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# Clinician Heal Thyself: Turning the Mirror Inward to Dismantle the Barriers of Psychotherapy

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# *Clinician Heal Thyself: Turning the Mirror Inward to Dismantle the Barriers of Psychotherapy*

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## Abstract

The practice of psychotherapy developed in the United States within and in response to its sociopolitical context. As such it has always been unable to live up to its stated value of being accessible and effective for all people who are willing to seek and accept help. We explore the practice of psychotherapy within the larger field of Psychology and its ongoing commitment to capitalism and the social hierarchy at its center. We consider how Psychology's intentional avoidance of class identity in the therapy space has allowed the field to justify and maintain this hierarchy while simultaneously ignoring its existence. We detail the ways in which Psychology packaged itself as a valuable tool for capitalism in a rapidly urbanizing and developing United States and explore our country's historic use of class to create division between those on the lower levels of the social hierarchy in a way that allows power and privilege to remain concentrated at the top.

This study sought to address the gap our field of psychology has intentionally ignored by exploring class identity and its influence on distress, attitudes toward therapy, and willingness to help-seek. First, we compared attitudes of working- and middle-class survey respondents regarding their sense of life satisfaction, stability, and expectations for the future to operationalize a definition of class. Next, we used this working definition to examine the impact of class identity on distress, attitudes toward therapy, and willingness to help-seek by comparing survey responses from middle- and working-class respondents. We then used semi-structured interviews to contextualize survey responses and identify overarching themes about attitudes

toward therapy both within and across class status. Finally, we offer a model of critical narrative humility as a framework for clinicians interested in decolonizing their own practice and offer suggestions for use of this framework to extend individual dismantling to a systems level.

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## Statement of Purpose

American psychotherapy has always been unable to live up to its stated value of being accessible and effective for all people who are willing to seek and accept help. Historic disparities in ability to access effective care continue to inform the limitations of psychotherapy and the larger field of Psychology as it strives to improve its multicultural responsiveness and practices. The connection between the historic disparities in the field and its current barriers to improving access to effective services across background and circumstance leaves us with two important questions: *Is the field of American Psychology defined by its development within and in response to a capitalist social structure? Would such a commitment to the values of capitalism keep the practice of psychotherapy accessible only to the western, educated, industrialized, rich, democratic (WEIRD) population capitalism is designed to benefit?*

We began to answer these questions by addressing an aspect of identity that historically created division through competition in a way that sustains the social hierarchy central to free-market capitalism without ever acknowledging its existence–class. As a social-justice oriented clinician-in-training with working class roots, this exploration is of personal significance for me. This project was inspired, in large part, by an exploration of my own identity as a class straddler (i.e., someone with working class roots currently navigating a middle-class environment as I pursue my future career in clinical psychology) (Lubrano, 2005). My hope in exploring class as an important identity factor impacting the field of psychology and the practice of psychotherapy is two-fold. First, it allows me to begin by reflecting inward with the aim of dismantling my own

internal barriers before making claims about the systemic barriers maintained by the field of psychology as a whole. Second, class has been highlighted by historians, legal scholars, sociologists, and others in psychology-adjacent fields as a powerful aspect of identity used to concentrate power at the top of the social hierarchy and keep those on the lower levels divided and at odds. This division informs and facilitates ongoing systemic racism (e.g., mass incarceration, inhumane wages and working conditions, redlining, school opportunity gaps, immigration policies) and interrupts and compromises efforts to redistribute power and resources. The field of Psychology rarely acknowledges class as an aspect of intersectional identity or considers its influence in the therapy space. Little research exists considering the impact of class on access to therapy, in either terms of logistical access (e.g., cost, availability of clinicians) or of practical application (e.g., effective intervention, meaningful therapeutic alliances). It is my hope that in exploring this complex aspect of identity, we might begin to dismantle systemic barriers by starting with our own and inviting others to do the same.

We began our exploration by assessing differences in experiences and beliefs expressed by survey responses from participants who self-identified as working-class with responses from those who self-identified as middle-class in order to inform an operational definition of class. We then assessed differences expressed in survey responses between these two class groups in regard to their attitudes about therapy and their willingness to help-seek when experiencing distress. Finally, we contextualized survey responses by conducting semi-structured interviews with individuals from diverse class backgrounds. We believe that a better understanding of class as an aspect of identity is a crucial component of dismantling the barriers to accessing and benefitting

from the practices of the field of psychology. Moreover, we believe that understanding the influence of this aspect of identity in the therapy space is an integral step in dismantling the field of psychology's commitment to capitalism and decolonizing the practice of psychotherapy. We offer our findings to shed light on the concept of class as part of identity. We hope that these findings will serve as a foundation for the field to build practices that are in line with its stated aims of increasing equity through intersectional responsiveness.

## Introduction

The practice of psychotherapy developed in the United States within and in response to its sociopolitical context. From its inception, the United States framed wellness as an individual pursuit—declaring in its Declaration of Independence that the right to pursue happiness is inalienable. Of course, these self-evident truths were not intended to extend across the population of the nation. In fact, in speaking to the self-evident nature of the rights of white, English-speaking, property-owning men, the founding fathers created an intentionally limited definition of what it means to be a citizen capable of pursuing happiness and deserving of wellness. This same framework of what it means to be a person inherently worthy of life, liberty, and happiness has been used by the field of Psychology as it developed in support of and response to the form of free-market capitalism that the emerging nation also embraced. Throughout history, the field of Psychology offered tools, interventions, and rationale legitimizing and maintaining an oppressive capitalist hierarchical social order by keeping individuals focused on themselves and claiming that every person has the capacity to create their own happiness, should they be willing to change. Psychology created language to distract from oppressive social systems by

individualizing sources of distress and then offered strategies for citizens to repair the things the field identified as being wrong with them.

Psychology's claim that psychotherapy can support the health and happiness of people of all backgrounds and walks of life is grounded in the deliberately limited understanding of what it means to be a person in the United States. This intentionally limited definition of personhood, which defined the normative culture of the country, kept American Psychology from living up to claims that its practices can benefit anyone willing to engage and open to change. Free-market capitalism is based on competition and, as such, necessitates a winner and a loser. Psychology cannot work in service of the wellbeing of all people while it remains committed to a colonial economic and social order equating wellbeing with domination and defining the success of some in light of the failure of others. Well-documented differentials in access to quality psychotherapy services rooted in race and class characterized the field throughout development and remain in place today. An inability to dismantle barriers begins with a refusal to acknowledge complicity with, and ongoing loyalty to the systems cementing these barriers in place. In stated attempts to increase the effectiveness and accessibility of psychotherapy, the field of Psychology built new strategies on the same foundational practices and cultural assumptions designed to keep the populations ineffectively served at the bottom of the social hierarchy. In other words, Psychology has sought to make its practices more accessible and effective for marginalized and underserved populations, but only by making surface level changes to strategies designed to justify keeping these individuals in the margins in the first place. The field has shown some willingness to name its failure to serve racially minoritized populations in the face of

overwhelming evidence and a larger social call for racial reckoning. The field, though, continues to ignore its failure to effectively serve individuals across class backgrounds by refusing to acknowledge class as an aspect of intersectional identity. This choice by the field mirrors the United States' historic strategy of manipulating those on the lower levels of the social hierarchy (e.g., the white working-class) to maintain a class hierarchy that aligns the interests of psychology with the interest of those who benefit most from free-market capitalism, while blaming those on its lowest levels (i.e., BIPOC) for their unfavorable position. Ignorance of class, then, allows the field of psychology to name failures as the problem of individuals and commit to improving therapeutic practice without acknowledging class and its implication for the field.

The field of Psychology has a choice to make: it can continue to prioritize the population it was designed to serve or it can choose to rebuild and become authentically inclusive. Rebuilding, though, can happen only after dismantling has occurred. Psychology simply cannot live up to its stated goal of supporting the wellness of all people until it confronts its history of intentional oversight and deliberate harm. Until practitioners of psychotherapy are willing not only to practice humility and self-reflection, but to do so through a critical lens, the field will continue to remain accessible only to those for whom it was designed—those who reflect the founding fathers' narrative of what it means to be a person.

Throughout this work we consider the ways American Psychology informs, justifies, and maintains the capitalist values of the United States and, as such, prioritizes and serves the same people these systems benefit. We consider psychotherapy from the time it began to grow in

popularity and influence after the Second World War and examine the expansion and evolution of the field both in service of and in response to the dominant socio-political narrative of a free-market capitalist society. We confront the evidence that the ongoing expansion of psychotherapy in support of a system that necessitates the oppression of many for the benefit of few has the field of Psychology in a self-created double-bind that prevents further accessibility or efficacy. We reflect critically on the idea that the field legitimizes and maintains the systems causing the kinds of distress it claims to address.

We address class in the way the field chooses not to by asking individuals with diverse class identities to talk about their identity and their attitudes and understanding of psychotherapy. We use this information to consider who is made to feel like the practice of psychotherapy is accessible to them and who is made to feel that their problems are a reflection of their own shortcomings and better left to be managed on their own. We offer a critical reflection on the attitudes and experiences of these individuals, from their perspective and in their voice. We use this information to consider the responsibility of clinicians who truly seek to promote wellness for all to not only listen to these narratives but to engage with them by examining their own assumptions, biases, and training. We explore what it means to authentically commit to dismantling the barriers of the field, not by working to build on practices designed to justify oppression through separation and individuation, but by being willing to reflect critically on our own narratives as practitioners inside of a field built around intentionally limited assumptions of what it means to be a person with a story worth telling. We consider what it would take to re-imagine the field and its practices by turning the mirror inward and critically reflecting on the

ways we as practitioners carry the kinds of biases, assumptions, and socialization that cement these barriers and keep the system working exactly as intended.

## Background

### Wellness and Individualism

From the very inception of the United States of America, wellness was framed as an individual pursuit. Individualism, in this sense, is talked about by psychologist Geert Hofstede (1980), in his cultural dimension theory, where personal goals are the priority and identity is relegated to the self. The Declaration of Independence asserts that every person has the right to pursue their individual happiness and charges every citizen with the responsibility of manifesting their own satisfaction through the pursuit of self-interest and a commitment to individual liberty (Zhao, 2005). Framing happiness as an individual pursuit binds success and failure to personal behavior and legitimizes an ongoing need for self-improvement through self-help (Prilleltensky, 1994). A commitment to individualism, while not an inherent value of capitalism itself, is perhaps the most integral aspect of western capitalism (Abercrombie et al., 2015). This commitment to individualism created a unique and specific role for the field of American Psychology.

Ironically, the commitment to individualism is informed by a need to keep free-marketplace actors from recognizing their true interconnectedness. In his writings critiquing the political economy, Karl Marx (1859) describes the ways in which capitalism relies on the division of labor such that individuals do not know they are part of the same profit-production process. With his labor theory of value, Marx points out that goods are produced by a series of

economic actors intentionally kept from seeing how dependent each is on the other for the ultimate production of their goods. Value, in this system of capitalist production, is the cost of production. The end goal of the capitalist organizer--the person who leverages the raw resources--is to produce the largest profit for themselves by minimizing the cost of production so that the difference between this cost and the ultimate selling price of the goods produced is as high as possible. Luxury clothing, for instance, cannot be produced without harvesting raw material, turning this material into fabric, sewing fabric into clothing and so on. The person harvesting raw material, though, has no knowledge of the journey these materials took to become an expensive high fashion item, nor is this person compensated for their labor based on the value of the end product (Brooks, 2005). Individualism allows the capitalist organizer to minimize production costs by keeping laborers separate from one another so that the value of the sum of this labor is considered only at the very end of the labor process—when the good is ready to be sold and the difference between production cost and selling cost is the organizer's profit to keep. Keeping laborers brought into the process of production without experiencing any of the ultimate benefit is where the field of Psychology played an integral role.

America's commitment to capitalism began with the arrival of the colonial settlers. As English settlers arrived in the US, they brought aspirations of reforming the Church of England and moving away from its Roman Catholic influences. This reformation theology and its commitment to individualism came to define American society and its devotion to a capitalist economic system. It also informed the settler's use of genocide as a strategy for the swift removal of the Native people who already lived on the land and did not view this land as

something to be owned, much less to be broken into pieces and sold. Martin Luther's criticism of the Roman Catholic Church that lies at the heart of Reformation theology is, in its essence, based in economics. Luther found fault with the suggestion that salvation could be bought and suggested that salvation is not a good to be purchased but rather the result of divine grace. As such, each individual has the opportunity and responsibility to work hard and cultivate their own relationship with God in order to ensure their personal salvation (Taylor, 2017). This assertion rooted the settlers in their belief system that each person was charged with working hard enough to prove that they were worth saving; having earned their right to eternal salvation.

This conceptualization of capitalism as a system where individual actors compete without any restrictions or scaffolding in order to meet their own individual needs is glorified by Ayn Rand (1966, 1986) in her *Capitalism: The Unknown Ideal*. Rand even goes so far as to assert that capitalism is the only moral system of government, which seems to mirror the Protestant understanding that individual hard work is the key to proving one's value and saving oneself. Rand maintains that if, as she supposes, rationality is the essence of being human, then the only logical and moral system of government is to provide the space for people to live in accordance with their own rational self-interest (Rubin, 2007). Framing capitalism as a moral obligation to allow individuals to prioritize their own best interest, though, is based entirely on an unexamined assumption that every competitor will have an equal opportunity to thrive in a free market. This assumes that every citizen will want to compete with those around them and will be able to improve their competitive positioning over time, so long as they have the drive to succeed. Here, the field of Psychology holds the power to create and maintain a narrative of self-fulfillment

through individual competition by keeping individual focus on personal circumstance and away from the lived consequences of a system set up to exploit the labor of the many to produce profit for the few at the top.

Capitalism in the US is an economic system rooted in a larger framework of cultural values and norms. American Capitalism refers not only to a system of capital, production, and wage earning but also to a narrative that accounts for social hierarchy and justifies a grossly inequitable distribution of resources and of power and privilege. American capitalism has three distinct features. First, the capital needed to organize raw resources to produce goods is privately owned. Second, the economy uses raw resources to create commodified goods to be sold. Third, the social structure consists of the owners of capital and free-wage workers who use this capital to produce goods and prioritizes the accumulation of profit by the capital owners. In order for this system to function, there must be structures in place ensuring a dependable supply of workers and a division of labor. Commercial institutions, including banks, must be set up to provide capital for production to support ongoing social productivity and there must be an openness to new ways of making a living. The legal structure must protect private property and the political process must allow for translation of economic power to governmental policy (Weinberg, 2003). While American capitalism tends to laud itself as a values-free system, one that allows every person the chance to work as hard as possible to create their own success, the very assumption that success is earned through competition is itself value-laden. A system of ownership and profit privileges those who “compete” most effectively and necessitates a winner and a loser. A competitive marketplace, in its essence, cannot be one in which everyone is able to

win. The story that American capitalism tells about itself intentionally overlooks the reality that the idea of a "top" to which people can rise necessitates the existence of a bottom. For this reason, capitalism needs the field of Psychology to help tell its story in a way that keeps people committed to their place in the hierarchy without acknowledging that such a hierarchy exists.

By the early 1900s, the American economy had become completely capitalist. Industry and agriculture became subject to the influence of capitalism and were set up to fit within the free market (Weinberg, 2003). A commitment to a completely capitalist economy required sustaining the industries that make production and wage earning possible and ensuring societal buy-in for the values and norms of this system. Moreover, buy-in to these values needed to occur without admitting that they exist. For a free market to thrive and produce profit for its private owners, citizens needed not only to be willing to serve as laborers but also to tie their identity and beliefs about happiness and wellbeing to this labor. This way, competition, private ownership, and profit could be prioritized as the greatest good, as citizens participate in the narrative that these things are what gives their lives value and purpose. This need for internalized buy-in allowed the field of Psychology to step in and make itself useful to the developing United States and solidified its place as a driving force behind America's commitment to capitalism.

