanic persons in the lowest-quintile SES group, receive less nephrological care for kidney disease (Nee, Yuan, Hurst, Jindal, Agodoa, & Abbott, 2017), and poorer children with cancer receive fewer medical screenings and less care during their treatment regimen (Caplin et al., 2017).

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 healthcare resources (Adler, Cutler, Jonathan, Galea, Glymour, Koh & Satcher, 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); as well, LIEM persons may have be unable to afford required copays and deductibles (Adler et al., 2016). Such patterns of disparity are critical to recognize, as strong evidence demonstrates that both access to, and quality of, care contribute significantly to disparities in disease severity at diagnosis, quality of condition management, and subsequent morbidity, recovery, and mortality.

Application

Individual Application

846 Prevention and intervention efforts may need to be altered for LIEM persons. Intervention
847 efforts, including flexible scheduling (e.g., nights and weekends), brief interventions within
848 integrated healthcare settings, and alternative delivery methods (e.g., telehealth), that may make
849 mental health treatment more accessible are described in the Treatment Domain of these
850 guidelines (See Domain 3). Short-term trans-diagnostic treatments have been shown to be
851 effective in primary care settings (Cape, Whittington, Buszewicz, Wallace, & Underwood,
852 2010), which may be more accessible to LIEM persons needing treatment for substance abuse,
853 anxiety and depression. In addition, prevention efforts are needed to better understand
854 population-level and individual-level barriers to health care. For example, the development of
855 multi-method assessments to identify barriers can be useful to highlight problematic access
856 issues, including income, that stand in the way of service seeking and delivery. Combinations of
857 qualitative inquiries with quantitative surveys across diverse groups of consumers and potential
858 consumers of psychological service would provide valuable insight into the factors that facilitate
859 and limit usage. Assessment methods may be modified for use with low literacy populations and
860 using localized idioms of distress may help ensure reliability and validity (Kohrt, Luitel,
861 Acharya, & Jordans, 2016).

862 ***Community/Structural Application***

863 Psychologists are encouraged to attempt to improve equity in access to physical and mental
864 health care across settings, including within their practice and institutions, and advocate for
865 policies that promote equity for all, regardless of socioeconomic conditions. At the
866 practice/institutional level, practitioners are encouraged to support pro-equity economic
867 procedures such as sliding scales and pro-bono work, when feasible, and advocate for within-
868 institution policies to support equity in both access and quality of care. Such actions are

869 challenging to implement, but psychologists are encouraged to consider how they can work
870 within the boundaries of third-party payer regulations and requirements to increase access to
871 uninsured and under-insured individuals through flexible pay scale options. Identifying a
872 manageable proportion of low-cost and pro bono services can be developed as part of an agency
873 or practice business plan, and services can be made more accessible through telepsychology or
874 remote service delivery. Psychologists are also encouraged to educate fellow practitioners,
875 educators, and policy makers within their institution on the rationale for pursuing equity,
876 including the link between socioeconomic status, access, and health disparities, and the societal
877 benefits of a healthier population.

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

886 Given that persons from LIEM backgrounds, who are often most in need of mental health
887 care, also have the most difficult time accessing such services, community strategies to increase
888 access can be critically important. One suggestion, which is applicable for both rural and urban
889 impoverished persons, is to utilize primary care services, including pediatric primary care, as a
890 line of first defense against mental illness, given that medical settings are the largest catchment

891 area for those with psychiatric needs (Hodgkinson, Godoy, Beers & Lewin, 2017), particularly
892 for African Americans (Hudson, Kaphingst, Croston, Blanchard, & Goodman, 2016).

893 **Domain 3: Treatment Considerations**

894 Though empirical evidence resoundingly demonstrates that psychotherapy is beneficial
895 for most clients (Wampold & Imel, 2015), documented disparities in treatment utilization and
896 outcomes exist for clients from lower as opposed to higher income groups (e.g., Nadeem et al.,
897 2009; Siefert et al., 2000). Until relatively recently, much of the limited psychotherapy literature
898 related to client social class focused on treatment dropout. Results suggested that psychotherapy
899 clients from LIEM backgrounds have higher attrition rates relative to their middle- to- upper
900 class counterparts (Miranda, Azocar, Komaromy, & Golding, 1998; Siefert, Heflin, Corcoran, &
901 Williams, 2000). Additionally, research using secondary analyses of data from randomized
902 clinical trials (RCTs) has demonstrated that patients from lower, as opposed to upper, social class
903 backgrounds have decreased treatment gains from psychotherapy (Miranda, Azocar, Organista,
904 Dwyer, & Areane, 2003; Organista, Muñoz, & González, 1994). For example, results from one
905 study (Cohen et al., 2006) demonstrated that older adults who occupied low-income census tracts
906 responded less to treatment and reported greater incidences of suicidality at its conclusion than
907 their counterparts who occupied higher-income census tracts. Interested readers can find
908 additional studies in Appendix B. The prevailing pattern of findings indicate that
909 socioeconomic status and financial difficulties do, indeed, impact the delivery and efficacy of
910 psychological treatment, often resulting in difficulties accessing and remaining in care, receiving
911 appropriate care, and manifesting expected benefits from psychological services. As such,
912 psychologists are strongly encouraged to address these areas in their treatment endeavors.

913 ***Guideline 5: Psychologists acknowledge the presence of social class as a variable that is***
914 ***present in mental health treatment settings. Psychologists are encouraged to seek to***
915 ***(a) understand how social class influences psychotherapists' ability to effectively engage***
916 ***clients in treatment, and (b) attend to ways that social class differences manifest and impact***
917 ***the experience of mental health treatment for clients.***

918 **Rationale**

919 Results from quantitative (e.g., Falconnier & Elkin, 2008; Smith et al., 2011;
920 Thompson et al., 2014) and qualitative (e.g., Balmforth, 2009; Chalifoux, 1996; Thompson et al.,
921 2012) investigations have demonstrated that both clients and therapists notice markers of social
922 class within the context of psychotherapy. Indeed, one explanation for disparities in treatment
923 outcomes, purported by some (e.g., Appio, Chambers, & Mao, 2013; Ballinger & Wright, 2007;
924 Bullock, 2004; Lott, 2002; Smith, 2005), is that psychologists hold biases toward individuals
925 who are low income or poor. There is some historical evidence in the psychotherapy literature to
926 support this assertion, including expressions that lower social class clients are less introspective
927 (Gould, 1967), have "lower estimated intelligence" (Brill & Storrow, 1960, p. 343), and more
928 severe symptoms (e.g., Abramowitz & Dokecki, 1977; Trachtman, 1971) than their higher-class
929 counterparts. In 1996, Schnitzer went further by arguing that psychotherapists pass along stories
930 about clients from low-income backgrounds that reveal unexamined classist assumptions,
931 including: "they don't come in" (p. 572), "they're so disorganized" (p. 574), and "they don't
932 care" (p. 575).