The power of the narrative of western capitalism lies in its ability to convince citizens that they have chosen to fill the roles ascribed to them by the system and that those looking to break outside of these roles are flawed in personal ways that must be repaired at an individual level (Prilleltensky, 2008). In reality, capitalism cannot be maintained at a systems level unless citizens are keeping themselves and others confined within a social hierarchy that depends on the

exploitation of many for the benefit of few. Maintaining a societal hierarchy that exploits the many is most simply accomplished by those in power convincing the many that it is natural and even desirable that they participate willingly in a system that does not serve or even actively harms them. A capitalist economy can only sustain itself if citizens are serving as cogs in the machine of the free marketplace. In this way, those who keep a free marketplace thriving must commit to their role in maintaining the machine, all while being made to believe that they, themselves, are the machine in its entirety. The field of Psychology is uniquely valuable to the maintenance of this narrative, as it works to influence people's beliefs about themselves and their ability to effectively navigate the world.

In his *Between the World and Me* Ta-Nehisi Coates (2015) suggested that American citizens do not have equal opportunities to compete in a free-market place, as told to them by those in power, because of who the government means when it talks about its people. Foundational to the capitalist economic system is the belief that the people will be governed by and for themselves. Rather than changing this narrative about democratic government to justify a social hierarchy that necessitates the oppression of some for the benefit of others, the US created language that allowed for distinctions to be made when talking about its people. Coates asserts that race was created as a social construct in order to organize individuals into a hierarchy. Concepts of race, he maintains, do not precede racism but are rather a way to create a social order that legitimizes economic exploitation and racism by suggesting that differences in outward appearance are somehow innately tied to value and personhood. In his *Stamped from the Beginning*, Ibram X. Kendi (2016) details the historical creation of race and racism, not as

responses to innately human interactions, but as justification for intentional division and exploitation that was already underway in the United States. In fact, the book title draws from a speech from Jefferson Davis, the president of the Confederate States in 1860, who asserts that because the government of the United States was created by white men for white men, that the inequality between white and Black men was stamped from the very beginning (Murrey, 2018). Activist and feminist Angela Davis (1981) points out that American capitalism is inherently intertwined with racism, as enslaved Black people were used as the country's first form of capital. The system of capitalism in the United States is so beholden to the use of Black bodies as capital, in fact, that even after the abolishment of slavery with the 13th amendment in 1865, the system of using unpaid Black labor to sustain a "free" marketplace has remained part of the fabric of American society throughout its history.

Racist ideology used to create division and justify a social hierarchy has been repackaged since this initial stamping of inequalities, as the country has evolved and its commitment to capitalism has deepened. In her *The New Jim Crow*, Michelle Alexander (2010) highlights ways that the narrative around race has evolved to maintain hierarchy as social systems and structures change. When slavery was abolished with the 13th amendment, it was first repackaged in the passing of the Jim Crow segregation laws. After these laws were targeted to be dismantled by the civil rights movement, legalized discrimination based on race was reincarnated in the supposed war on drugs and the ensuing policies of mass incarceration. In a reflection on the 10-year anniversary of the publication of *The New Jim Crow* (2020), Alexander reflected on the cycle of racial reform, backlash, and re-reform in which our country finds itself trapped. She points out

that after the nation's experience of its first Black president (one who spoke of civil rights in a way that was not supported by his policy implementation), the narrative that America had reached a "post-racial" era allowed for the presidential election of a man who campaigned on returning America back to its "greatness." The great time in America's history that this narrative points to is, of course, a time when racial hierarchy was maintained more openly and the supremacy of white men was more readily accepted (Alexander, 2020). Continued repackaging of a system the United States has continuously claimed to disavow begs the question posed by activist and feminist Audre Lorde throughout her works: who benefits from an unjust status quo? (Lorde, 2017).

The narrative of western capitalism frames society as the product of the output of its individual members. Every person is tasked with contributing to a strong and healthy society through the manifestation of their own strength and health. Individualizing both success and distress is a particularly powerful strategy for control, as it keeps people monitoring both themselves and one another (Parker, 2007). Italian philosopher Antonio Gramsci described this individual commitment to maintaining the status quo as the hegemonic culture. He asserted that the ruling class uses a set of cultural and ideological strategies to create a sense of belongingness to the state in the working class. This creates the illusion that the capitalist state is a legitimate institution and motivates the working class to align their interests with the interests of the ruling class (Bates, 1975). Lorde (2017) points to this strategy of cultural hegemony when describing capitalism as particularly cruel because of its use of individuals' wants and needs against them. Capitalism, she explained, demands that we define our value through our labor so that we are

motivated to meet the requirements the system has forced upon us. Cultural hegemony is a critical component of capitalism because the free market cannot function unless the majority of the population is convinced to tie their value to their labor, for the few at the top of the hierarchy to profit from labor efforts without pushback from those who produce without profit. Convincing laborers to couple their work with their personhood also means manipulating the working-class into monitoring and shaming those who do not want to fit themselves into the system in this same way. Those who are not fitting themselves inside the free marketplace, oftentimes, are the ones who are on even lower levels of the capitalist hierarchy (in the United States: Black, Brown, and Indigenous people, specifically) and as such, are more actively harmed by the system they are being forced into. Those who are slightly above the bottom are told that their labor is tedious and joyless not because it is being used to maintain the power and privilege of the few at the top but because the many at the very bottom are not doing their fair share.

The leveraging of longing for personal meaning and belonging within society by those in power was extensively considered by Michel Foucault. In his *Discipline and Punishment* (1977), Foucault considers the evolution of the ways those in power keep order and maintain their status. He asserted that a population is much more readily and effectively controlled when they can be influenced to monitor and police themselves rather than being made to feel like they are being controlled by those in power. The creation and normalization of a societal standard keeps citizens monitoring their own behavior and that of others, without the need for any obvious displays of control from those at the top to ensure that these standards are met (West, 2018). The power of this strategy lies in the fact that people have internalized the expectations of those in

power and seek to meet these expectations not out of a sense of obligation but out of a longing for self-fulfillment. In this search to meet the mark and live up to their full potential, individuals do the work needed to maintain the systems that created the mark they are worried about missing in the first place. The focus on ongoing improvement of the self keeps individuals from ever questioning where the standards for being "good enough" came from and who this standard really works to benefit.

Parker and colleagues (1995) extended the power of internalized individual expectations to control citizens to the field of mental health in their consideration of the construction of psychopathology. As the field of Clinical Psychology and, in particular the practice of psychotherapy developed, the narrative around mental illness shifted from one of punishment and isolation and toward one of treatment and rehabilitation. In this shift, mental illness was reframed as a kind of failure to live up to societal expectations that could, with the right interventions, be repaired. While this shift is often understood as a humanization of mental illness, an understanding of mental distress as a rectifiable internal process presupposes that the solution for these problems must also come from within. Inherent in the hope that comes with an assertion that psychopathology is not an irreparable external problem is the assumption that ongoing suffering from distress is the result of an individual reluctance to be well (Prilleltensky, 2008). The internalization of mental illness serves as a powerful framework of control as it shifts the responsibility onto the person experiencing distress to repair their own experience by trying harder to live up to societal standards.

In order for mental health to be understood through the lens of psychopathology, the framework of psychopathology needed to be created. In legitimizing itself as a consumable good and a valuable service, Psychology needed to name the problems they intended to fix. As Kurt Danziger (1990; 1997) pointed out, psychological phenomena exist only because the field of Psychology has constructed and named them as things that are out there in the world. In naming the parameters of what constitutes disorder, the field of Psychology created its own standards for success. Naming the boundaries of social norms allows the field of Psychology to provide the tools needed for individuals to live in ways that they themselves have identified as being normal and preferential. Psychotherapy, then, serves as a strategy to influence the understanding of what it means to be ill and to what it looks like to get well, rather than as an intervention to treat objective illness (Benish et al., 2011). Perhaps more importantly, psychotherapy as the authority on social norms also gave the field of Psychology the power to identify those who have stepped outside of these social boundaries so that they can be encouraged to change. In this way, the field of Psychology has served not only to keep the machine of the free marketplace moving but also as an authority on how this machine should look in order to run most effectively.

As the field of Psychology evolved within the western capitalist system it was helping to create, the practice of psychotherapy provided a framework necessary for individuals to understand wellness as an individual pursuit and to internalize the invisible values system of a capitalist economy. In order to provide the framework needed to encourage help-seekers to tie personhood and value to labor and production, the field of Psychology needed to legitimize itself and its practices within the value system it was helping to create and working to keep hidden. For

this to happen, psychotherapy needed to be understood not as a dynamic and interactive experience between unique people, but as a set of strategies that make it an effective tool to predict and control behavior. In order to fulfill this role, the field of Psychology committed itself to the framework of logical positivism that still permeates many of the social sciences today (Kincheloe & Tobin, 2015). Logical positivism asserts that the only problems worth considering are the ones that can be considered empirically, through observation with the senses and a process of logical analysis (Pierre, 2016). This framework was used as a base for Psychology to build its identity as a science and to solidify its argument that it was just as valuable a tool to a capitalist society as its more medicalized counterpart, Psychiatry. If we are to understand how American Psychology became one of the linchpins holding our capitalist society together, we must first explore the repackaging of Psychology as a science.

**Psychology as a Science**

The field of Psychology and its scientific study is rooted in treatises considering one's sense of self produced by philosophers such as Renee Descartes, John Locke, Immanuel Kant, and G.W.F. Hegel. To develop in the United States, though, the field moved away from these European and humanistic roots to establish itself as its own field. German psychologist Wilhelm Wundt's foundational and widely adopted framework of Psychology as a study of introspection and internal processes did not lend itself to the socio-political narrative of the United States as this work was being brought back with American academics completing their studies in Germany. Wundt's experiments consisted of a handful of subjects, often his colleagues and co-researchers, and included his own experience and perspective. This structure of collaborative

experimentation and research did not position the person conducting the experiment over those being experimented upon. No one was considered to be in an expert role, as everyone involved were part of both the production and the collection of experimental data, and no one researcher had any power over the others (Pickren & Rutherford, 2010). This model did not lend itself to the hierarchical structure of race and class in the United States and the system's need for tools to encourage the internalization of its assumptions and standards. If wellbeing, as Isaac Prilleltensky (2008) suggests in his consideration of the influence of power on wellness, is created through a balancing of personal, collective, and relational needs, then a field that is committed to promoting wellness as being located only at a personal level must first work to re-frame how wellness can best be understood. To be of benefit to a capitalist society, the field of Psychology needed to keep attention focused on personal needs and away from any sort of consideration of collective or relational needs or goals.

William James is perhaps one of the earliest instrumental influences in this reframing of wellness that allowed for the application of the American framework of capitalism and individualism to the field of Psychology. James (1890) used his foundational textbook, *The Principles of Psychology,* to move away from a European understanding of Psychology as the study of the human experience and toward a delineation of boundaries that affirmed Psychology's place in the domain of science. As he sought to promote Psychology as a field with valuable information to share about mental processes and individual internal processes, James (1907; 1909) used his philosophical commitment to pragmatism and functionalism as a foundation upon which to base these claims. Notably, pragmatism grew out of an earlier "process

philosophy," with the application of James' assertion that the value of ideas comes from their application, or "cash value"--a profoundly capitalist notion. James understood the concept of the "self" as resulting from a person's experiences and their subsequent reactions. Our understanding of who we are, according to James, exists only within context and it drives us toward action to respond to our environment. This understanding of consciousness as a sum of responses to the world informed James' promotion of Psychology as the science of mental experience. In other words, Psychology can contribute the most to the field if it moves away from a concern for the general human experience, a theme already being considered by the field of philosophy, and toward a focus on the kind of processes (sensations, desires, emotions) that can be considered at an individual level at a specific moment in time (Pickren & Rutherford, 2010).

Francis Galton used this understanding of individualized human experience in a much different way as he developed the field of differential psychology to prioritize the study of the things that differentiate us from one another. Galton hailed Darwin's survival of the fittest framework (1859) and even corresponded with Darwin, who applauded his work, looking for the differences that would set some human beings apart from others in order to capitalize on these differences to improve society. Galton even went so far as to suggest that this theory be taken on as a kind of "social religion," (p.4); one that could rid society of those deemed unfit and create the environment needed for those deemed the most desirable to thrive (Yakushko, 2019). An understanding of a society that can be improved by prioritizing its strongest members is, of course, based in the narrative of capitalism that insists that those who rise to the top have done so solely because of their hard work and ability.

The concept of survival of the fittest was actually first used by philosopher Herbert Spencer, years before Darwin published *The Origin of Species*. Spencer later misread Darwin, and used his findings as proof that learned characteristics, the kind that he saw as benefitting or hindering society (e.g: the drive to accumulate wealth; laziness) could be passed down to descendants. In his writings, Spencer denied the inherent value of all people with his assertion that societies that cared for the sick or the poor did so at the expense of their most valuable members and that the logical thing to do was to enact social policies that prioritized the progress of the "fittest." This, he suggested, would allow nature to fulfill its "plan" and support societies in their evolution toward their most productive iterations. He argued for laissez-faire capitalism, one that has no kind of government regulations that would inevitably hold the "fit" back by aiding the "weak" (Falk, 2020). Removing survival of the fittest framework from its origins in nature, though, ignores the fact that humans, unlike animals, have the capacity to create systems and structures that prioritize and promote characteristics that are valued not by nature but by those in power.

In many ways Psychology used this same framework of individual fitness to promote its practical value and social utility with tests that claimed to scientifically assess a person's fitness by measuring their intelligence, personality, and wellness. James McKeen Cattell (1890) suggested that mental tests could serve as a tool for Psychology to build up a base of experiments and measurements necessary to legitimize itself as a science (Pickren & Rutherford, 2010). Moreover, mental tests were understood as a way to consider differences between individuals and circumstances in a systematic way that would lend itself to the creation of laws around

human behavior (Faber, 1928). An understanding of differences in experience as part of a uniform and predictable pattern of human behavior frames society as a composition of individual actors who can and should be understood through the same lens and held to the same narrow understanding of "fitness," regardless of their specific circumstances, backgrounds, or contexts. More importantly, though, it legitimizes the capitalist narrative that those at the top have earned their place there. Psychological tests were created using capitalist values to determine who has demonstrated the most success within and as defined by this social structure and, as such, are set up to advantage white middle- and upper-class individuals (Aston & Brown, 2020; Snowden, 2003; Williams et al., 1980). Test results, though, are packaged by the field of psychology as a values-neutral scientific assessment of innate ability. Using results in this way supports the narrative that white-, male-, middle- and upper-class individuals are the most valuable members of society. Testing provides a framework for privileged identities to prove themselves as being most worthy of the resources needed to remain at the top of the social hierarchy, at the expense of others, because it ignores the fact that the questions being asked were developed with the success of these individuals in mind.

The opening decades of the twentieth century marked the beginning of a new era in American society. The US was receiving an unprecedented wave of immigrants and was rapidly moving toward urbanization and industrialization (Cushman, 1996). This time of expansion and change provided an ideal framework for Psychology to prove its value as a tool for societal regulation and control. In this same time period, Sigmund Freud was working to develop the field of Psychology in Germany with his belief that healing distress could best be done by

accessing and working with the unconscious (Pickren & Rutherford, 2010). Freud was asked by those working to establish this same field in the US, to share these ideas and his practice of psychoanalysis at a lecture series at Clark University. About a decade and a half (1892) before this talk at Clark University, this same space was used to host a group of individuals who would today be defined as WEIRD (white, educated, industrialized, rich, democratic), looking to create an organization to discuss psychological matters. As this organization, now known as the American Psychological Association (APA), developed in the years leading up to Freud's lecture, they created a set of principles to guide nomination (Fernberger, 1932). These principles became the foundation for standards for participation, training, and legitimacy in the field. The assertion at the core of these foundational principles, that APA membership should be made available to those working to promote Psychology as a science, reflected the ongoing mission of psychologists to legitimize the field as one that could support the US's commitment to building and maintaining its free-market capitalist economy.