933 More recent results from a series of vignette-based studies (Dougall & Schwartz, 2011;
934 Smith et al, 2011; Thompson et al, 2014) with therapists or therapists-in-training, however,
935 reveals a mixed pattern of findings regarding the presence of therapist biases. Taken together,

936 the work of these researchers indicated that mental health practitioners notice social class
937 differences in hypothetical clients and that practitioners vary in the extent to which such
938 perceived social class differences impact their overall perceptions of clients.

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

948 **Application**

949 *Individual Application*

950 Given that social class differences can introduce conscious and unconscious bias into a
951 psychotherapist's clinical judgment (Sue & Sue, 2002; Liu et al., 2004), psychologists are
952 encouraged to examine how such biases may negatively affect treatment (Gelso & Mohr, 2002;
953 Ward, 2005). Indeed, qualitative interviews with licensed mental health practitioners highlighted
954 the presence of a variety of emotional reactions that therapists have to client social class and
955 social class-related conversations in therapy, including feelings of guilt, anger, sadness, and fear
956 (Thompson et al., 2015). Psychologists are, therefore, encouraged to be attuned to their own
957 reactions that emerge in psychotherapy. Specifically, psychologists should reconsider how their
958 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 empirical 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 low-income 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 have begun to focus on characteristics of the therapist as a contributor to differential 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 patient outcomes (Baldwin & Imel, 2013). Therapist effects have been demonstrated to have implications for treatment outcomes for individuals from diverse racial/ethnic groups (Imel et al., 2011) and for clients who reported greater levels of financial distress (Thompson et

981 al., 2018). Specifically, the risk of early client attrition for clients with higher baseline financial
982 distress was attenuated (or amplified) depending on the therapist (Thompson et al., 2018).
983 Psychologists are encouraged to actively address social class as a cultural variable in
984 psychotherapy training (e.g., Bullock, 2004; Lott, 2002; Smith, 2005; Smith et al., 2012;
985 Thompson et al., 2015). Indeed, themes from qualitative interviews with clinicians (i.e., Smith,
986 Li, Dykema, Hamlet, & Shellman, 2012) indicated that practitioners had limited training specific
987 to working with clients who are living in poverty, and that they recognized their own previously-
988 held stereotypes toward individuals who are poor.

989 ***Guideline 6: Psychologists aim to understand the barriers that prevent persons with low SES***
990 ***from better accessing mental health care and make efforts to alleviate these barriers when***
991 ***providing psychological interventions and/or creating mental health care delivery systems.***

992 **Rationale**

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

997 In the United States, persons living in low-income counties have higher levels of unmet
998 mental health needs and, as per capita income increases, these unmet needs decrease (Thomas et
999 al., 2009). For example, in a study examining geographic access to mental health treatment in a
1000 large national database of over 30,000 communities based on zip code, low-income areas have
1001 fewer mental health practices and providers, but are more likely to have safety-
1002 net treatment facilities such as community health centers. As such, community health centers are

1003 often the main infrastructure of mental health services in low-income areas, perhaps because
1004 these facilities are more likely to accept Medicaid for services (Cummings et al., 2017).
1005 Children, adolescents, and adults with low-income status are often first connected to
1006 mental health care through primary care (Benson, Nierkens, Willemsen, & Stronks, 2015;
1007 Hodgkinson, 2016) or emergency services. In a study of over 100,000 persons who sought
1008 emergency treatment for a mental health reason, more than half had no prior outpatient mental
1009 health care, did not have an outpatient primary care provider, and were more likely to have low
1010 income, have immigrant or refugee status, and a rural residence (Gill et al., 2017). Such findings
1011 confirm a growing body of research indicating the importance of partnering with primary care
1012 providers and settings to encounter low-income persons with mental health needs.
1013 Clients who are from low-income backgrounds may also have unique needs and may
1014 experience a variety of barriers that make accessing and engaging in traditional mental health
1015 treatment challenging. Indeed, prior evidence suggests that individuals with social class-related
1016 concerns and stressors are less likely to access treatment given the variety of
1017 environmental barriers that make access difficult (Nadeem, Lange, & Miranda, 2008). For
1018 example, logistical difficulties (e.g., lack of or low access to transportation, difficulty
1019 attending appointments during work hours, poor access to phones or other forms of
1020 communication with treatment providers) may make accessing and engaging in mental health
1021 treatment difficult (Johnson & Zlotnick, 2009; Lenze & Potts,
1022 2017; O'Mahen, Himles, Fedock, Henshaw, & Flynn, 2013). Persons with low socioeconomic
1023 status are also less likely to have a college level education (Han et al., 2015), which is correlated
1024 to ability to understand medical information and communicate with service providers
1025 (Mantwill, Monestel-Umaña, Schulz, 2015). Language can also be a barrier for low-income

1026 persons. In a study examining referral of Latinx low-income persons to community mental
1027 health services, about one third successfully received care. However, this rate is higher than
1028 found in previous literature and is possibly attributable to the staff being bilingual and bicultural,
1029 and that mental health care was integrated into a primary care setting (Hochhausen, Le, & Perry,
1030 2011).

1031 In addition, clients from LIEM backgrounds may also be confronted with systemic
1032 barriers related to oppression and stigma that further decrease their likelihood of seeking mental
1033 health treatment. Community and familial perceptions of psychotherapy within certain
1034 communities may further decrease individuals' likelihood of seeking treatment (e.g., Santiago,
1035 Kaltman, & Miranda, 2012). As well, individuals from lower income backgrounds may face
1036 challenges that relate to basic survival needs including food security, stable living conditions,
1037 and the ability to provide a safe environment for their children (e.g., Fass & Cauthen, 2008; Foss,
1038 2012). Such needs may contribute to their belief that psychotherapy will not be helpful and/or
1039 may pose additional obstacles to treatment engagement (e.g., lack of childcare to attend sessions;
1040 allocation of limited financial resources).

1041 Perhaps not surprisingly, some authors (e.g., Goodman et al., 2010; Goodman, Pugach, &
1042 Smith, 2012) have asserted that traditional mental health interventions do not sufficiently address
1043 the complex needs of LIEM individuals, given the prevalence of an array of poverty-related
1044 characteristics (i.e., social isolation, stress, and powerlessness) in their lives. Others (e.g.,
1045 Chalifoux, 1996; Hillerbrand, 1988; Kim & Cardemil, 2012; McCarthy, Reese, Schueneman, &
1046 Reese, 1991; Parnell & Vanderkloot, 1994; Smith, 2005; Sue & Lam, 2002) have gone further to
1047 critique the historical grounding of traditional psychotherapy in middle-to-upper class values,
1048 experiences, and assumptions as contributing to its limited ability to meet the needs of clients

1049 from low-income backgrounds. Moreover, available evidence suggests that mental health
1050 care providers often feel inadequate in their ability to address client's basic needs (e.g., Kim
1051 & Cardemil, 2012; Smith et al., 2012; Thompson et al., 2015).

1052 **Application**

1053 *Individual Application*

1054 Psychologists are encouraged to consider acts of advocacy that may contribute to client
1055 treatment engagement, retention, and outcomes. Small advocacy-based steps can improve the
1056 therapeutic alliance and act as psychological intervention. Goodman and colleagues (2003) made
1057 the case for therapists to engage in acts of advocacy on behalf of clients from lower income
1058 backgrounds, which may entail working "beyond the 50-minute hour". Several authors (e.g.,
1059 Goodman et al., 2010; Santiago et al., 2012; Sells et al., 2007) have further suggested that
1060 psychologists working with LIEM persons be called upon to extend or be flexible within their
1061 roles. Such acts were highlighted by self-identified LIEM clients as enhancing psychotherapy
1062 experiences in one investigation (Thompson et al, 2012). When appropriate to the
1063 situation, psychologists may consider activities such as writing letters of support regarding
1064 clients' access to particular benefits (e.g., housing subsidies, Social Security Disability Income,
1065 scholarship opportunities for education or training), providing flexibility in fees (e.g., utilizing
1066 sliding scale fee structures, making provisions for gaps in insurance coverage), and facilitating
1067 the coordination of a client's mental health care (e.g., communicating directly with the client's
1068 prescriber, assisting with insurance concerns). Clients who identify as low income highlight the
1069 importance of the small, yet meaningful acts of advocacy undertaken by their therapists, which
1070 were perceived as contributing to their positive treatment experiences (Thompson et al., 2012).

1071 Psychologists are also encouraged to consider the many external factors that prevent
1072 individuals from low-income backgrounds from accessing care. Barriers to treatment can include
1073 transportation concerns, long waiting lists, or complex intake processes that require access to a
1074 permanent phone or mailing address or access to a computer (Santiago, Kaltman, & Miranda,
1075 2013). Psychologists might consider taking steps when creating and providing services to reduce
1076 these barriers. For example, to help reach participants in a recent study examining the efficacy
1077 of psychotherapy with low-income women experiencing depression during pregnancy, they were
1078 provided with public transportation vouchers for appointments, flexible visit times, reminder
1079 calls, and activities for children during appointments (Lenze & Potts, 2017). This research
1080 highlights the need to make services available at non-standard hours, including evenings and
1081 weekends. Given that many LIEM individuals are working in situations where they may be
1082 unable to take time off for appointments, access to treatment is dependent on having a broad
1083 range of service hours.

1084 Using technology is a helpful, often inexpensive, means to provide psychological
1085 intervention. Telephone calls and mailings (Fu et al, 2016), cell phone messages and texts
1086 (McInnes, Li, & Hogan, 2013), and tele-psychology treatment of depression (Sheeber et al,
1087 2017) have all demonstrated effectiveness with clients from LIEM backgrounds. In sum,
1088 alternative forms of therapeutic outreach may provide psychologists with additional means to
1089 provide needed services to LIEM individuals.

1090 Psychologists will likely benefit from being mindful of language and client literacy
1091 level. This may be accomplished by insuring that therapeutic approaches and materials are
1092 educationally-appropriate, given that persons with low SES often have lower levels of education

1093 and health literacy. For instance, recent adaption of group cognitive behavioral treatment to
1094 adjust for literacy levels has shown efficacy (Thorn et al., 2018).

1095 *Community/Structural Application*

1096 At a systemic level, psychologists are encouraged to examine their assumptions about
1097 traditional definitions of mental health treatment. Some scholars and practitioners (e.g., Appio et
1098 al., 2013; Ballinger & Wright, 2007; Bullock, 2004; Goodman et al., 2010; Lott, 2002; Smith et
1099 al., 2012) have noted that sentiments passed among psychotherapy training programs speak to a
1100 general lack of appreciation for engaging in "non-traditional" work activities. Indeed, some
1101 therapists in Thompson et al.'s (2015) qualitative investigation noted their "frustration toward
1102 their colleagues who scoff at them when they engage in this 'extra' work or who argue that case
1103 management or advocacy is 'not a therapist's job'."

1104 How psychologists deliver psychological interventions to persons with LIEM can also be
1105 broadened. This can include outreach work in non-traditional settings including conducting in-
1106 home psychotherapy, visiting community sites, and homeless shelters. Given the difficulty in
1107 making community appointments, in-home psychotherapy is an option to reach this population,
1108 and may be more cost effective than standard care (Ammerman, Mallow, Rizzo, Putnam, &
1109 Van Ginkel, 2017). Psychotherapy provided in shelters is beneficial and decreases PTSD
1110 symptomatology and improves psychosocial functioning. Importantly, shelter-based
1111 interventions can be strengthened by including collaboration with shelter staff to better facilitate
1112 client success across life domains (Johnson & Zlotnick, 2009).