In the years that followed Freud's lecture, psychoanalysis became a widely discussed theory and psychotherapy grew, throughout the century, to be one of the most influential social practices in the western world (Cushman, 1996). Perhaps unsurprisingly, the APA's commitment to promote Psychology as a science was used to interpret Freud's work. In his *Constructing the Self, Constructing America: A cultural history of psychotherapy*, historian Phillip Cushman argues that Freud's work and influence was distorted to fit the sociopolitical narrative of 20$^{th}$ century America and used to strengthen the foundation for a practice of psychotherapy that could both influence and support the societal values within which the field was growing. This made it

possible for psychotherapy to secure its place in the fabric of the western capitalist society—as a force that could be used to build, legitimize, and maintain this social system. Cushman goes on to explain that the mental hygiene movement built on this foundation by creating a framework for Psychology to assert itself as being a science of the mind. Mental hygiene framework suggests that distress is best understood as the consequence of experiencing toxic interpersonal relationships.

The principles of Psychology were used throughout the 20th century to predict and guide the behavior of individuals in order support the aims of the free-market economy. Corporations made use of psychological principles to create customers and ensure that consumption kept pace with production. These principles were also used to encourage and support engagement in labor—marketing "career choice" as an integral component of one's personhood (Cushman, 1996). Testing and assessment remained a central component of the field throughout its development in ways that are still seen today. Assessments were used to provide concrete information about the intelligence of individuals and to make predictions about how their personal characteristics might impact their functioning and their behavior. Assessments compare individuals to control groups and as such provide the kind of concrete data needed to be of value in a capitalist framework. Their aim was to highlight any sort of abnormalities that existed within the person being evaluated as compared with someone who meets societal expectations. The *Minnesota Multiphasic Personality test,* for instance, uses scales that were created by contrasting responses from individuals with identified mental health disorders against the responses of a control group (free from any identified mental illness) (Farreras et al., 2016). Despite being

understood as one of the most influential assessments of personality still today, this assessment focuses only on how a person's characteristics either adhere to societal norms or deviate from them. Testing and assessment allows the field of Psychology to name expectations for how people should behave, use these boundaries to evaluate whether individuals are meeting expectations, and offer suggestions for how people should change if they are falling outside of these boundaries.

John B. Watson further Americanized the field of psychology with his publication of *Psychology as the Behaviorist Views it* (1913). Watson authored this text as a kind of challenge to the field of Psychology to define itself as an objective experimental branch of natural science. He asserted that in order to become cemented in this role, the field should not waste time trying to interpret the ways individuals think or how they experience their lives. Scientific data should not depend on interpretations of consciousness and should instead center around what can be observed, measured, and analyzed. Watson even went so far as to assert that he draws no distinction between humans and animals, as it is the outward behavior, not the experiences behind these behaviors, that are worthy of consideration (Schneider & Morris, 1987). This framework deepened Psychology's case for its membership in the field of science by broadening claims that individual behavior can be understood as part of a predictable pattern that extends across humanity. Psychology, this framework suggests, can offer a sterile, scientific service as long as individual behavior is understood as something that is extricable from a person's being.

Movement away from the philosophical roots of psychology and toward a consideration of human nature as something observable and measurable made Psychology one of the most

effective tools for social management as the US developed throughout the 20th century (Pickren & Rutherford, 2010). In his *The Search for Order* (1967), historian Robert Wiebe argued that American capitalist ideals (competition in the international marketplace, a national credit system, the railroad system) could not be sustained without a reordering of society. Wiebe points out that a capitalist society cannot allow for the autonomy of the kind of "small republics" created by the founding fathers to allow for citizen participation in local government that did not extend to a state level (Turner, 2014). Capitalist values cannot allow the kind of "small-town" communities that defined the early-American social landscape to operate on their own and to thrive and care for themselves. This need for a new modern social order from the late 1870's through 1920 gave rise to the middle class– a group of modern business professionals, intent on instilling order, centralizing control, and moving away from the old system of autonomy characteristic of small-town America. The field of Psychology facilitated this shift, by working to suppress the kind of cooperative group action that could empower individuals to organize and maintain their autonomy as sustainable communities outside of the centralized system of capitalism. Psychology kept individuals from observing this new system within which they began to operate and kept them from considering the role of these structures in creating and maintaining their distress (Cushman, 1996; Parker, 2007). Prioritizing the individual and their self-contained behavior allowed Psychology to move people away from the kind of experience sharing or story telling needed to see themselves as interconnected parts of a greater whole and toward a personal inward focus that left people so focused on meeting the expectations set for them by the

dominant social system that they had little energy left to bring awareness to the existence of the system itself.

In her *Strangers in Their Own Land* Arlie Russell Hochschild (2016) explores the influence of individualism on the political polarization of the American people. She suggests that every person has a "deep story" that they tell themselves about their lives and that these narratives (rather than our lived experiences) come into conflict with one another. This conflict keeps us from uniting over our shared interests: better infrastructure, more effective healthcare, better wages, because we have been convinced that those with different stories are doing things wrong, at our expense. Interestingly, these shared interests, that we have been convinced are not important enough to motivate reaching across our differences, are the kinds of things that would allow us to shape a government that more effectively cared for an supported its citizens, if it was held to these standards by a unified people.

This narrative of needing to prioritize one's own needs to survive keeps wellness confined to the framework used by Rand (1986) to advocate for free-market capitalism. Rands' assertion that free-market capitalism is the only logical and moral choice for rational individuals is supported by an understanding of distress as limited to individual minds. If distress, as the mental hygiene movement suggested, is the result of personal choices not to live up to the human desire to be rational, then healing is best promoted by providing opportunities for interactions with reasonable actors that are sterile and health promoting. Understanding emotional distress as a personal shortcoming able to be treated by reasonable professionals, allowed clinicians (in this sense, practitioners of psychotherapy) to fit emotional experience within the boundaries of a

capitalist economy. Categorizing distress in this way allowed for the application of objective standards to emotional experience. This made it possible for the field of Psychology to assign a value and a price to the practice of addressing emotional experience through psychotherapy (Cushman, 1996). This fee-for-service framework also freed the field from the responsibility of asking complex and nuanced moral and social questions (Prilletensky, 2008). If emotional experience is reduced to symptoms that can be addressed with monetized interventions, then the only questions that need to be answered are whether the service was rendered and how payment will be received. Once psychological wellness was effectively monetized and set up to exist within the framework of consumerism, and later, within systems of managed care, the field of Psychology was able to become an effective player in the free marketplace.

As the field of Psychology continued to inform and support the sociopolitical context within which it had legitimized its own existence, the Second World War provided a unique set of circumstances for psychotherapy to continue proving its value by promoting and maintaining a capitalist society. The loss and devastation caused by the war left a vacuum for psychotherapy to present itself as a kind of product people could consume in their search to fill up the space created by their grief. These circumstances effectively ushered Psychology into its "Golden Age." In order to best understand the current value system of psychotherapy, we must first reflect on this period of global loss and devastation that allowed American Psychology to strengthen its narrative in support of a profit-over-everything capitalist system with language about what it means to be in distress, how this distress might best be addressed, and what it looks like to be well enough to make meaning of one's life through effective contribution to society.

**The "Golden Age" of Psychotherapy**

In the wake of World War II, interest in psychotherapy expanded and further legitimized the usefulness of the field to a strong capitalist society. Psychologists, who were largely understood as technicians and testers, became necessary practitioners addressing the extensive psychological damage caused to those involved in the war (Farrera et al., 2016). Rebuilding a post-war individualist society as its members grappled with the shared losses incurred throughout the war meant that Psychology needed to define and operationalize its practice in new ways (Miller et al., 2020). Casualties from the war created needs that were greater than the capacity of the professionals prepared to provide support and the Department of Veterans Affairs (VA) increased its psychological training, research, advocacy, and practice (Miller, 1946). As the psychological toll of the war became more apparent, the VA reached out to the APA to request a list of institutions prepared to provide students with doctoral training in Clinical Psychology. This request was received by the recently established Committee on the Graduate and Professional Training of Psychologists (CGPTP) and intersected with the work being done by the committee to collect data on the universities offering this kind of training. The funding offered by the VA gave the APA the resources it needed to begin incentivizing an accreditation program, where the names of programs that met criteria established by the CGPTP were passed onto the VA for funding (Farrera et al., 2016). Consequently, the VA developed influence in the ideology, credentialing, and employment of psychologists throughout this time period in ways that are still seen in the field today (Baker & Pickren, 2007; Zeiss, 2013). Moreover, an increase in professionals prepared to meet the needs of those impacted by a war that spread across the world

at an individual level, allowed for the personalization of a shared global trauma. Consequently, rebuilding in the aftermath of the war became understood as a charge for individuals to rebuild themselves personally-- in ways that allowed them to, once again, contribute to their society.

Efforts to rebuild centered around the capitalist notion that the whole is no more than the sum of its parts and the subsequent conclusion that society is best rebuilt through the individual labor efforts of each of its members (Prilleltensky, 1994). This focus on the individual and their personal recovery and happiness neglected to consider the impact of the unique political and social factors that lead to the distress these individuals were experiencing (Parker, 2007). Left to manage the impact of a world war in private and on a personal level, individuals internalized the losses of the war and sought to rebuild by filling up what felt empty with goods, services, and indulgences. In his *Culture of Narcissism,* Christopher Lasch (1978) suggests that this time period was the beginning of a focus on the self at the expense of family and community. Lasch draws from Karl Marx's conclusions about the influence of economic structures on personal characteristics and the work of Freud around the unconscious mind to conclude that the social changes incurred by the end of the Second World War eroded the value of community wisdom and the authority of experience. He maintained that the culture of individualistic self-help, the kind promoted by the field of Psychology, asks individuals to consider each moment as being a chance either to succeed or to fail; limiting the worldview of each person to their own desires and their propensity to successfully achieve these desires in every given moment (Siegel, 2010). As the loss of community, tradition, and collective meaning making was managed in private, psychotherapy rose up as a kind of good to be consumed in an attempt to fill up the self and

make meaning of one's life and circumstance (Cushman, 1990). Psychotherapy cemented itself as part of the fabric of a capitalist narrative by serving as a solution to the kind of personal failure identified as the root cause of societal dysfunction.

The post-war sense of an empty self-created a need for psychotherapy to fill, not through reflection on the social problems depleting those who had lived through a world war, but through the offering of tools and strategies to fix identified individual shortcomings. As a consumable good, psychotherapy began to develop a plethora of strategies aimed at addressing problems within the individual—building society by fixing its members. It was, of course, also the job of the field to identify and name the problems their strategies were designed to fix (Danziger, 1997). As it developed the language necessary to justify its own treatment, the field of Psychology chose to contain psychopathology within the individual. This, Prilleltensky (2008) suggests, is the role of power in the promotion of wellness. The function of power lies in the ability to meet or obstruct needs. The choice to explain distress as a malfunction in the brain rather than as a reaction to context allowed the field of Psychology to attend to identified needs of clients at an individual level. This allowed for a maintenance of the status quo, as social systems and structures would not be called into question or even considered as an influence on wellbeing (Albee, 2000).

Throughout its golden age, the field of Psychology used its power to focus on individual needs while obstructing relational and collective needs. As the field grew with the influence of the VA, the kind of competition and uniformity inherent in western capitalism became greater hallmarks of the field. The APA was restructured in order to incorporate more applied

psychologists and more individual care was provided to those struggling to manage societal distress on a personal level (Pickren & Rutherford, 2010). The CGPTP became the Committee on Training in Clinical Psychology (CTCP) and began setting standards for accreditation through site visits and in-person evaluations (Farrera et al., 2016). This move away from collecting information from training programs through their own self-reports gave the APA greater control over setting the standards that programs needed to meet to receive funding and maintain their place in the field. These standards, of course, were heavily influenced by the APA's desire to legitimize the field of Psychology as a science. As the field continued to expand, it produced services designed to meet the expectations of insurance companies operating in a model of managed care. In a managed care model, insurance companies are paid fees in advance of services rendered and then delegate which services these fees cover. The field also collected evidence to prove its efficacy as a part of this model. Though the evidence collected found that the most impactful aspect of the therapeutic intervention was the interpersonal relationships and interactions, the field remained committed to producing time-limited, reproducible interventions that can be charged to insurance. In order to remain committed to practices that stand in the face of its evidence base, the field of psychology needed to find new ways to package distress as an individual endeavor.

**The Evolution of Individualism in Theoretical Orientation**

As the field of Psychology moved through its golden age, its assumed value came under increased scrutiny as memories of the war became more distant. Questions arose around whether the field, which had worked to solidify itself as a science, could operate as concretely and

empirically as Psychiatry (Psychology's medicalized counterpart) and whether the practice of psychotherapy even had any demonstrable efficacy (Miller et al., 2020). Psychology turned to research to answer these questions as part of its commitment to being housed within the sciences. In a meta-analysis of 400 studies, Smith and Glass (1977) found that those who participated in psychotherapy had better outcomes than about 75% of untreated individuals (Landman & Dawes, 1982). This led to the publication of texts hailing the benefits of psychotherapy (Smith et al., 1980) and scholars since to presuppose the efficacy of psychotherapy in the search to discover what about this practice is most effective. Other studies, though, maintained a stance that psychotherapy is ineffective, asserting that its effects cannot be differentiated from proven rates of spontaneous recovery (Eysenck, 1952) and that, in many studies of patients experiencing diagnosed psychopathology, treatment outcomes were no more effective than placebo effects, or a belief that one is receiving treatment when that is not the case (Frank, 1983).

As this evidence for the effectiveness of psychotherapy was studied more closely, consistent findings emerged suggesting that the most important aspect of this process of change is not the specific intervention or strategy offered but rather the connection formed between the provider and the patient in the therapy relationship (Leibert & Dunne, 2015; Nienhuis et al., 2018; Norcross & Lambert, 2010). In fact, this connection, termed the therapeutic alliance, has shown to account for a greater amount of therapeutic gains (between 7 and 15%) than a provider's adherence to techniques or even their overall competence at delivering psychotherapy (Nienhuis et al., 2018). Evidence for the impact of relationships in psychotherapy is pervasive throughout the field's development, with findings pointing to all aspects of relationship building

and interpersonal connection as being foundational to outcomes. One study by Norcross and Prochaska (1983) found that clinicians identified their specific theoretical orientation and their theory of pathology/personality as being the most important influence in their practice of psychotherapy. Later research went so far as to suggest that patient hope in the process of psychotherapy accounts for many of the common factors that extend across intervention strategies and the various research findings that individuals benefit from believing they are receiving interventions when they are, in fact, part of a control group (Snyder et al., 1999). These findings highlighting the influence of therapist meaning making and client hopefulness seem to stand in the face of Psychology's claim that individuals can be reduced to their outward behavior and that this behavior can be changed with consistent and easily replicable intervention strategies.