1113 Given the disparities in health status and high psychosocial need among persons from
1114 LIEM backgrounds, a multidisciplinary approach is particularly useful when working with this
1115 population, as interprofessional collaboration can enhance service provision (APA, 2017). For

example, in an analysis of recruitment channels for persons with LIEM 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 LIEM persons 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, additionally, advocate for policy change to improve low-income persons access to mental health care (APA, 2017).

1139 ***Guideline 7: Psychologists strive to understand the common clinical presentations that may be***
1140 ***more likely to occur among persons who are LIEM and how to best address these in***
1141 ***treatment settings.***

1142 **Rationale**

1143 As described earlier in this document, persons with LIEM often have higher levels of
1144 mental health symptoms (Hudson, 2005; Javanbakt et al., 2015; Sareen et al., 2011; Stansfeld et
1145 al., 2011; WHO, 2014). Yet, psychologists are also encouraged to be mindful to not over-
1146 pathologize clients living in LIEM circumstances, simply due to assumptions about potential
1147 psychopathology associated with low socioeconomic status.

1148 It is important to understand how social determinants of health, such as
1149 poverty, contribute to the frequent experience of stressors that underlie the risk for, and
1150 development of, mental health symptoms (Evans, 2004). Societal systemic disadvantage also
1151 limits the external resources which a person has available to manage their stress, including
1152 familial, social, financial, and time resources (APA, 2017).

1153 Developmentally, the effects of experiencing childhood low socioeconomic status are
1154 often long lasting, with multiple studies revealing childhood low SES as a risk factor for adult
1155 psychopathology (Hudson, 2005; Javanbakt et al., 2015; Stansfeld et al., 2011). Conversely,
1156 mental health disorders may also contribute to the experience of poverty, via social drift. This
1157 theory posits that persons with mental health disorders are more likely to have difficulty
1158 maintaining employment and housing, thereby affecting their quality of life and socioeconomic
1159 status. Social drift theory has been mildly supported in a longitudinal study where
1160 childhood mental health disorder correlated with low SES as an adult, based on employment and
1161 housing, even when accounting for childhood SES (Stansfeld et al., 2011). Likely, a bidirectional

1162 association exists where mental illness contributes to poverty which, in turn, makes it more
1163 difficult for the person to improve their socioeconomic status, thereby furthering their level of
1164 poverty (Stansfeld et al., 2011; WHO, 2014).

1165 Common presenting clinical concerns that may arise for psychologists working with this
1166 population are anxiety disorders, mood disorders, substance use, serious mental illness, and
1167 cognitive difficulties (Chow, Jaffee, & Snowden, 2003; Sareen et al., 2011; Stansfeld et al.,
1168 2011). The experience of trauma and hyperarousal and increased stress
1169 reactivity, and/or symptoms posttraumatic stress disorder is common among socioeconomically
1170 disadvantaged persons (Bender et al., 2015; Pluck et al., 2011; Riley et al., 2014; Kessler et al.,
1171 2014). Hyperarousal and increased stress reactivity are commonly found in persons with
1172 posttraumatic stress disorder (American Psychiatric Association, 2013), suggesting that perhaps
1173 the experience of poverty is a type of trauma. In general, increased experiences of trauma are
1174 also correlated with having an increased amount of additional mental health disorders (Riley et
1175 al., 2014).

1176 Low socioeconomic status is also considered to be a risk factor for developing depressive
1177 disorders later in life (Lorant et al., 2003; Sareen et al., 2011; Stansfeld et al., 2011), suggesting
1178 its cumulative effect. Furthermore, there is a strong correlation between having low SES and
1179 experiencing suicidal ideation (Sareen et al., 2011; Wetherall et al., 2015).

1180 Substance use is a common concern among LIEM persons. Stress, in the form of a
1181 decrease in income, is related to the onset of substance use behaviors (Sareen et al.,
1182 2011). There are also fewer resources for persons with low SES to manage stress, making it
1183 difficult to avoid or reduce substance use behavior (APA, 2017). Of note, substance use is also
1184 particularly high among persons experiencing housing instability; for example, in a sample of

over 3000 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, Jaffee, & Snowden, 2003). Similarly, persons diagnosed with paranoid, schizoid, schizotypal, and borderline personality disorders are more likely to have low socioeconomic status (Sareen et al., 2011). This may reflect a relationship between symptom severity and difficulty managing employment and housing.

Lastly, poverty also deleteriously affects a person's cognitive capabilities, particularly executive functioning and working memory. Such deficits are found even if someone is experiencing poverty temporarily (e.g., financial crisis), due to the excess cognitive load that poverty-related stress creates (Mani et al., 2013; Hackman et al., 2015).

Application

Individual Application

Among persons with low SES and mental health symptoms or disorders, psychological intervention at the individual level are important and effective (Santiago, Kaltman, & Miranda, 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). Cognitive behavioral therapy (CBT) has demonstrated effectiveness for low-income populations (Organista, Munoz, & Gonzalez, 1994; Sheeber et al., 2017; Thorn et al., 2018). CBT has, furthermore, been found effective with persons experiencing homelessness and/or housing instability, including adolescents (Shein-

1208 Szydlo et al., 2016). Moreover, there is efficacy in using behavioral therapies and dialectical
1209 behavioral therapy for substance use in this population (Slesnick, Guo, Brakenhoff
1210 & Bantchevsha, 2015; Nyamathi et al., 2017). Recent studies show that just a few encounters of
1211 motivational interviewing or motivational enhancement interventions are effective with a low-
1212 income population (Fu et al., 2016; Slesnick, Guo, Brakenhoff & Bantchevsha, 2015).