Perhaps unsurprisingly, it was psychodynamic practitioners, who aligned more closely with Freud's original understanding of psychoanalysis as an exploration of experience rather than as a tool to control and change behavior, who first considered the impact of the therapist-client relationship on outcomes in the 1970s (Feller & Cottone, 2003). While a comprehensive qualification of the specific factors that operationalize strong alliance building remains elusive, therapist empathy and genuineness have been identified across studies as factors that stand out as strongly relating to outcomes (Nienhuis et al., 2018). Genuineness and empathy do not lend themselves to the kind of empirical and positivistic framework needed for psychotherapy to market wellness as a commodifiable good available to be consumed at an individual level. Feeling connected to or understood by someone simply cannot be commodified and monetized

the way that a strategy for behavior change can. Moreover, feeling seen and understood might instill in individuals a sense of inherent value, separate and apart from the work they do to contribute to their society, that could lead them to question the societal roles they have been convinced will give their lives meaning.

Consistent findings about the importance of relationship building in the practice of psychotherapy (Lawson et al., 2020), creates a double bind for the field of Psychology. If the relationship between the practitioner and the client is the key component to effective psychotherapy, then intervention strategies cannot be generalized or manualized in ways that make them easily replicable and easily distributed within a free market economy. If the field of Psychology is committed, as it claims, to data and evidence, then it should grow in the direction of its proven efficacy. In the case of psychotherapy, though, this commitment to growing in response to data and evidence would mean prioritizing the kind of interpersonal relationship building that is incongruent with a goal of reducing client experience to individual concerns and outward behavior. Moreover, prioritizing relationship in the therapeutic process would call the "objectivity" practitioners claim to espouse as a part of the scientific paradigm into question.

Attempts to assimilate findings around the crucial role of the therapeutic alliance into the strategies of psychotherapy without moving away from the field's commitment to individualism is highlighted in Psychology's shift away from strict behaviorism and toward person-centered and humanistic practices. Carl Rogers (1957) first considered the drive of the individual person to create their own success and happiness in his quest to better understand how psychotherapy can best guide individuals to change. Abraham Maslow (1962;1971) expanded this conversation

around the inherent desire of individuals to manifest their own fulfillment through self-actualization with his hierarchy of needs. Here he asserted that basic personal needs (e.g: food, water, safety) must first be met before a person can consider how best to change themselves to move toward their full potential. Both of these theories of person-centered change built on Paul Tillich's (1952) assertion that having the courage to be—to live up to our own humanity in spite of distress or barriers—is an ethical act. This desire to prioritize the wellness of every individual kept both cause and solution of suffering relegated to the personal level, often assuming the influence of society and environment to be a given source of distress over which the individual has little control. Wellness, these person-centered theories maintain, is best promoted through an acceptance of the forces that one cannot control (society, context, environment) and an intentional focus on the aspect of lived experience that can be controlled: one's own reaction to this experience.

This understanding of what it means to be person-centered, though, strips down lived experience to an iteration that can be understood through an individualistic lens. In this context, the "person" aspect of person-centered is limited to personhood as defined by the founding fathers–those who fit within the WEIRD framework. Maslow's hierarchy of needs, for instance, was originally influenced by the time he spent with Blackfoot Indians (Blackstock, 2011). This influence is reflected in Maslow's initial assertion that individual wellbeing is best understood within the framework of collective and interconnected human need. Maslow's final version of his hierarchy of needs, though, failed to incorporate the Native understanding of ancestral knowledge, spirituality, and multiple dimensions of reality and limited lived experience to the

individual. This failure to situate individuals within their community context and to consider them as a part of a greater, interconnected whole seems to speak to an intentional choice to strip rich, longstanding theory and understanding down to a bare-bones framework that advances the aims of an American Psychology designed to fit within an individualistic western capitalist framework.

The field's move toward cognitive therapy and, later, toward cognitive-behavioral models reflects this same drive to provide interventions that manage distress at an individual level as efficiently as possible. In his consideration of the foundation of cognitive therapy, Albert Ellis (1962) pointed to eastern philosophers (e.g: Lao-tse, Confucius, Buddha) and Greek and Roman philosophers (e.g: Socrates, Epictetus) as early practitioners of the model of cognitive therapy. He suggested that in each of these theories and in many cases, religious practices, followers were encouraged to separate themselves from their circumstances in order to focus intentionally on the aspect of their distress that they could control—their thinking about their situation (Rosen, 1989). Aaron Beck (1963) extended this thinking to account for the role thoughts play in keeping individuals stuck in depression. Beck and his colleague Marjorie Weishaar went on to suggest that all psychopathologies can best be understood in terms of the underlying cognitive vulnerabilities, or mistakes in thinking, that underlie each identified disorder (Rosen, 1989). These disorders, of course, are the ones named and categorized by the same field now working to shine a light on the inaccurate thinking that informs each.

Ellis's framework of irrational beliefs, the 12 most prominent of which were outlined in his *Reason and Emotion in Psychotherapy* (1962) was used to test for common thinking patterns

between patients in distress and to evaluate how effectively different interventions addressed problematic thought patterns (Rosen, 1989). In his *Principles of Behavior Modification*, Albert Bandura (1969) built on this work with his consideration of the role of thoughts in maintaining patterns of behavior. In combination with the publishing of Michael Mahoney's *Cognition and Behavior Modification* (1974), this work began to legitimize intervention strategies aimed at changing behavior through the adjustment of thoughts and moved the practice of Cognitive-Behavior Therapy (CBT) to the forefront of the field (Rosen, 1989). CBT was a powerful framework for the field, as it confined distress to the thoughts in someone's head. Darwin himself suggested that recognizing the need to control our thoughts is the hallmark of reaching the highest level of a moral society (Yakushko, 2019). This presupposes that every person has the same ability to change their experience by changing their mindset and aligns itself almost seamlessly with Rand's (1986) assertion that free-market capitalism is the only logical and moral system of government, as it affords individuals the space to allow themselves to be rational, should they choose to do so.

Moreover, CBT is well situated to market psychotherapy as a consumable good within the free-market economy. CBT interventions are generalized, easily replicable strategies that can be taught to individuals, at a fixed price. The system of managed care that had come to define the field of Psychology in the time after the Second World War was particularly excited about CBT as a psychotherapy strategy because of its time-limited nature (Shook, 2018). Unlike interventions based in relationships that depend on time spent building the rapport and trust necessary for exploration of personal experiences and distress, CBT calls clinicians to teach self-

help strategies that clients can quickly learn and then replicate on their own. This allows insurance companies to send the message to their members that they have access to the services they need, without compromising their bottom line. CBT treatment promises quick and timely change and as such lends itself to being approved for a set of finite payments. This minimizes the risk for insurance companies that the treatment might extend past the point where they stand to lose profit by paying more than what has been paid into coverage by the person being insured.

The same strategy used by Maslow of stripping rich cultural theory down to pieces easily distributed and consumed within a system of managed care are seen in many CBT interventions and in those that followed in the third wave of cognitive behavioral therapies (e.g: Acceptance and Commitment Therapy (ACT)). Mindfulness practices, for instance, are removed from their rich Buddhist tradition and repackaged as simple self-help strategies. This re-packaging of mindfulness as a chance for individuals to personalize their distress by directing their focus on themselves and their experience in the moment is particularly poignant, as it stands in direct contrast to the Buddhist tradition of using awareness to increase one's capacity for social responsibility. The goals of traditional mindfulness, in fact, are directly opposed to the aims of capitalism, as the ultimate intention of this practice is to rid the mind of greed and ill will in order to cultivate insight, compassion, and concern for all other living beings (Purser & Milillo, 2015).

Not only did these theories move away from more time consuming, dynamic, interpersonal interventions, they also limited the consideration of how individuals exist within communities, cultures, and socio-political contexts. Prioritizing time- and cost-effective services

over strategies that consider the complex and interconnected nature of individuals is reflected in the voices of the field that were distorted, the ones that were amplified and expanded upon, and the ones that were ignored. A poignant example is the field's move away from scholars who brought the influence of Gestalt Psychology from Germany to the US. Kurt Lewin (1946) and Egon Brunswick (1955), for instance, both used Gestalt Psychology to consider the impact of the environment on behavior. Lewin suggested that the best way to understand the behavior of those living in any community is to spend time in that environment. Brunswick went so far as to assert that the environment must, in and of itself, be considered as an integral aspect of an individual's experience (Pol, 2006). The kind of complexity involved in the meaning-making of lived experience considered by these scholars and others from these schools of thought do not lend themselves to easily monetized, replicable, and timely intervention strategies. More importantly, though, they extend the consideration of distress past the individual in ways that call the assumptions at the base of a free-market system of capitalism into question.

In order to maintain the assertion that distress is best considered as being located firmly within the individual, the field of Psychology needed to show that its theories and strategies had the capacity to effectively influence individual change. Smith & Glass's (1977) meta-analysis was later expanded upon by Glass & Miller (1980) and the body of evidence for the efficacy of psychotherapy increased. The evidence that those engaging in psychotherapy reported more positive change-oriented outcomes than those who did not, did not keep the medicalized culture of managed care from expressing skepticism that interpersonal strategies could be as impactful as pharmacological interventions. The role that Psychology played in building and legitimizing

this system that prioritized profit in the promotion of wellness did not shield it from the scrutiny of those seeking to continue maximizing the profit margin. Proving the capacity of psychotherapy to be both time and cost-effective became increasingly important as Psychology grew to depend on funding from the government throughout its golden age. In many ways, funding became both the means and the ends of the field, with funders operationalizing the field's practices while also determining how to prioritize and demonstrate outcomes. For this reason, the development of the field's theoretical orientations, theories, and strategies is best understood within the context of funding sources, their value systems, and their overarching agenda.

**You get What you pay for: The Role of Funding**

Throughout its golden age, the field of Psychology became increasingly dependent upon federal funding to support its research. Much of the early funding that came in the wake of President Roosevelt's New Deal and an ensuing popular belief that the government should support and advance the health of its people, was unrestricted (Farreras et al., 2016). This kind of funding of research and practice around wellness for its own sake, though, did not fit within the capitalist framework that Psychology had developed and evolved to support. The push begun after the Second World War to train and equip clinicians to address the psychological impact of the war eventually gave way to closer monitoring, scrutiny, and reductions in funding and resources wherever possible. At the same time, the field of psychiatry developed within a biomedical research model. This allowed the field to market itself as one with providers well versed in training and research and practices that fit within a clean, concise, and profit-oriented

medical model (Pickren, 2007). As funding became more limited, the field of Psychology sought to legitimize itself as being worthy of funding from a government committed to its capitalist economic structure and its inherent values. In order to affirm its value as a consumable good, the field of Psychology worked to prove its ability to produce and provide interventions aimed at predicting and changing behavior in ways that were timely and easily quantifiable.

One of the federal sources influencing the APA accreditation standards for clinical programs was the Division of Mental Hygiene of the US Public Health Service (PHS). The Division of Mental Hygiene, like the APA, was looking to identify training programs to fund. Central to this search were commitments to recognize and treat mental illness, research the nature and etiology of mental disorders, train practitioners to do the work of promoting mental hygiene, develop methods that work to address and reduce mental disorders, and address community factors that inform and maintain mental illness. With these aims, the bill for the National Neuropsychiatric Institute was created and later passed as the National Mental Health Act. The signing of this bill created the National Institute for Mental Health (NIMH) which, by 1949, was funded and formally established (Farrera et al., 2016). The establishment of the NIMH represented an important shift in the field of health. Unlike other federal agencies designed to advance healthcare, NIMH's mission centered around actually promoting mental health rather than simply moving to address and intervene against disease.

Though rhetoric around mental wellness was expanding beyond psychopathology and moving toward a consideration of overall mental health, a dependence on federal funds left the field of Psychology beholden to the priorities and commitments of varied administrations. In the

1970s, congress established criteria for reimbursement for psychological treatment and expressed concern that there was a lack of quantifiable data proving the treatment the government was financing was safe and effective (Farreras et al., 2016). This proof that psychotherapy was safe and effective, of course, needed to fit within the framework of the system providing the funding. Proving that psychotherapy interventions are worthy of funding means speaking the language of those with the funds. This influenced the field of Psychology's move toward sterilized testing of interventions on groups of randomly assigned individuals as compared with other groups of randomly assigned individuals not receiving the intervention. This strategy of testing, randomized control trials (RCTs), became the standard for legitimizing psychological intervention strategies in ways that appealed to its funders—in this case, the federal government (Rosner, 2005). RCTs offered a framework to test interventions within a vacuum by isolating the intervention and comparing it against no other form of treatment.

As RCTs became the method for receiving federal funding, the NIMH began offering workshops on creating the kind of manualized RCT protocols that would lend themselves to funding approval (Farreras et al., 2016). In this way, RCTs allowed the government to influence not only what research is proposed but how research is conducted, where it is focused, and what sort of data outputs are considered. Prilleltensky (2008) points out that practitioners in the field of Psychology use our power not only to study what power means but also to define power in such a way that we are not impacted by it. By setting both the standards for effective treatment and the criteria for meeting these standards, the government was able to ensure the continued mutually beneficial nature of its relationship to the field of Psychology.

This mutually beneficial relationship is highlighted in the way that the influence of the VA that began after World War II continued to influence the field's development after the post-war era. Rating scales and assessment measures, for instance, were prioritized in treatment at the VA, as they allowed clinicians to make note of whether or not new medications were leading to effective behavior change in veterans (Pickren, 2007). Psychometric assessment gave the field a powerful framework to name and identify those who fell outside of the social norms and standards. These priorities can be seen in the development of the theories of the field. For the field to effectively package deviations from societal expectations as categorical psychopathology, it needed to shift attention and resources away from psychoanalysis and other psychodynamic treatment modalities and toward individualistic orientations (behavioral and later cognitive) and intervention strategies.

The influence of federal funding on the field of Psychology is, unsurprisingly, also reflected in the models of clinical training that are themselves dependent upon this funding. In order to remain competitive in the field, institutions must meet the standards of funding sources who understand value as existing within a capitalist cost/benefit framework. As such, education programs prioritize training students in therapies that are easily replicated and able to be considered empirically. In order for therapies to fit these expectations, they must be supported by the kind of RCTs identified by the government as providing adequate evidence of an intervention's safety and efficacy. Since the impact of long-term relationships cannot be tested in this sterilized way, little attention and resources are dedicated to training students in relationship-based intervention strategies (Shook, 2018). Programs that prioritize training in this way are

positioned to make the claim to the APA and its funders that they are preparing future clinicians to deliver services that are based on evidence. The problem here lies in the fact that this means only prioritizing certain information as evidence (Western & Bradley, 2005). Students are entering the field prepared to deliver the kind of services identified as most valuable by the government that funds the work without ever considering the rich history of the field or the value of its relationship-based strategies, many of which are utilized across the world with great success.

In order to use RCTs to create the evidence base needed to prove itself worthy of funding, the field of Psychology needed to find participants willing and able to be studied in a vacuum. As the call for empirical evidence for psychological interventions increased, researchers needed to examine samples of the population that were large enough to legitimize their theories and interventions. Unsurprisingly, the field prioritized study recruitment from the most easily accessible population: the one it was already serving. By conducting controlled experiments on individuals with WEIRD (western, educated, industrialized, rich, democratic) identities (Henrich et al., 2010) the field of Psychology produced the concrete data needed to legitimize its practices. It then used this data to justify continued support and funding from the government. This led to creating an evidence-based therapy used to promote and expand practices designed to serve the same limited population Psychology always prioritized in its service provision. Psychology's commitment to ensuring its own survival by continuing to serve those it was already set up to prioritize and value can be seen in its move toward prioritizing evidence-based practice.

**A Move Toward Evidence Based Practice**

Evidence-based practice (EBP) emerged in the 1990s as a framework to standardize and operationalize the practices of psychotherapy. The stated aim of basing treatment in evidence was to minimize error by grounding clinical decisions in the best available research. This, of course, meant standardizing the principles developed to benefit those holding WEIRD identities. In 1995, the APA's Clinical Psychology (Division 12) Task Force on Promotion and Dissemination of Psychological Procedures, published criteria for identifying treatments that are empirically validated for particular psychological disorders. Within the EBP framework, psychological interventions could be more effectively legitimized as their own sort of medication, with particular interventions being matched to specific sets of symptoms understood to extend throughout the population. The very language of matching treatments to "disorders" suggests that psychotherapy is a tool to address and rehabilitate those unable or unwilling to effectively play their role in maintaining societal order. This tool has a particularly poignant power to serve its purpose, given that it is a practice of the very field that is charged with defining what it means to be "disordered" in the first place.

In 2005, the APA Presidential Task Force on Evidence-Based Practice officially defined the EBP model as "the integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (P. 273). The purpose of this model, the task force went on to assert, is to prioritize therapeutic tools most supported by evidence to advance the practices of psychology and support public health (APA, 2006). This understanding of what it means to practice psychotherapy from an evidence base assimilates research documenting the impact of the therapist/client relationships by side-stepping the questions these findings raise.

Instead of confronting evidence that the most impactful aspects of psychotherapy have nothing to do with specific intervention strategies, the EBP model adds these findings into a kind of Venn diagram that suggests best practice psychotherapy occurs when practitioners use their clinical expertise to tailor treatments that are supported by evidence to fit the needs of the individual with whom they are working.

In this model, the therapeutic alliance is not thought of as a dynamic interaction between two people but as its own quantifiable component of treatment. This way, the importance of the therapeutic relationship is understood as a tool for clinicians to use to create environments in which clients feel confident enough to change (Holmes & Lindly, 1997). In fact, Division 29 of the APA (the Psychotherapy division) established a task force to research and disseminate information on empirically supported therapy relationships (APA, 2006). This task force maintained that an over-reliance on empirical validation of specific treatments would keep clinicians from harnessing the documented power of the therapeutic alliance and cautioned that a focus on treating disorders risks overlooking the parts of the person being treated that lie outside of their diagnoses (Norcross, 2002).

The irony of these cautions, though, is that they are being issued by the same organization creating the very rigid guidelines it warns against. Searching for empirical support for relationships reduces this complex and nuanced process to something that can be fit neatly within sterile medical boundaries. This framework binds the nature and experience of the therapeutic relationship to the same sociopolitical expectations used to inform and maintain the very diagnoses the task force cautions could limit clinicians' perspective of their clients.

Moreover, use of an EBP framework means that practitioners can only remain relevant in the field if they are contributing to its evidence base. In order to do so in a timely and, of course, cost effective manner, researchers must find large sections of the population who are easily accessible and readily willing to participate in studies. The aim of building an evidence base applies a quantity-over-quality lens to studies with the stated intention of identifying intervention strategies that are most likely to generalize from large samples to the general population. This need gave rise to online labor markets that allow researchers to crowdsource their research topics and access large numbers of research subjects in low-cost ways, both in the sense of financial resources and of personal power. One of the most popular of these platforms, Amazon Mechanical Turk (MTurk,) absorbs most of the legwork of recruitment by providing a space where researchers can make requests for tasks to be completed and participants can then elect to do so, often in exchange for some kind of compensation (Chandler & Shapiro, 2016). Use of this platform, it seems, applies the framework and inherent values of a capitalist economy rather seamlessly to an online space: allowing researchers to act as the private owners in search of laborers to produce their product (in this case, data) and create a profit (in this case, evidence to add to the field.)

As platforms like MTurk seek out workers to fulfill research tasks, the inherent assumption is that these workers already see themselves as having something to contribute to the field. Psychology often justifies its over-reliance on samples that are overwhelmingly WEIRD with an explanation that these are the most easily accessible populations (Henrich et al., 2010; Nielsen et al., 2017). This assertion, though, intentionally disregards that these “easily

accessible" identities are the ones the practices of the field have historically been extended to and normed-upon. Convenience sampling, lauded as the research strategy least likely to drain resources (both in the sense of time and of funds), has well-documented exclusion of what the field often terms "underrepresented" groups. The irony here is that the use of this language often serves as an excuse for why the field does not effectively understand, much less meet the needs of non-white, lower-income, non-English speakers. When we look more closely at the actual language, the intentionality of this barrier becomes clear: the groups falling outside of WEIRD framework are not included effectively in our work because we choose not to represent them in our research in ways that reflect their presence in our population.

One of the primary assumptions made in the claim that study findings can generalize is that there are no significant differences between the population being studied and the general population. The deep seated and ongoing nature of this bias in studies that consistently center WEIRD study participants in ways that do not reflect the actual presence of these identities in the general population points to intentional disregard for the diversity of the population American Psychology claims to serve. In her *The Body is Not an Apology* Sonya Renee Taylor (2018) described the privileged identities in American society as ones that are assumed to be a kind of "default body." She pointed out that our nation's founding promises (of life, liberty, and the pursuit of happiness) were intended for the people who looked like the ones naming them: white, property-owning, English-speaking men. These same assumptions, about who we understand to make up the "general population" extend throughout the field of Psychology. The evidence base upon which interventions and strategies are normed reflects this assumption of the "default

body" rather than our actual population. It follows, logically, that when Psychology functions as a system set up to maintain a social order prioritizing these default bodies, its strategies for self-improvement are not accessible or beneficial to those relegated to the margins so that the default body can be prioritized. After all, a hierarchical system can only function when those at the bottom remain there to serve as a base upon which the success of those at the top can be built. If capitalism depends on a societal hierarchy that it justifies with the created language of race and the veiled construct of class, the field of Psychology can only support and operate within this system by buying into structural racism.

As the field of Psychology continues to legitimize itself as a science, it finds itself in the same double bind it has worked to ignore. As a self-proclaimed science, Psychology is committed to research that identifies the intervention strategies most effective for the greatest number of people. In order to embrace the hierarchical social structure needed for capitalism to thrive, though, the needs of those at the bottom cannot be prioritized at the risk of compromising the privilege of those at the top. Psychology's commitment to capitalism, then, can only remain intact through an intentional disregard for the experiences and needs of the ever-expanding segments of the population that fall outside of the default body. Rather than name the problem of underrepresentation as an inextricable outcome committing to an economic system dependent on the oppression of some for the benefit of others, the field began to supplement its narrative of evidence-based strategies. They did so with language about the complex and intersectional nature of identity.

This allowed Psychology to continue legitimizing itself as a cornerstone of the capitalist economy by suggesting that the needs of those that psychotherapy is not set up to support are both nuanced and common. These needs, this narrative maintains, lend themselves to the interventions already being produced by the field, should some small changes be made. Efforts of the field to become more inclusive and accessible, then, are concentrated on building up what already exists: adding a layer of cultural competence or humility onto already established and readily consumable products. These efforts are designed to make psychotherapy and its intervention strategies more palatable to those these practices keep in the margins. The ongoing unwillingness to examine or question the field's foundational values and practices historically used to keep non-WEIRD identities out of the dominant societal narrative is woven throughout the conversation and the efforts to make the field more accessible to those with marginalized identities.

**The Call for Multicultural Competence**

As the field of Psychology gained resources and attention in the post-war era, it began to face criticism around the ethnocentrism inherent in many of its practices. The American population was becoming increasingly diverse, and the one-size-fits-all intervention strategy of behavior change was becoming a less desirable good, as it was ineffective for everyone who did not fit into or benefit from the standards of the default body. Rather than question the values of the field, practitioners were asked to develop "competence" responding to the needs of those who did not have the default body prioritized by the field (Sue, 1998). In this way, the commodified services allowing Psychology to serve its role in a capitalist society were built

upon instead of critically examined or changed. This allowed the practice of psychotherapy to continue providing a framework to influence individuals to play their necessary roles in society—with the goal of making people feel attended to, even when their needs were in conflict with the values of the system that Psychology worked to build and evolved to maintain.

In 2001, the US Surgeon General released a report explicitly naming the fact that not all Americans share in equal hope of having their mental health needs effectively addressed. The addition of the public health sector to the narrative on mental wellness shone a light on the fact that psychological services were not designed for non-WEIRD populations, and in many cases, services were not even made available to them. In highlighting the ongoing barriers to accessing effective mental health services faced by minoritized populations, the report asked these groups to continue seeking services to meet their mental health needs. This advice, they explained, can only be meaningful if barriers to quality, effective, and affordable mental health services are addressed and eliminated (Satcher, 2001). These same concerns were reflected in the CDC's Healthy People Initiative, as they pointed to persistent disparities in access to mental health services for racial and ethnic minority populations of up to 50% (Healthy People 2010, 2000). These historic and ongoing disparities, while often framed as complex challenges or even unintentional oversights, actually make sense given Psychology's role in creating and maintaining a society designed to support those it has identified as being most "fit" for society and most worthy and deserving of resources.

Psychology's ongoing assertion that psychotherapy can be of benefit to everyone across the human experience has allowed the field to remain rooted to its stated commitment to be

apolitical and ahistorical. The field remains tied to these assertions in spite of ongoing failure to effectively serve anyone outside of the population prioritized by the socio-political framework it created. Taylor (2018) asserts that our ladder of social hierarchy holding the default body as the standard to which everyone should aspire, is made possible, in large part, because we do not value diversity in the human population the way we do in nature. This assertion is reflected in the ongoing resistance of the APA and the field of Psychology in general to explicitly name the barriers keeping the field from being accessible or beneficial to so many. While diversity in our ecosystem is generally valued and even considered an integral component of a thriving environment, we resist extending this valuing of diversity to the humans inhabiting these ecosystems. The APA warns that addressing too many areas of individual difference could undermine the aspects of the human condition that are shared across experience (APA 2003; Sue, 1999). This emphasis on shared human experience points not only to a devaluing of diversity but also to a belief in common factors that should make psychotherapy accessible across background and experience in a way that has never been realized.

The APA responded to the overwhelming evidence that the field was not effectively meeting needs across the population it claimed to serve through the establishment of guidelines designed to address barriers to accessing effective services. These guidelines, the APA suggested, would help practitioners supplement their services with practices that more effectively address the needs of an ever-diversifying population (Arredondo & Perez, 2006; Bettancourt et al., 2003). Within these guidelines for Multicultural Practice, the APA (2003) suggested that clinicians “may want to actively increase their tolerance and trust of racial/ethnic groups” (p.26).

Making services more accessible to marginalized populations is framed as something clinicians may want to consider—by challenging and building upon their ability to tolerate and sit with the "other." Inherent in this suggestion is the reality that the field's practitioners largely mirror the (WEIRD) population it was designed to serve. This challenge to clinicians to increase their comfort with those who are different from them (and as such, who fall outside of the dominant identities the field was designed to prioritize) did not include a consideration of how those who have been historically marginalized and oppressed might themselves be challenged to build trust in the professionals of a field that helped build the culture that thrives by keeping them in the margins.

Over a decade later, the APA considered the importance of updating guidelines for multicultural practice every 10 years and developed a task force to reconceptualize multicultural guidelines for the 21st century—with an emphasis on the ongoing disparities maintained by race and ethnicity (APA, 2015). Updates to the guidelines called for an ecological approach and prioritized intersectionality (APA, 2017; Crenshaw 1989; 1990). Most recently, guidelines have called for more responsiveness in the promotion of equity (APA, 2019). Equity, as opposed to equality, prioritizes justice rather than equality. In this case, an emphasis on equity should mean services that are not only accessible to non-WEIRD populations but that are meaningful and effective for these populations once accessed. The APA's shift in focus from tolerance building to equity moved the field away from the harmful framework of tasking privileged practitioners to become more comfortable with the marginalized populations they fail to serve. It did nothing,

though, to address the fact that inherent in Psychology's commitment to capitalism is a an unexamined bias in favor of maintaining the inequities needed for this system to thrive.

In fact, the way the APA prioritizes intersectionality in its most recent guidelines undermines the truth told by Kimberlé Crenshaw in coining the term. Crenshaw (1989) explained that asking Black women to identify harm caused to them as either the result of race or of sex is like calling an ambulance for a victim of a crash only after the person responsible for the crash has been identified. She explained that Black women experience discrimination similar to white women while also experiencing discrimination similar to Black men– sometimes experiencing sexism or racism separately and sometimes experiencing both in a compounded way. The oppression of Black women cannot be reduced to a capitalist understanding of the whole as no more than the sum of its parts. Black women, Crenshaw maintained, also experience a kind of discrimination that is its own unique experience—not simply as people of color who are also women but specifically as Black women. This key assertion, that the experience of those with intersecting marginalized identities is in some ways comparable to the experience of each of these identities and in other ways its own unparalleled experience, stands in the face of the APA's assertions that clinicians can meet the needs of any person with evidence-based practices, provided they are willing to use their clinical expertise to make these practices fit the identity of the person. Crenshaw (1991) went on to build on her work by asserting that intersectionality can be used to deconstruct the systems maintaining inequality by reflecting critically on the ways social hierarchies sustain themselves by existing at every level of society-- not only at its center

but also at its margins. Crenshaw suggested that intersectionality should be used as a dynamic tool to "map the margins" and dismantle the harmful influence of social inequity at all its levels.

A map of the margins is something that the APA has been consistently unwilling to consider. The APA consistently uses an important distinction to qualify their framework for multicultural best practice. The APA talks about multicultural practice not as a set of standards but as a set of guidelines. The key difference here is that standards are practices to which clinicians must adhere while guidelines are aspirational suggestions that clinicians can choose to integrate into their practice. Moreover, guidelines focus on the practitioner, rather than the client (APA, 2017). Use of guidelines suggests that the field of Psychology can repair the harm of prioritizing WEIRD identities and default bodies by asking practitioners, who overwhelmingly reflect these identities, to add a consideration and concern for those the field has shut out, to their list of "best practices." The field continues to build on inequitable practices in response to calls for increased accessibility, in spite of the inherently opposed nature of these two aims.

Emphasis on guidelines over standards also stands in the face of recommendations from multicultural experts that called for the APA to take the lead in weaving multicultural competence throughout the practice of Psychology. The National Multicultural Conference and Summit of 1999 was held in response to the election of the first Asian American president of the APA and the recognition that five other people of color had been elected to their respective divisions of the APA.Tasked with an examination of issues in ethnic minority psychology and identification of strategies for difficult dialogues on race, gender, and sexual orientation, this group of experts highlighted barriers to training in and development of culturally competent

practices. The field of Psychology, they pointed out, was training practitioners in theories and concepts created within a Euro-American context and, consequently, limited in applicability to populations that are increasingly diverse (Sue et al., 1999). Moreover, the complex nature of culture coupled with an ever-changing sociopolitical context makes the APA's use of broad and categorical reference groups an ineffective framework. This framework also fails to take another important component of intersectionality into consideration: many individuals holding marginalized identities have some identities that are privileged (Prilleltensky, 2008). Psychotherapy simply cannot effectively understand complex lived experiences, much less meet the needs of individuals with identities it was not created to value, within a socio-political context it refuses to acknowledge.

While the APA (2017) celebrates their Multicultural Guidelines as a way to acknowledge important individual differences while simultaneously appreciating shared human experience, a call to build on the already established mandates of the field ignores the ways these mandates reflect a very intentionally limited understanding of the experience that we as humans share and a complete refusal to consider what these experiences truly look like at society's margins. The foundations of the field of psychology were built to serve those who thrive in a capitalist society and as such are culture-bound and reflect the values and assumptions of this particular dominant societal narrative (APA, 2017; Sue et al., 1999). In order to truly address the unique needs of individuals across background and experience, the assumptions of clinicians trained in a field that assumes the perspective of a "default body" as normative must be addressed and considered in each clinical interaction (Comas-Diaz, 2006; Sue et al., 1999). Moreover, the field must

meaningfully acknowledge the finding in the APA's first set of guidelines (2003) that the number of ethnic minority psychologists at the time were "too small to break down by ethnicity" (p. 7). Any time spent encouraging already established professionals to become more comfortable with and accessible to the "other" is time not used to consider who is othered by the field and how the profession of Psychology makes itself inaccessible to practitioners with these identities. No amount of training or insight can infiltrate provider bias around what constitutes wellness until this bias is recognized and named as a part of the psychotherapy process.