1213 The teaching and practice of specific coping strategies to manage the chronic stresses
1214 of persons with LIEM may be particularly beneficial. For example, given the impairment in
1215 executive function that is correlated with chronic social marginalization through poverty,
1216 interventions aimed at strengthening skills such as attentiveness, cognitive control, problem
1217 solving, affect regulation, and stress management, are beneficial (APA, 2017; Wadsworth et al.,
1218 2011). An additional therapeutic intervention of importance includes cognitive restructuring
1219 (Troy, Ford, McRae, Zarolia & Mauss, 2017; Wadsworth et al., 2011). Additional treatment
1220 recommendations, emerging from a review of the literature focused on poverty-based stress,
1221 include mindfulness and social cognitive interventions for stereotype threat and identity
1222 concerns (APA, 2017). These findings from psychotherapy studies show that, despite poverty
1223 and/or housing instability, psychological intervention with LIEM persons is effective.

1224 Given the high prevalence of trauma and stress among this population, a trauma informed
1225 care perspective may be particularly useful and appropriate. Trauma informed care aims to
1226 prevent re-traumatization and improve health outcomes through awareness and education at
1227 individual and organizational levels of care (SAMHSA, 2014). Overall, evidence suggests that
1228 persons experiencing poverty benefit from high-quality, evidence-based psychological
1229 intervention (Santiago, Kaltman, & Miranda, 2013); yet, there continues to be a dearth of
1230 knowledge in this area and, so, psychologists are encouraged to further examine and research

1231 effective and applicable individual interventions for persons who are economically
1232 disadvantaged.

1233 *Community/Structural Application*

1234 Psychologists attempt to recognize that socially marginalized persons often experience
1235 legitimate feelings of powerlessness and lack of control over their environment (Troy, Ford,
1236 McRae, Zarolia & Mauss, 2017). For example, one's perception of their social class is associated
1237 with suicidal ideation, suggesting the strong deleterious impact that stigma and discrimination
1238 can have on a person's emotional well-being (Wetherall et al., 2015). Psychologists, therefore,
1239 can help to mitigate psychopathology by not only addressing client's individual perception of
1240 their social status but also help address client's related experiences of stress, stigma, and
1241 discrimination in the community.

1242 The extant literature espouses the need to intervene across multiple systemic levels,
1243 including individual, community, and policy levels, to combat social determinants of mental
1244 health disorders, with poverty as the main contributor (Wahlbeck, Cresswell-Smith, Haaramo,
1245 & Parkkonen, 2017; WHO, 2014). Yet, in some recent meta-analyses of international
1246 interventions to lessen poverty's effect on mental health, individual and family-level
1247 interventions are found to be more robust than some community or policy-level interventions
1248 (e.g., economic development projects, debt relief programs). Meanwhile, other meta-
1249 analyses reveal that community interventions have mixed results in alleviating mental health
1250 symptoms. Though all levels of intervention are important, this perhaps suggests the importance
1251 of including individual psychological interventions in community and systemic approaches to
1252 mitigate the effect of poverty on psychological functioning (Lund et al.,
1253 2011; Wahlbeck, Cresswell-Smith, Haaramo, & Parkkonen, 2017). There are several important

1254 complementary frameworks from which to better deliver care in community and organizational
1255 settings. These include: person centered care, trauma informed care, and delivery
1256 of programming from an understanding of social determinants of health and systemic and
1257 institutional discrimination. When consistent with professional judgment, psychologists may
1258 consider the value of focusing on prevention at the systemic and community levels and are well
1259 equipped to engage in such work.

1260 **Domain 4: Intersection of LIEM with Career Concerns and Unemployment**

1261 Work is seen as a pathway to power and economic well-being, thereby increasing access
1262 to resources (Blustein, 2007). Although work does increase access for many, it is also important
1263 to acknowledge that work does not necessarily alleviate poverty. For the year 2016, the 22.8
1264 million US citizens living below the poverty line included 2.5 million who were working full
1265 time and another 6.3 million who were working part-time, as well as many people who were
1266 unable to find suitable work or had given up trying to find employment (U.S. Census Bureau,
1267 2017). Even among those living in poverty, however, access to work is critical, as individuals
1268 who work 30 weeks per year are one third less likely to return to poverty than those who work 20
1269 weeks of the year (Stevens, 2012).

1270 Guided by a framework that acknowledges barriers that limit work opportunity and career
1271 development, psychologists are encouraged to take specific actions that aim to reduce social
1272 barriers while increasing access to resources known to affect career and work opportunities, such
1273 as equitable education and training, available and attainable quality child care, living wages,
1274 equitable health care, and an equitable living environment (Smith, 2010; Blustein, 2007).

1275 ***Guideline 8: Psychologists seek to understand the impact of social class on academic success***
1276 ***and career development throughout the lifespan.***

1277 **Rationale**

1278 Social class is inherently interwoven with work and career aspirations and success, in part
1279 because educational and vocational outcomes are often used as indicators of socioeconomic
1280 status (Diemer & Ali, 2009). Beyond that tautology, however, social class also has demonstrable
1281 predictive impacts on future academic and career achievement and is therefore an important
1282 consideration in any efforts to support academic, career and economic success. Low income and
1283 working-class people face social and logistical barriers that limit access to resources and
1284 opportunities to realize academic and career goals (Blustein, 2007; Lott & Bullock, 2007; Smith,
1285 2010;).

1286 *Academic Success*

1287 The impact of social class on academic achievement starts at a very early age and
1288 continues through multiple academic and career milestones. For example, vocabulary at 24
1289 months was greater among those from higher SES and a larger vocabulary predicted later success
1290 in kindergarten (Morgan, Farkas, Hillemeier, Hammer & Maczuga, 2015). Students are likely to
1291 have poorer social and academic outcomes when they are socioeconomically marginalized
1292 (Benner & Wang, 2014); specifically, students from lower SES in middle- or upper-SES schools
1293 are likely to have greater levels of loneliness and lower levels of school engagement and
1294 educational attainment (Benner & Wang).