**Expansion Without Efficacy**

Psychology's refusal to acknowledge the socio-political context in which it operates, much less to consider its role in creating and maintaining this context, has kept the field stagnant in its accessibility and efficacy. In spite of the ways Psychology has built its evidence base to fit itself more effectively within the medical model, evidence suggests there have been no real improvements in psychotherapy outcomes since initial evidence of the value of psychotherapy as compared to no other treatment was published in the 1970s (Garfield, 1981; Miller et al., 2018). New interventions, strategies, and theories also continue to be added to the field without any consideration or critical examination of the ongoing perspectives and strategies that have left needs unmet (Duckitt, 1992). As the field grew within the confines of its commitment to individualism, new intervention strategies and theories of change that lend themselves to this framework have been recycled and refurbished. Perhaps unsurprisingly, the efficacy and impact of a field that promotes its established value system over the evidence of its practical impact has remained largely unchanged. In fact, it seems that a field that continues to grow and expand

without becoming more effective must be building upon assumptions that work against its stated aims and interests.

The field of Psychology justifies its continued refusal to acknowledge socio-political context, by asserting that these factors lie outside of their purview as a field. The field maintains that it must remain ahistorical, asocial, and apolitical to provide effective services to individuals of all backgrounds and walks of life. Matters of social order, they suggest, are best left to other areas of the social science field (Cushman, 2018; Prilleltensky, 1989; Sarason, 1981). These claims are maintained in spite of Psychology's documented roots in eugenics and historic aims of using tools to identify the most valuable members of society to create a culture for those people to thrive once the least valuable have been rooted out (Yakushko, 2019). In addition to re-writing the field's history, these claims of maintaining neutrality to provide effective services have not been lived out at any point in the field's development. Even if remaining apolitical was truly possible as a social science in an inherently political society, Psychology has made the choice not to do so and has kept its attention and resources directed toward the members of society that fit their political narrative. The pseudoscience of phrenology, for instance, influenced the conversation on slavery and gave justification for racist policies by providing, what purported to be, scientific evidence for differences in psychological functioning between races (Hamilton, 2008). Racially biased intelligence tests were similarly used to justify and fuel racist rhetoric and support the passage of the Immigration Act in 1924 (Cushman, 1996). The field also categorized gay and lesbian individuals as experiencing a mental disorder and created "treatment" modalities for the purpose of sexually re-orienting (Haldeman, 1994). Even if sociopolitical context could

lie outside the purview of a field seeking to target the distress of those living within these contexts, the strategies used by Psychology to manage distress are informed by the societal narrative of who is inherently well that the field itself created.

In 1960, Psychology worked with the Department of Defense to support project Camelot—a project designed to use social science to fight against national liberation movements both in the United States and globally (Herman, 1995). This is not an outlier decision, as the field has a long history of working with the US government to develop, implement, and standardize techniques for torture (Rohde, 2022). Use of psychological principles to effectively design strategies was even sanctioned by the APA, who repackaged torture as "enhanced interrogation" (Thomas, 2017). In fact, active participation in government torture of prisoners of war took place for the better part of a decade following the September 11th (2001) terrorist attacks and were not denounced until an independent review documented significant evidence of this collusion of the APA with the government in 2015 (Gómez et al., 2016). The field of Psychology made the intentional decision to use its principles to enact as much psychological harm as possible on people who were understood by the government as having information that superseded their inherent human dignity. This shines a light on what the field truly wants to keep its distance from: not participation in political decisions but rather transparency around the commitment to an economic social structure that informs the political stances readily taken.

As the field of Psychology has developed within this refusal to acknowledge the socio-political context that it both creates and responds to, the need for effective strategies to address distress and promote wellness has remained. Mental health has extended beyond the field of

Psychology and its framework of psychopathology and become a more general component of the conversation on health and wellness. Toward the end of the 20th century, the topic of mental health was more openly discussed and more readily considered, if not more effectively treated. In 1999, the Department of Health and Human services prepared its first Secretarial Initiative on Mental Health, and the White House held its first mental health conference. In this same time, the Surgeon General published their report on mental health, affirming the inextricably interconnected nature of physical and mental health and wellbeing. The report highlighted several disparities in availability of and access to care for mental health needs, particularly as compared with other areas of health care. They suggest that the mental wellness of all Americans can be advanced only through societal investment—not just with dollar amounts but with a public commitment to become educated about mental health (Surgeon General, 1999).

The Center for Disease Control and Prevention (CDC) used this report by the Surgeon General (1999) to make the case to include mental health in their mission of public health promotion. The argument to include mental health in public health initiatives included an assertion that the rate at which Americans were impacted by mental illness (at the time, a reported 1 in 4 people) made it its own health crisis. Additionally, it was argued that the experience of mental illness likely impairs a person's capacity to effectively understand or engage in practices of self-care, disease prevention, and public health promotion. These arguments, though, came second to the primary assertion of the interconnectedness of the mind and body and the inextricable connection between physical and mental health. If the promotion of physical health cannot be effectively addressed without the consideration of mental health,

then mental health must be prioritized in the promotion of wellbeing (Safran, 2009). The documented mind-body connection serves to deconstruct the barrier between mental and physical healthcare, as one has shown to influence the other in ways that simply cannot be understood separately.

The major takeaways from the Surgeon General's Report and the CDC's response frame the paradox of the mental health field: mental health is both an integral aspect of healthcare that extends across the population and a largely inaccessible specialty characterized by stigma and ongoing inequity. The medical field and public health organizations can more readily shine a light on this paradox as they have not had to prove their worth to a capitalist economy the way that the field of Psychology has. Medical practices readily lend themselves to a monetized system and do not need to prove that they can be operationalized in ways that convince those on the receiving end that participating in this system is in their best interest.

The World Health Organization (WHO) (2005) echoed this same understanding of mental health as an integral component of overall health. Mental health, they maintained, is not simply the absence of mental disorders or disabilities but rather an overall state of wellbeing. This state of wellbeing is categorized by the ability to recognize personal strengths and abilities and to effectively manage the stressors of daily life. Notably, the WHO suggested that well-being is defined not only by the ability to manage personal lives, but also by the capacity to work productively and contribute meaningfully to the community (Herman et al., 2005). Health and wellness, the WHO suggested, is not simply a matter of how you feel but rather a reflection of how you are able to contribute to your own context. The WHO's highlighting of meaningful

community contributions as integral not only to emotional wellbeing but to personhood highlights a crucial stance the field of Psychology must make as a field that dedicates itself to the promotion of mental wellbeing. Meaningful community contribution might be understood as the capacity to engage in life-affirming work that creates a sense of personal value through the adding of value to the community. It can also be understood, though, as a call to hit the ever-moving target of contributing enough individually to feel personally valuable, with the hope that this feeling of value will create the experience of happiness and fulfillment (Prilleltensky & Prilleltensky, 2021). Lorde (2017) framed this second conceptualization of community contribution as the joyless work of capitalism. She suggested that in this system of labor and profit those engaged in the former to produce the latter have only numb sensation to the products they are producing, as they are continuously being called to increase profit.

Psychology's commitment to individual success and meaning making through productivity, unsurprisingly, is informed by its commitment to capitalism. The field uses the framework of development to talk about living a valuable life and reaching one's highest form of being. Inherent in the framework of development is the assumption that one's life is best oriented toward changing oneself enough to rise to the top. Taylor (2018) pointed out the flaw in this assumption, with her assertion that if it were possible to reach the top of the ladder, we would not have the ongoing sense of competition that defines our capitalist economy. Taylor's concept of radical self-love suggests subverting the demands of capitalism by choosing to reject the idea that we need to aspire to anything other than what we already are. She uses the concept of natural intelligence to illustrate our natural intention to become the highest form of ourselves. Taylor

uses the example of an acorn to illustrate this point. An acorn, she asserts, has all that it needs inside of it to grow into a tall oak tree. It does not need to work hard to become its highest self but rather is already designed to do so, if the environment and nutrients needed for growth are provided.

The Surgeon General's report on mental health (1999) used Psychology's framework of development to highlight and affirm the influence of mental health across the lifespan. Similarly, the CDC (2013) framed mental health as a developmental process and defines mental health in childhood as the achievement of developmental, emotional, and social milestones. This process, they maintain, is characterized by the development of coping skills that allow children to have a positive quality of life and effectively navigate life at home, school, and in the community (Perou et al., 2013). Mental wellbeing here is understood as life-long work—an ongoing process of meeting and building upon the next important social and emotional milestone. This stance from the field of public health affirms Psychology's stance valuable contributions adhered to the societal roadmap of wellbeing. This roadmap ensures that citizens continue to compete with one another by affirming that value comes from contributing enough to feel meaningful and that this sense of enoughness can only be understood when compared with individual contributions of others. Mental health as a developmental process is the inverse of Taylor's intelligent design framework, as it asserts that falling short of one's highest potential indicates a lack of will to work toward success and fulfillment rather than an absence of the environmental resources needed to thrive. The self-help philosophy at the heart of psychotherapy affirms psychotherapy's

value with the suggestion that distress resulting from not reaching one's highest form can be resolved through willingness to learn and practice new socially sanctioned strategies.

The APA maintains that the delivery of research-based techniques in a supportive environment by an objective, neutral, and nonjudgmental clinical provider is what makes psychotherapy the right tool to help all people learn strategies to change behavior and live up to their full potential. This process of reorienting toward one's developmental path is described as collaborative and interactive—provided the client is open to the process. This process centers around providing whatever information a clinician deems important and incorporating techniques identified as best able to change the thoughts and behaviors identified as maintaining problems and distress (APA, 2019). A commitment to understanding wellness as a personal commitment to changing behavior in order to be one's best, when followed to its logical conclusions, frames mental illness as a sort of personal shortcoming, if not a personal failure. If benefitting from psychotherapy is as easy as being willing to change, suffering from ongoing distress must be the result of an individual reluctance to be well. This inherent understanding of the responsibility of the individual to manifest their own wellness has been used, throughout the development of the field, to justify the way psychotherapy has remained inaccessible to certain populations, even as these barriers are named by the field as manageable obstacles that are being addressed.

**Barriers to Accessing Psychotherapy**

The APA asserts that while stigma against help seeking once created barriers to accessing psychological care, they were replaced by a social understanding of help-seeking as resourcefulness. Asking for help, they maintain, is the start of feeling better and the gateway to

understanding thoughts and emotions. Building a better life, the APA goes on, is possible for anyone willing to participate in research-based techniques designed to repair problems identified as existing within the client by a neutral and supportive clinician (APA, 2019). In order to continue validating this assertion, the field of Psychology directed its attention and poured its efforts not into understanding distress and its maintaining factors but rather into building an evidence base demonstrating the capacity of psychotherapy to identify, address, and change personal reactions to distress.

In spite of historic and ongoing evidence of the field's inability to effectively meet the needs of marginalized populations (Buchanan & Wiklund, 2020; Primm et al., 2010; Smedley et al., 2003; Snowden, 2003; US Surgeon General, 2001) the APA continues to assert that psychotherapy can be of benefit to anyone willing to ask for help and open to the process of change (APA, 2019). They explain that the field is accessible to anyone because of a commitment of practitioners to understand individual identity as a nuanced and dynamic concept. Urie Bronfenbrenner's bioecological theory is often used to demonstrate the field's appreciation for the dynamic and nuanced nature of identity development (Bronfenbrenner, 1979; 1989). Bronfenbrenner's process-person-context-time (PPCT) model emerged as his theory developed across several decades. It points to Bronfenbrenner's own process of coming to appreciate the impact not only of context but of the individual as they exist in their context within and across time (Bronfenbrenner, 1989; 2005; Tudge et al., 2009). Identity development, the theory suggests, is not simply the result of places or encounters but rather a complex process of interaction between individuals, their environments, and their experiences.

Moreover, social contexts themselves are considered by the APA to be best understood as nuanced and dynamic--made up of the intersection between personal characteristics, systemic influence, and historical time (APA 2017; 2019). This assertion of identity developing in response to individual circumstances affirms identity development as a fluid process that is the result of unique combinations of each of these factors. If each of these elements influences the others in order to shape identity in ways that are more than simply the sum of their parts, then the experience of individuals is as diverse as is our population. The problem here seems to lie in the dissonance that exists between this belief in the intersectional nature of process, context, and time on a person's individual experience and a commitment to providing consumable goods that guide individuals to fill pre-determined societal expectations and maintain a capitalist social hierarchy. As Psychology strives to make itself more accessible across populations by building upon practices that were designed to affirm the value of some identities over others, the field of Psychology is held back by the impasse it created for itself by refusing to confront the history of the field and the subsequent assumptions inherent in its practices.

Persistent disparities in access to and benefit from care exist across different populations and point to the critical gap created by Psychology's effort to maintain its place in a capitalist marketplace while enhancing its services to meet the needs of the individuals this system is set up to oppress. This dissonance in the field first became prevalent in responses to the criticism of ethnocentrism in the 1970s and continues to exist in the language used today. The APA's most recent iteration of its multicultural guidelines (2019) call for equity without any sort of reflection

on the role of the field in building and maintaining a social order that is based on competition and, as such, cannot exist without hierarchy and disparity.

American capitalism is dependent upon an individualist belief that every person can climb to the top of the social hierarchy if they work hard enough. This commitment to individualism keeps those in the hierarchy from questioning how and why people came to the place that has been ascribed to them by distinguishers (race, class, gender) capitalism created to justify the practice of benefitting the few at the expense of the many. The capitalist narrative that one's place in the hierarchy is reflective of one's effort and ability, and not of the self-serving feedback loop capitalism uses to legitimize itself, keeps the focus on the individual and their charge to climb to the top and away from an examination of the hierarchical system as a whole. Sonya Renee Taylor asserted that our focus on the default body motivates our continued climbing of the social ladder as we attempt to get to the rung that affords us the promises of the founding fathers and validates our worth. This ladder, though, only exists because we continue to climb it. Taylor explains that we all work to maintain the social systems that relegate all those who fall outside of the default body to lower rungs of the social ladder. We do so through our ongoing attempts to climb to a higher rung on the ladder—one that our systems tell us we are inherently unworthy of reaching (Taylor, 2018). The field of Psychology plays an integral role in keeping this ladder in place by providing the framework needed for individuals to assure themselves that if they could just change more effectively, they could transform their circumstances and finally climb the ladder as someone worthy of the pursuit of happiness– the way those at the top of the ladder have always been able to do.

Unsurprisingly, race and ethnicity impact both diagnoses and access to effective quality care in the field of Psychology (Smedley et al., 2003; Snowden, 2003; US Surgeon General, 2001.) This is particularly poignant given the correlation between experiences of discrimination and racism and symptoms of depression and other mental health concerns in racial and ethnic minority populations (Bazargan et al., 2005; Bernard et al., 2020; Essed, 1991; Volpe et al., 2020). Immigration status and English proficiency also maintain similar barriers to accessing care—both in combination with race and ethnicity and of their own accord (Dedania & Gonzales, 2019; Sentell et al., 2007). Income level and ability to access quality health insurance also create serious gaps in access to specialized care, including mental health services, that have outlasted efforts to expand affordable access to primary health care services. Class and income also interact with race and ethnicity and with area of residence in ways that inform complex and deeply ingrained disparities to access (Felland et al., 2004; Miranda et al., 2008; Safran et al., 2009). Those who fall outside of the default body (white, middle class) are not only less able to find services, but they are also less likely to receive quality care when and if it is made accessible to them. It seems likely that this reflects problems inherent in our field's definition of "quality" and "efficacy" in regard to care that is designed with only the needs of the default body in mind.

These disparities in access to care and the likelihood of receiving effective services once care is accessed are not reflective of the rates of distress endorsed. In fact, ethnic and racial minority groups have documented higher rates of psychological distress as compared with the general population and tend to access psychotherapy only after the symptoms of their distress have become very severe. Upon accessing care, these groups are also more likely to receive

inferior care and to prematurely terminate participation in services (Benish et al., 2011). These groups are more likely to self-report experiences of symptoms of psychopathology without accessing medical care and to receive diagnoses from medical professionals without being connected with effective follow-up services (Bazargan et al., 2005). The field of Psychology has also documented that those in poverty are not less interested in or less able to benefit from psychotherapy but have historically been unable to access these services at the same rates of those with higher socioeconomic status (Smith, 2005). Ongoing disparities in the field not reflective of the makeup of the population or the needs of its members begs an important question. Are these groups resistant to asking for help and being open to the process of change, as the APA suggests, or are they suffering from the distress of being forced to remain in oppressive roles that prop up the capitalist system within which Psychology has legitimized itself? Are these acorns being kept from the fertile environment they need to grow because their growth would mean that the landscape and the entire ecosystem would have to change?

As society has evolved and changed from the time of Psychology's "Golden Age," the field has been facing a complex dilemma. As psychotherapy sought to market itself as an effective service and a desirable good in a society increasingly less reflective of the population the field was designed to serve, it became more and more challenging to convince individuals to buy into using self-help to contribute to a social order that requires their suffering. To remain relevant and address the growing gap between stated aims and practical effectiveness, the field of Psychology added its voice to the social narrative persuading those at the lower levels of the social hierarchy to ignore the systemic factors maintaining their distress by instead looking to

those next to and below them for an explanation for their failed climb to the top. In many ways, this evolved narrative is a repackaging of Psychology's historic strategy of using preoccupation with self-improvement to keep attention focused on the self and away from the systems and structures maintaining distress. A preoccupation with the idea that those who are struggling alongside us to climb the social ladder might take up too much room on the rung and keep us from rising to the top keeps blame from being directed toward those who are already at the top, refusing to make any space.

**Competition Through Division**

Keeping those on the lower rungs of the social ladder at odds with one another by focusing on competition and false promises of rising through the ranks is as foundational to the fabric of American society as capitalism itself. Many of the original colonial settlers arrived from England because they had been convinced by landowners, many of whom kicked these peasants off of their land to begin with, that commitment to a colonial venture was the most viable path to land ownership. Many of these initial European settlers, seen as disposable by landowners in their native land, worked in bondage to pay for their passage and fulfilled a predetermined labor contract as indentured servants to secure land (Isenberg, 2017; Kulikoff, 2014). As settlers replicated this use of competition and acquired land and capital to finance labor at lower levels, the need for labor increased. Settlers could not effectively force Natives to work for them, as they knew the land better than the settlers did and had a kind of resilience and resourcefulness not found in this transplant population. Moreover, the Native populations lived more prosperously off the land with less effort than the colonists (Zinn, 2010). Rather than learn from

the Natives' community collaboration and respect for the environment as a dynamic and important part of their interconnected community, the settlers applied their own framework of individual ownership and profit to what they saw as their new space and eliminated everything that kept it from being divided and sold.

Settlers used genocide to guarantee their access to privately owned land and turned to Black slaves for labor. This is, perhaps, the most poignant depiction of how American free-market capitalism truly functions—private owners of capital do whatever they deem necessary to secure and legitimize their ownership and rely on the exploitation of a labor force in order to ensure their profit margin. Unlike the Natives who knew the land better than those claiming ownership over it or the European indentured servants who, in spite of their debts, still shared in the culture and the outward appearance of those in power, Black slaves were removed from their land and their culture and were easily identified as separate from the private landowners (Zinn, 2010). As Foucault (1977) and Paulo Freire (1972) have pointed out, though, power is most effectively yielded when oppression is internalized. To this end, Black slaves were not only physically forced to labor, but they were also regularly exploited mentally and emotionally with messages rooted in white supremacy that equated blackness with inherent inferiority. The same individualism that characterizes the field of Psychology today was used to deepen divisions between Black slaves oppressed by the same system of white supremacy. Labor was divided into different hierarchical roles--less labor-intensive housework as compared with field world, for instance-- to foster competition and deter any sort of collective action (Zinn, 2010). To keep

hierarchy in place through division, unity could not occur between any of the groups producing the labor needed to provide profit to those at the top.

The power of unity among the oppressed was highlighted in a very tangible way in the early days of the settlement of American land with a landmark demonstration of the oppressed uniting against those in power: The Bacon Rebellion. In 1676, white settlers overlooked for land grants were frustrated at being pushed into land occupied by Native tribes that they were unable to effectively dominate and coordinated with Black slaves to create an uprising. Though the rebellion against the ruling class ultimately failed, the damage done when poverty served as a unifying factor across color served as a reminder of just how dangerous the organizing of the lower class could be. In order to maintain the social hierarchy needed for division of labor, powerful white men needed poor white men to see Black slaves the same way they saw the Native people—as subhuman barriers to their prosperity. White indentured servants could not, of course, be persuaded to internalize oppression with the same strategy of equating whiteness with inferiority. Instead, poor white laborers were manipulated into forgetting that, while it was certainly to a lesser degree, they too were being exploited and degraded by the same systems exploiting free labor from Black individuals. Landowners began granting white indentured servants land and crops at the completion of their servitude. These resources settled feelings of exploitation and discontent in poor white laborers and provided hope that one could use labor to rise through the social ranks. In this way, poor whites were set apart as superior to Black slaves, not through the surrendering of any real power or resources by those at the top, but with incentivization of participation in the competition (Alexander, 2010; Zinn, 2010).

As white settlers sought to expand and settle the land already being stewarded by the Native people, this same strategy weaponized the Native people's reverence for and commitment to cultivate steward the land to care for one another. Native people were forced by continued broken promises and brute force of the government to make the impossible decision of whether to abandon their land or to remain and endure ongoing violence. In 1832, for example, the Supreme Court ruled that the Cherokee Nation had the right to maintain and self-govern on their land. Then president Andrew Jackson made it clear that he did not have intentions of upholding this decision and left the Cherokee people open to ongoing assault without any protection. The hopelessness created by a government that refused to protect the established rights of people on their own land left tribal leaders vulnerable to manipulation and division. Two powerful leaders, the Ridges, went against then-Chief Ross's intentions of remaining on their land and signed the removal treaty of New Echota hoping to secure a better life and to maintain sovereignty for their people by leaving the increasingly racialized south. This treaty led to the deaths of thousands of Cherokees who marched across the country in the now infamous (though often ignored) Trail of Tears. The Ridges, too, lost their lives, as members of the Cherokee Nation rose up against them and punished them for their betrayal (Meraji & Demby, 2020). In this way, the government was able not only to take land identified by the highest court as belonging to a sovereign Native people, but to do so by manipulating these people into directing their fear and anger at one another, instead of at those responsible for robbing them of everything they had and leading them to die.

The government doubled down on efforts to force the Native people into an individualistic framework of private property and land ownership with their subsequent policy of allotment. Under the guise of addressing Native poverty (that did not, at the time, exist) the Dawes General Allotment Act divided up what had been communal land shared between tribes. Senator Henry Dawes marketed himself as "sympathetic" to the Native people and voiced concern that they did not have the competitive spirit that allowed white men (the ones with the same kind of power and privilege Dawes held, at least) to prosper. As owners of individual plots of land, Dawes argued, the Native people could finally join the free market and become part of the competition. The head of each Native family was granted a piece of land that the government decided they deserved. Oftentimes land was split up into segments hundreds of miles apart. Many Native people were granted land in states they had never visited to which they did not have the means to travel. Instead of bringing Native people into the free marketplace as competitors, allotment made them vulnerable to having their land, their dignity, and sometimes even their lives taken by those on higher levels of the competitive hierarchy they had never wanted to be a part of. Dismantling the collective power of the Native people was never meant to empower them (Nagle, 2019). In fact, the *Dawes Act* created the kind of poverty it claimed to address and strengthened the system of capitalism in the United States by forcibly eliminating those calling the assumptions of this system into question by succeeding outside of its limits.

Individualism was similarly used to keep poor and working-class individuals separated by race within the struggle for equality between sexes. In the 1980s, Black feminist scholars organized to produce a collection of their voices to call for a revolutionary solidarity with the

publication of *This Bridge Called My Back*: *Writings of Radical Women of Color* (Anzaldúa & Moraga,1981). In this same time, Angela Davis (1981) wrote her *Race, Women & Class*, to highlight working-class white women's focus on the oppression of those who looked like them at the expense of Black women and even Black men oppressed by the same capitalist systems of power and control. Davis pointed out that in her fight for women's suffrage, Susan B. Anthony prioritized fighting against the power men had over women and refused to consider that both working class women and Black women were inextricably tied to their men by the exploitation of the entire working class by those at the top of the capitalist hierarchy. The tactics of oppression meant to keep a few at the top at the expense of the many, Davis pointed out, certainly does not discriminate on the basis of sex.

Capitalist social hierarchy needed white women, like white indentured servants, to be convinced of their ability to rise to the top, should they be willing to work hard enough individually by cultivating purity of self and home. This, of course, was not possible for poor and working-class women who needed to work outside of the home and even less so for Black women who, in addition to needing to work outside of the home, were dehumanized and hypersexualized. The women's rights movement began by building on the anti-slavery movement before this division was solidified. At the Seneca Falls convention, Frederick Douglas took a strong stance on the controversial opinion of including women in the suffrage movement, asserting that if a just government governs by the free consent of the governed, then there is no reason to keep women from this process. Two years after this convention, of which no Black women were a part, Sojourner Truth was uniquely positioned to speak to the criticism by upper-

class white men of their female counterparts at the first National Convention on Women's rights. Men argued that women needed to be helped across puddles and into carriages and could certainly not be burdened with the responsibility of voting. This did not apply to Truth's experience of a lifetime of manual labor and little assistance from the men around oppressed by the same systems. Truth was able to undermine these arguments formed with white women in mind by asking whether or not everyone could agree that she, too, was a woman (Davis, 1981). Truth's question points to another false narrative perpetuated to create division: that the role of women was always as counterpart to their husband and caretaker of their home. The truth of American women is that poor and rural women have, unquestionably, always worked. Moreover, this idealization of a "typical" home life was largely the creation of a post-World-War-II society in which men returning from war were reasserting their dominance over their families and taking back the role of breadwinner from women who had, without problem in the absence of men, been working (Friedan, 1963; Tyler May, 1988).

The power of Psychology to maintain these systems of oppression seems to lie in the answers it provides to questions like the one posed by Sojourner Truth. Keeping its focus on the individual and their behavior, the field keeps questions like Truth's from being extended past her own experience in ways that would point to the flawed logic used to uphold systems supporting a capitalist society. In her *The Feminine Mystique*, Betty Friedan (1963) pointed out that the narrative of the role of women and the "ideal" home life was fabricated after the Second World War as women suffered discontent in silence due to a belief that their experience was unique to their personal inability to live up to the role they were meant to fulfill. The field of Psychology

even went so far as to distort the work of Black feminist thinkers calling for revolutionary solidarity, by taking Crenshaw's assertions about the nuances of intersecting identities to justify its own commitment to focus on individual experience and measurable behavior. If the complex and dynamic nature of identity complicates questions of how and why individuals are harmed, as Crenshaw maintains, then Psychotherapy cannot effectively attend to these varied experiences of distress while also remaining committed to the individualistic, hierarchical framework of free-market capitalism. As Audre Lourde (1984) pointed out, the master's tools can never be used to dismantle his house. For the field of Psychology to move beyond serving the WEIRD population it was designed for, it must first be willing to confront its history, dismantle its foundation, and change its toolbox.

**Turning the Mirror**

Lawyer and activist Bryan Stevenson (2014) wrote *Just Mercy* to detail his work with wrongly condemned, incarcerated individuals on death row. Stevenson's work in Alabama centered around many of the same populations Psychology claims to be trying to effectively reach. He explained that truly considering the experience of another, the heart of what psychotherapy purports to do, requires becoming "proximate." Stevenson learned from his grandmother, who would hug him tightly enough to make sure he could still feel it after she had let go, that we cannot understand others unless we are willing to be close to them—to spend time in their community, to hear their stories, to take in their contexts. Stevenson (2019) went on to extend his reflections to a discussion about our societal responsibility to stop trying to stand outside of the narratives we have created. In our divided American culture, he asserts, we cannot

have reconciliation without first engaging in truth telling. This is particularly true for the field of Psychology and the practice of psychotherapy in the United States, in particular. The field of Psychology simply cannot make itself accessible to those it has relegated to the margins until it is willing to name and account for its history, and to commit to facing and dismantling the harm it caused. Practitioners of psychotherapy cannot hope to effectively consider the distress of their clients until they are willing to become truly proximate.

Calls for cultural competence from the APA have become more inclusive calls for cultural humility. Multicultural humility reflects a shift toward acknowledging that providing culturally relevant services is a commitment to an active, lifelong learning process and not as a competency to master (Hook et al., 2017; Tervalon & Murray-Garcia, 1998). Lifelong learning is often framed as willingness to maintain an interpersonal stance that is other-oriented in relation to aspects of the identity of the "other" that feel most salient to them (Clauss-Ehlers et al., 2019). Humility, in this sense, is a call for clinicians to be a sort of blank slate-- opening themselves up to hearing experiences of marginalization from those who have been relegated to the margins. This framework invites clinicians to make themselves aware of the client's environments, to consider the influence of social inequities and disparities on development and self-conceptualization, and to remain mindful of how intersectional experiences influence what a client brings to the therapeutic relationship. The APA suggests that opening oneself up to hear experiences of marginalization improves clinical practice, research, education, and consultation with the aim of better serving those whose experiences are now being considered (APA, 2017). Improving practice in this way, though, tasks marginalized individuals with the responsibility of

educating clinicians about their experience to receive support for the distress these experiences create and maintain. While reframing competency as humility addresses some of the harmful rhetoric around culture as something finite, monolithic, and categorical to be understood and mastered, it also shifts the responsibility of having needs met within a therapeutic relationship onto the person with the marginalized and underserved identities. In addition to burdening underserved individuals with the task of educating the field on their need for support, the call to use humility to develop the field does not allow for proximity. Honoring the diversity of human experience through an other-oriented framework frees clinicians from the responsibility of owning and sharing their own experience and removes clinician's responsibility to address the role they might be playing in upholding the systems responsible for the distress marginalized clients are being asked to help clinicians understand.

Considering cultural humility through a critical framework—recognizing taken-for-granted assumptions and considering their effects-- allows us to acknowledge that considering structural inequity and power imbalances through an other-oriented framework shifts the burden of creating culturally informed clinical practice to those in the margins (Kincheloe, 2008; Nixon et al., 2017; Moon & Sandage, 2019). Multicultural guidelines anchor clinicians to a commitment to consider biases they may hold toward marginalized clients when they do not meaningfully understand how their individual identity and experience has informed, contributed to, and maintained those biases. Moreover, biases are likely particularly difficult to notice and address when practitioners have been trained in a field developed around the understanding of WEIRD identity and experience as normative (Snowden, 2003; Sue et al., 1999). How can

practitioners become proximate to experiences they view as deviating from the "norm" before first critically examining the assumptions, biases, and even training that has informed their understanding of what it means to have an experience that is "normal."