1295 The continuing impact of family SES on students in the United States has been
1296 demonstrated through associations of lower SES with high school dropout (Parr & Bonitz, 2015),
1297 successful transitions from school to work (Blustein et al, 2002), and SAT college admission test
1298 scores (Sackett, Kuncel, Arneson, Cooper, & Waters, 2009). Sirin (2005), in a meta-analysis of
1299 58 studies, including 75 independent samples, concluded that familial social class was a strong

1300 predictor of individual student success and was even more strongly associated with school-level
1301 achievement.

1302 *Career Development*

1303 The impact of social class continues into adulthood and career preparation activities in a
1304 variety of ways. Using the multi-wave National Longitudinal Study of Adolescent Health, Lui,
1305 Chung, Wallace and Aneshensel (2014) found that family social class tended to be persistent for
1306 those at the extreme ends of the continuum and more flexible for middle-class youth.
1307 Specifically, youth from low SES backgrounds, as compared to those from higher SES
1308 backgrounds, were less likely to complete high school or go to college, more likely to have
1309 children at a younger age, more likely to live with parents as young adults, and more likely to
1310 either never marry or marry during young adulthood and to divorce. Youth from lower SES
1311 backgrounds were also less likely than other youth to work full-time and they had less personal
1312 income and accumulated assets by adulthood (ages 25-31), as compared to their peers from
1313 higher SES backgrounds.

1314 Socioeconomic status generally relates positively to vocational aspirations (Schoon &
1315 Parsons, 2002) and is likely to have an influence on vocational preferences (Fouad et al., 2012).
1316 In addition to the academic preparation and achievement factors leading to career success,
1317 individuals of lower SES, such as those receiving Temporary Aid to Needy Families (TANF),
1318 are likely to encounter numerous barriers in the realms of job search and employment attainment
1319 (Juntunen, Ali, & Pietrantonio, 2013). These include factors such as lack of educational
1320 requirements, higher levels of depression and other mental health concerns, higher rates of
1321 physical health limitations, caring for young children or other family members, being in an
1322 abusive relationship, and having no employment history (Dworsky & Courtney, 2007). In

1323 addition, practical barriers such as lack of childcare and lack of transportation services can be
1324 formidable barriers to job-seeking or steady job attendance (Juntunen et al, 2013).

1325 **Application**

1326 *Individual Application*

1327 When working with adolescents of lower social class, it may be useful to focus on
1328 increasing their sociopolitical development (Diemer et al., 2010), which is defined by Diemer
1329 and colleagues as "consciousness of, and motivation to reduce, sociopolitical inequality" (p.
1330 619). In multiple samples of African American, Asian American and Latina/o American
1331 adolescents in the 10th and 12th grades, the authors found that sociopolitical development was
1332 associated with increased work salience and, to a slightly lesser degree, vocational expectations.
1333 They concluded that increasing sociopolitical development may increase social mobility and
1334 access to existing resource infrastructure for LIEM youth. Interventions psychologists can use to
1335 increase sociopolitical development include those that increase awareness of inequality, help
1336 students link inequality to their own experience, and engage students in supporting community
1337 engagement and social action (Diemer et al., 2010; Morsillo & Prilleltensky, 2007). These can be
1338 demonstrated in class discussions and in-service learning projects geared toward community
1339 needs and equity issues, including job shadowing activities.

1340 Psychologists can also help clients identify both the reasons they engage in work and the
1341 values they attribute to work, supporting client self-determination. In a qualitative study of adult
1342 women facing major financial barriers, Clark and Bower (2016) identified the important role
1343 providers can play in supporting the intrinsic motivation and determination of clients seeking
1344 work. They identified, in interviews with 10 women, three major reasons to engage in work:
1345 survival, social connection, and support for children and family members. Although the

1346 participants identified numerous barriers to gaining employment, they also highlighted that self-
1347 determination and resilience were keys to overcoming those barriers. The authors further
1348 suggested that peer support groups may also be a valuable supplement to individual vocational
1349 psychology interventions.

1350 *Community/Structural Application*

1351 Psychologists working with adolescent individuals or groups may consider exploring role
1352 models and leaders in various careers as part of career counseling interventions. Among African
1353 American 10th-graders from a low SES community, researchers found that attitudes toward
1354 health science and future health careers were highly influenced by respected leaders or mentors
1355 in health science (Boekeloo, Randolph, Timinons-Brown, & Wang, 2014). The authors
1356 suggested that exposure to respected leaders, and particularly those identifying as African
1357 American, may help support career decision-making among youth from lower-income
1358 backgrounds. It may also be useful to help youth explore how their own career goals or
1359 achievement may contribute to their community, as a way of supporting their connection to their
1360 culture (including social class), as well as their goals for the future (Ali & Saunders, 2006).

1361 ***Guideline 9: Psychologists seek to understand the interaction among economic insecurity,***
1362 ***unemployment, and underemployment and attempt to contribute to re-employment processes***
1363 ***for individuals***.

1364 **Rationale**

1365 Individuals without decent work may be in a variety of different employment
1366 circumstances, but all share poverty as a threat. At one end of the spectrum, people may have a
1367 job, yet be underemployed. *Underemployment* occurs when a person holds a job that is
1368 inadequate in some respect relative to their financial needs or desires (McKee-Ryan & Harvey,

1369 2011). At the other end, people who are *unemployed* are unable to utilize their skills and abilities
1370 until they successfully complete a job search and become employed or re-employed. In addition,
1371 there is a growing segment of individuals who are *non-employed*; in other words, their
1372 unemployment experiences have persisted for so long that they have effectively exited the
1373 workforce entirely (Bureau of Labor Statistics [BLS], 2017a).
1374 Identifying the prevalence of these employment statuses is difficult. In the U.S., 5.2
1375 million people are underemployed in the sense that they are involuntary part-time workers who
1376 hold jobs, but despite their efforts, are unable to secure full-time work with salary and benefits
1377 (BLS, 2017b). Data concerning the rate of underemployment related to overqualification or skill
1378 under-utilization is far more difficult to collect and documented rates of unemployment and
1379 underemployment are likely to underestimate actual rates of these work statuses due to the
1380 difficulty of identifying people who have insecure housing, who are not actively searching for
1381 work, or who are not receiving government benefits.
1382 Unemployment, underemployment, and nonemployment have a wide range of “human
1383 costs,” which include financial loss, increased social isolation and stress, decreased social status,
1384 and loss of daily routine (Ali, Fall, & Hoffman, 2013). Loss of employment undermines one’s
1385 sense of identity, security, and self-worth due to the centrality of work in many people’s lives
1386 (e.g., Ali et al. 2013; Blustein, 2006). These losses, in turn, increase individuals’ susceptibility to
1387 mental and physical health concerns (e.g., Price, Choi, & Vinokur, 2002). Paul and Moser
1388 (2009), in a meta-analysis, found that people who were unemployed exhibited higher levels of
1389 distress, depression, anxiety, and psychosomatic symptoms, and lowered levels of subjective
1390 well-being and self-esteem.

The consequences of job loss ripple outward to family members (e.g., Schliebner & Peregoy, 1994). Unemployment within the family often leads to decreases in income, increases in financial stress and strain, increased rates of abuse, and a decreased ability for caregivers to financially support all family members (e.g., Kalil, 2013; McLoyd, 1989). Following job loss, partner relational stress, strain, and conflict often increase (e.g., Flanagan, 1990), and unstable employment is considered a risk factor for divorce (Jensen & Smith, 1990); this stress accumulates over time and trickles down to children and adolescents in the family (e.g., Christofferson, 1994; Sleskova et al., 2006). This experience, known as *vicarious unemployment* (VU), has been shown to have long-term consequences that persist into young adulthood (e.g., Christofferson, 1994; Thompson et al., 2013).

The downstream negative outcomes for children and adolescents who experience VU include increased depression and negative mood (e.g., Sund, Larsson, & Wichstrom, 2003), lower self-rated health (Sleskova et al., 2006), and increased suicidal ideation (Christofferson, 1994).

Just as changes at the familial level affect a family's ability to access resources, broad economic changes at the community level affect the community's levels of income, wealth, debt, crime rates, and educational resources (e.g., Dahling, Melloy, & Thompson, 2013; Wilson, 1996). These macroeconomic changes operate in communities through a variety of mechanisms. For example, massive job loss within a community contributes to a reduction in employed adults who are available to serve as role models, increased stress in teacher-to-student interactions when teachers are feeling the effects of unemployment (within their own families or that of their friends or colleagues), and increased stress in student-to-student interactions (Yoshikawa, Aber, & Beardslee, 2012). A variety of other macro-level variables, such as regional shifts in economic

1414 outlook (e.g., factory closings or relocations) and political instability (e.g., social unrest and
1415 war), are also important to consider in the context of job recovery. Such events may affect
1416 workers within varying job classifications disproportionately (e.g., factory closings are more
1417 likely to affect blue collar workers; neighborhood unrest may be more likely to affect retail
1418 workers) and may contribute to lowered levels of neighborhood stability as fewer individuals are
1419 likely to remain in their homes over time.

1420 Being a member of a stigmatized or underrepresented group further complicates job
1421 recovery. Racial and ethnic minority individuals face added challenges when seeking re-
1422 employment, due to a variety of factors that are often compounded by poverty, including
1423 insufficient local job opportunities, documented disparities in post-secondary educational
1424 attainment, prior work history, and discrimination from potential employers (e.g., Bertrand &
1425 Mullainathan, 2004; Holzer, Offner, & Sorensen, 2005; Schaffer & Taylor, 2012). In addition,
1426 individuals who are transitioning out of the criminal justice system, and those with a criminal
1427 record, are likely to struggle to gain and maintain stable employment, the lack of which is related
1428 to increased rates of recidivism (e.g., Filella-Guiu & Blanch-Plana, 2002; O'Brien, 2002; Pager
1429 & Quillian, 2005; Thompson & Cummings, 2010). Similarly, older job seekers and job seekers
1430 with disabilities often find re-employment more difficult following job loss than younger job
1431 seekers or people without disabilities, respectively (e.g., Wanberg, Watt, & Rumsey, 1996).

1432 **Application**

1433 *Individual Applications*

1434 Psychologists are encouraged to assist individuals with securing and maintaining decent
1435 work, as a mechanism that allows individuals to avoid or escape poverty and longer-term income
1436 insecurity. Re-employment and job recovery refer to the process by which individuals who are

1437 underemployed or unemployed regain work that is satisfactory in terms of rewards, fit, and job
1438 characteristics that align with a job seekers' needs, values, and goals (e.g., full-time versus part-
1439 time; Kalleberg, 2008). Successful re-employment is related to improvements in well-being (e.g.,
1440 Gowan, 2012; Park, Chan, & Williams, 2016) and allows individuals to accrue economic
1441 resources to meet basic needs for survival (e.g., Gowan, 2012; Paul & Moser, 2009).

1442 At the individual level, psychologists are encouraged to use interventions that increase
1443 agency and hopefulness among unemployed individuals, like those that are successful in
1444 combating stigma directed at people who are poor (Hall et al, 2014). Interventions that
1445 emphasize practice and mastery of skills are likely to be useful. Meta-analyses reveal that re-
1446 employment programs that emphasize mastery experiences (i.e., "learning by doing") and
1447 behavioral modeling are particularly effective at boosting job search self-efficacy, proactivity,
1448 and career goal-setting (Liu, Huang, & Wang, 2014). Several established intervention programs
1449 leverage these experiences to improve job seeking outcomes. One of the most successful and
1450 long-standing re-employment interventions is the JOBS program developed by Caplan et al.
1451 (1989). The JOBS program was developed to support individuals in finding a job via four
1452 program components: active learning, augmenting coping self-efficacy, enhancing social
1453 support, and positive feedback from program facilitators. The JOBS program has been
1454 demonstrated to be successful among individuals who are unemployed in the U.S. (e.g., Capland
1455 et al., 1989; Vinokur et al., 1991; Vuori et al., 2002) and among individuals who were long-term
1456 unemployed in the Netherlands (e.g., Brenninkmeijer & Blonk, 2011).

1457 Psychologists can also use career and employment interventions grounded in cognitive
1458 behavior therapy (CBT) that have also been demonstrated to be efficacious in supporting
1459 individuals who are unemployed. Such programs focus on constructive thoughts and goals to

1460 improve personal agency. For example, a vocationally-oriented cognitive-behavioral training
1461 (VO-CBT) was designed to bolster motivation and challenge negative thinking among
1462 participants who were long-term unemployed (Rose, Perez, & Harris, 2012). Components of the
1463 VO-CBT program included increased learning opportunities (i.e., hands-on activities, peer
1464 learning, peer learning) and strategies to self-regulate cognitions and behaviors.

1465 Taken together, these programs demonstrate promising evidence that psychologists may
1466 consider using to contribute to client reemployment, via individual career counseling and group
1467 intervention programming strategies.

1468 *Community/Structural Application*

1469 Unexpected work transitions, including the moves from employment to unemployment or
1470 under-employment and subsequent loss of financial security, are increasingly common in the
1471 contemporary workplace (Fouad & Bynner, 2008). Perhaps not surprisingly, adult workers with
1472 fewer financial and asset resources are more likely to anticipate negative employment decisions
1473 and feel that the future is uncontrollable (Atkinson, 2010). Given the high rates of unemployment
1474 and underemployment nationally and internationally, and the negative long-term outcomes
1475 associated with VU, psychologists are encouraged to contribute to new primary prevention
1476 strategies directed toward children with VU experiences. Such interventions could target growth-
1477 enhancement by bolstering resilience, coping appraisal, and strengths-building (e.g., Afifi et al.,
1478 2006; Waters, 2000).

1479 At a social level, psychologists are encouraged to work with local and regional
1480 employers, and to address potential sources of discrimination and stigma that may prevent them
1481 from pursuing or hiring employees who are unemployed, under-employed, and financially under-
1482 resourced (Juntunen & Bailey, 2014; Juntunen et al, 2013). Finally, psychologists can also have

1483 an important influence by advocating for improved policies and programs that support living

1484 wages for all workers (Juntunen et al, 2013).

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APPENDIX A

Definitions:

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 – 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, health care, legal assistance, politics, public policy, and more (Lott and Bullock, 2007).

Cultural Capital - 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 - Refers to the highest level of education that an individual has completed. This can be operationalized by 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 - 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 (Institute for Policy Studies, 2016). 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 U.S. Although income inequality may be operationalized and measured in numerous ways (see Kawachi [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 - 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 (US 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, Deng, Nair & Burrell, 2005). A more comprehensive measure, the Supplemental Poverty Measure (SPM), was developed by the US 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 5-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 – The collective value of social networks that is determined by specific benefits that flow 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 (SES) – 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, 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, 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, Banaji, & Nosek, 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 areis 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).

Supplemental Supporting Literature, provided by Guideline.

<u>Guideline 1:</u>

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, Springer, Yaeger, Pascarella, & Nora, 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, Afifi, McMillan & Asmundson, 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 U.S., when only considering African Americans (Hudson, Neighbors, Geronimus & Jackson, 2012; Willams, Priest & Anderson, 2016). Such subgroup differences 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: these include 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. Sexual 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 (HPSA; U.S. Department of Health and Human Services, n.d.), further limiting their access to psychological services or any health care. 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 NIMH Treatment of Depression Collaborative Research Program to better understand the impact of social class on treatment outcomes across three treatment modalities (Cognitive Behavioral Therapy (CBT), Interpersonal Processing Therapy (IPT), and pharmacotherapy). Results demonstrated that lower SES (as measured by Hollingshead's Two-Factor ISP [Hollingshead, 1971]) 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 (in press) 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, Jaffee, & Snowden, 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 client presented via a written case vignette and 4-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 (GAF) 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 (Baker, 1996; 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 National Institute of Mental Health (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, Himles, Fedock, Henshaw, & Flynn, 2013).

A randomized control trial using outreach methodology via 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 LIEM clients 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, Guo, Brakenhoff & Bantchevsha, 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 6 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 socioeconomic status (Sareen et al., 2011). Moreover, a strong negative correlation was found between socioeconomic status, and 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 LIEM persons experience frequent systemic disadvantage can affect neural 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 et al., 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 is commonly found in persons with posttraumatic stress disorder (American Psychiatric Association, 2013), suggesting that perhaps the experience of poverty is a type of 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).

In randomized control trials, cognitive behavioral therapies are effective for low-income populations experiencing depression, anxiety, posttraumatic stress, and chronic pain (O'Mahen, Himle, Fedock, Henshaw, & Flynn, 2013; Cho, Son, Kim, & Park, 2016; 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, Guo, Brakenhoff & Bantchevsha, 2015; Nyamathi et al., 2017), and efficacy for interpersonal psychotherapy, for the LIEM persons experiencing PTSD, both in individual and group formats (Krupnick et al., 2008; 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, Guo, Brakenhoff & Bantchevsha, 2015).

Findings from psychotherapy studies show that, despite poverty and housing instability, psychological intervention with LIEM persons is 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, Ford, McRae, Zarolia & Mauss, 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-income (Troy, Ford, McRae, Zarolia & Mauss, 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, Kaltman, & Miranda, 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 trauma and 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 (SAMHSA, 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). It may be beneficial to be cautious when assessing for trauma and to not assume that LIEM persons do not experience psychological trauma if they do not meet criteria for posttraumatic stress disorder. As mentioned earlier, LIEM persons experience stress responses in response to the stressors of their economic status.

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Guideline 8

For the year 2016, the 22.8 million US 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. Census Bureau, 2017). The US 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 health care 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 U.S., 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., Villabos, 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.

A vocationally-oriented cognitive-behavioral training (VO-CBT) was designed to bolster motivation and challenge negative thinking among participants who were long-term unemployed (Rose, Perez, & Harris, 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 non-existent and high rates of disability and trauma from their military service (Stein-McCormick, Osborn, Hayden, & Van Hoose, 2013).

As low-income workers attempt to re-gain employment, they may experience important barriers related to stigma. In general, people who are poor or of lower social class are widely stigmatized (Hall, Zhao & Shafir, 2014), and frequently associated with negative attributes such as laziness, being "welfare queens," and incompetence. Given the increasing use of economic layoffs in US 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 et al., 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.