The call to remain multiculturally humble does not include any commitment to actively engage in the process of personal identity examination and sharing that needs to occur for the unique and complex experiences of clients to be effectively considered. Without any responsibility to engage in the personal aspect of the therapeutic relationship, clinicians have the privilege of using their positions of power in these dyads to make meaning of the complex experiences of their clients in whatever ways they feel best serves their practice—the very practices that justify and maintain systems that cause the kind of distress clients are experiencing. An other-oriented framework exculpates clinicians from the responsibility of considering the role their privilege and their practices might play in actively maintaining the distress of their clients.

Sayantani DasGupta (2008) called for a practice of narrative humility in the field of medicine, explaining that in striving for cultural competence, clinicians avoid the reality that patient's stories are dynamic experiences that cannot be mastered. Patient narratives, she suggests, are something that can be approached and engaged with, if clinicians are willing to consider and reflect upon how these stories interact with their own. A move beyond understanding patients as bringing practitioners different cultural perspectives that should be taken in and addressed in treatment planning is certainly an important shift. Considering how the perspectives of those receiving services might influence the practitioner and the kind of care they

give is certainly an important step in dismantling the barriers that keep healthcare (both physical and mental) inaccessible and ineffective for certain populations. Narrative humility moves beyond cultural humility with its understanding that quality care does not mean asking those we see as "other" to explain their differences to us, but to hold ourselves accountable for how we, as practitioners, hear these stories. The ways we hear clients' stories, narrative humility suggests, reflects not the differences of the help-seeker, but the lived experience of the practitioner, their internalized expectations for stories, and their relationship to client narratives.

For the practice of psychotherapy, this framework lacks the intentionality necessary to dismantle barriers rooted in the values of the field of American Psychology and its historic and ongoing commitment to a free-market capitalist economy and the individualism upon which this system depends. It is not enough for practitioners to consider how they are being influenced by another person's narrative. We must consider the why. Before we can make our practices meaningful and accessible to marginalized and underserved populations, we must ask ourselves how our practices and our beliefs about how and why they promote wellness are tied to narratives that were intentionally created to keep these individuals on the bottom rungs of the societal ladder. Adding a critical lens to the narrative humility model (see appendix K) allows clinicians to reflect on how they are showing up in their service-provision relationships and on why they are showing up in these ways. Critical narrative humility framework allows us to understand that our clients might be on a different rung of the ladder than our own and to confront the ways our services might be designed to keep them there.

The APA has recently issued an apology for the harm it has caused to marginalized groups and has highlighted the responsibility of the field of Psychology to work toward achieving health equity (Kelly, 2022). Until clinicians and leaders in the field of Psychology are willing to turn the mirror and direct their reflection inward, though, the shortcomings and barriers of psychotherapy will remain, just as they have until this point. Multicultural practice that does not burden and oppress those it intends to serve requires a redistribution of power and responsibility (Freire, 1972). For meaningful change to occur through the consideration of identity and context, clinicians must be willing to bring themselves fully into this process. A consideration of intersectionality that reflects the actual lived experience of the client rather than our expectations of what this experience ought to be cannot occur without proximity. We cannot truly hear clients, much less understand them, if we as clinicians refuse to locate ourselves within the socio-political context of our clients. Effective multicultural practice can only occur when there is a willingness to engage in critical reflexivity throughout the entire therapeutic process. Reflexivity allows practitioners to remain in a process of self-examination and interpretation and to understand their role as a dynamic part of the psychotherapy process (Arczynski, 2018; Hoover & Morrow, 2015). Willingness to consider one's own experience and identity builds the competence and confidence needed to engage in complex and challenging conversations around difference. Willingness to dialogue in this way, in turn, shows our faith in our ability to share experience and to deconstruct and recreate practices that are truly accessible across identity, context, and experience.

The field of Psychology created its own double bind. As a field that claims to work to promote wellness for all people while simultaneously serving as a cornerstone for a system of government that can exist only by forcing people into a hierarchy, Psychology is always working against its own aims. The only way for the field to free itself from this double bind that it has created is with a critical reflection on its history and an examination of its agenda and value system. There is simply no amount of building that can make the field accessible to marginalized populations when that building is being done on a foundation that was designed to keep these individuals on the bottom rungs of the social ladder. The only way out is through.

One of the most crucial first steps in working through the field's history in order to dismantle its harmful practices is for clinicians to examine how they keep the ladder of social hierarchy in place—not only by attempting to climb it themselves, but also by convincing others that those who cannot get to the top have simply not been willing to change. Until clinicians are willing to reflect on their role both inside and in support of the social hierarchy, there is simply no way to make services accessible to those this hierarchy is designed to oppress. Bryan Stevenson (2019) maintains that until we tell ourselves the truth, we deny ourselves the opportunity for the beauty of healing. Where could this be more applicable than in the field of Psychology? Until clinicians are willing to speak to the truth of their own experiences and to examine the ways these experiences contribute to the distress of those shut out by the field, there can simply be no healing. Not for the practitioners of the field of Psychology and certainly not for its clients.

## Study Aims

American Psychology's documented role in creating, legitimizing, and maintaining a hierarchical social order suggests that its practices contribute to intentional divisions used throughout the country's history to justify its inequitable social order. Ibram Kendi (2016) uses the words of Frederick Douglas to point out that oppressors legitimize their oppression by finding justification for it within the oppressed. The practice of psychotherapy, as it is currently offered, legitimizes this practice, by individualizing distress and offering self-help strategies for self-improvement. In the case of marginalized populations, self-help means attending to that which has been identified as existing within the oppressed to justify their oppression. Kendi goes on to point out that the creation of racial hierarchy sustains all other hierarchies: those built on ethnicity, sex, gender, class. Unsurprisingly, class, one of the key factors historically used to keep power securely in the hands of the most privileged few, is an aspect of identity not addressed by the field of Psychology, even in its stated aims of offering services that are more equitable and responsive to intersectional identities.

Lower rates of accessing mental health services by the populations on the lower levels of our social hierarchy are not reflective of their reported rates of distress or even their attitudes. It is well documented that ethnic and racial minorities experience disproportionately higher rates of psychological distress. It is equally well documented that these populations only access psychotherapy after symptoms have become severe and are more likely to receive lower quality care. Unsurprisingly, help-seekers of color are more likely to terminate services prematurely, if they access them at all (Benish et al., 2011). In spite of these documented disparities in access to effective care, Black and Latinx individuals have been found to report more positive attitudes

about mental health services than the general population (Diala et al, 2001; Mojtabai, 2007). These rates seem to point to an unfulfilled ideal for people of color around the potential benefits of mental health services.

In 2016, the American Sociological Association studied response rates of over 300 psychotherapists receiving requests for services. The study found, unsurprisingly, that callers who were Black were much less likely than their white counterparts to be offered an appointment. This difference, though, only emerged when considering white callers who were middle-class. Working-class help-seekers were much less likely to receive appointments than middle-class individuals across race (Kugelmass, 2016). Just as Kendi suggested, the practices of the field prioritizing white clients seem to extend themselves to a prioritization of the middle class as well. In spite of the evidence that the working-class is an underserved population in the field of Psychology, little research exists examining the role of class in accessing psychotherapy services. A systematic review by Arundell et al. (2020) of intervention studies addressing mental health inequalities found most focused on socioeconomic status, age, and race/ethnicity. Note was made of the way that barriers (limited access to/awareness of services, experiences of discrimination, financial constraints, trust in the system, appropriateness of services available) impacted these populations, with specific attention paid to individuals experiencing homeless, the poor, those who are not English-speaking, aboriginal communities, and ethnic minorities.

While those at the very bottom of the socio-economic hierarchy were considered, their experience was largely examined in terms of logistics. Questions are posed as to how they might make it to appointments and afford services rather than in relation to whether or not they feel that

the therapy space is made with them in mind. Very little mention is made of the working class and their experience of and barriers to accessing psychotherapy. This gap seems to speak not to the likelihood that this population is part of the picture of inequity in mental health care, but rather to the fact that they are not often included as a population of interest in research. The current research seeks to address the gap in the clinical psychology research field.

The working-class is often framed by those in power (including researchers) as having little in common with the poor and the marginalized, or completely left out of the narrative altogether. It seems likely that people of color and individuals experiencing poverty are not accessing psychotherapy at rates that are reflective of the distress they experience for similar reasons —psychotherapy was not designed with them in mind (Benish et al., 2011). It seems just as likely that working-class individuals are not accessing psychotherapy for this very same reason. This common reason is, of course, packaged very differently in the narrative psychology creates about its barriers to fit within the dominant societal narrative that keeps working-class individuals intentionally separate from people of color and those experiencing poverty. The story told by the field of Psychology—both to itself and to those it deems as difficult to access—are that barriers are maintained through individual challenges and shortcomings. People who do not access services, the field purports, do so because they have allowed stigmas about the weakness of expressing feelings or what it means to identify as a help-seeker make them ambivalent or even resistant to changing. Nowhere in the narrative of stigma against mental health is the question asked: what if those who stigmatize mental health services are the ones who, historically, have been harmed and oppressed by these services?

A study by Ogden & Avades (2011) of individuals experiencing homelessness in the UK found that individuals often identified wanting support managing housing challenges but were reluctant to turn to formal channels of help, as they felt that helping professionals often characterized and labeled them in ways that felt stigmatizing. This suggests that the problem extends beyond where most research is centered, on the logistics of accessing care, to the way that marginalized clients are made to feel when and if services are received. The individuals experiencing homelessness in this study also reported feeling that peers could better understand and validate their situation and their distress but that these individuals often colluded with their problems and kept them trapped within the same problematic patterns of behavior. This suggests that certain populations feel that their experiences are stigmatized by the professionals in the system designed to address them and leaves the undesirable choice of seeking support from peers who understand the situation and are likely caught in the same experience or looking to someone who can help facilitate change by reducing the help-seeker to their symptoms.

The Behavioral Model developed by Anderson (1968) in the late 1960s suggests that use of health services is determined by a combination of predisposition to use these services, factors that enable or impede their use, and the personal need for care. An expanded version of this model as it relates to vulnerable populations was considered by Gelberg and colleagues (2000) with an assertion that the factors that make certain populations vulnerable might be the same ones that keep them from accessing effective care (Gelberg et al., 2000). While underutilization of services by certain populations is often framed as a resistance to seek help due to stigma, evidence suggests that hesitance to utilize services identified as potentially helpful is often

informed by a fear that service providers will not be genuine and will not understand the help-seeker's perspective.

Focus groups conducted by Thompson et al. (2004), for instance, found that African Americans felt that race should not matter in psychotherapy but also felt that psychologists were insensitive to the African American experience. In a similar way, a qualitative study by Trot and Reeves (2018) in the UK found that when class differences exist between the psychotherapist and the client, leaving the influence of class unacknowledged is likely to inhibit the therapeutic relationship and to compromise overall outcomes. Perhaps more importantly, this study found that research around the influence of class in the therapeutic relationship is scarce and deserving of increased attention from those looking to consider psychotherapy through a social justice lens.

This study sought to address the gap in our field's available research and its subsequent ineffective service provision and delivery by better understanding class as an important aspect of identity and exploring the influence of this identity on distress, attitudes about therapy, and past, current, and anticipated life satisfaction. We aimed to elevate the voices of individuals from various class backgrounds in order to better understand their lived experiences and influence of these experiences on their wellness and their attitudes about therapy. We intended to use these narratives to identify and present themes about class identity and its influence on the field of psychology, both at a systems level and in the practice of talk therapy.

## Method

### Study Design

A mixed-method design was used to explore the impact of identity, in particular class identity, on attitudes about therapy. A pre-survey to assess differences between working- and middle-class respondents was used to create an operational definition of class. Quantitative surveys were used to determine participants' attitudes toward psychotherapy; their experience of distress; and their willingness to seek help with the aim of assessing the moderating effect of middle vs. working class identity on willingness to seek help when in distress. Finally, semi-structured interviews were conducted with 20 participants. Interview questions asked about identity and about attitudes toward and experiences with talk therapy, with the aim of contextualizing quantitative findings.

## Participants

Pre-surveys designed to assess differences in reported attitudes between respondents who identify as working- and as middle-class were limited to individuals who self-identified in one of these two ways. In order to avoid conflating race with class, these surveys were also limited to respondents who self-identify as white. Given the scarce literature available in the field of psychology on the influence of class in therapy, our population of interest for this study extended to adults willing to discuss their identity and their attitudes toward and experience with therapy.

### *Pre-survey*

Survey responses were screened for inauthentic responses (bots) using best practices suggested in the literature (Teitcher et al. 2015) and by the Qualtrics platform (2023) as related

to surveys that offer incentives (i.e., entrance into a raffle for a $25 gift card upon completion.) Strategies to identify responses to exclude from assessment included: several identical responses in a row, responses that do not answer the question posed, and strangely worded responses. After responses deemed likely to be inauthentic were removed, the data set contained survey responses from 60 respondents who identified as working-class and 101 who identified as middle-class. Mean age was 39.04, median age was 34 and mode was 33. Of the working-class respondents (n=60), 60% (n=36) identified as female and 38.3% (n=23) identified as male. One respondent identified as non-binary. Of the middle-class respondents (n=101), 79.2% identified as female (n=80) and 19.8% (n=20) identified as male. One respondent identified as non-binary. In order to avoid conflating race and class, responses were only included from respondents that identified as white. Level of education varied between both groups of respondents. Notably, level of education was relatively evenly spread among working-class respondents with 30% (n=18) indicating that they did not have a college degree, 33.3% (n=20) indicating that they had a college degree and 31.7% (n=19) indicating that they had a higher-level degree (e.g., masters, doctorate). Respondents who identified as middle class also indicated various levels of education. 11.9% (n=12) indicated that they did not have a college degree, 40.6% (n=41) indicated having a college degree and 46.5% (n=47) indicated having a higher degree (e.g., masters, doctorate). The majority of respondents in both groups indicated working full time. Of the 57 working-class respondents who provided this information. 10.5% (n=6) indicated that they work part-time (up to 39 hours a week), 73.7% (n=42) reported that they work full time (40 hours or more), 7% (n=4) indicated that they are self-employed and another 7% (n=4) described

themselves as retired. One person indicated that they are unemployed and are not looking for work. Of the 100 middle-class participants who provided this information, 4% (n=4) identified as students, 14% (n=14) indicated that they work part time, 68% (n=68) indicated that they work full time, 7% (n=7) indicated that they are self-employed and 7%(n=7) indicated that they are retired.

***Survey***

Protective measures were used to limit inauthentic responses (i.e., bots) for the main survey as suggested by Qualtrics (2023). Final responses were also screened for inauthentic responses using the same criteria as the pre-survey. Once likely inauthentic responses were removed, the data set contained survey responses from 156 respondents. Mean age was 32.48, median age was 30 and mode was 25. Of these respondents, 53.3% (n=80) identified as female, 46.7% (n=70) as male, and 3.8% (n=6) as other. 88.5% of respondents identified as white (n=138), 3.8% (n=6) identified as Black or African American, 3.2% (n=5) identified as Hispanic, Latinx or Spanish origin, and 2.6% (n=4) as Asian. One participant identified as Middle Eastern or North African and two as "other." 19.2% (n=30) of respondents reported having a high school diploma or less, 44.2% (n=69) reported having a college degree, 35.3% (n=55) reported having an advanced degree (e.g., masters or doctorate). 32.7% (n=51) of respondents described themselves as working-class and 53.8% (n=84) described themselves as middle-class. 4.5% (n=7) described themselves as low income and 9% (n=14) as wealthy. 46.2% (n=72) of respondents identified themselves as democrat and 17.3% (n=27) as republican. 33.3% (n=52) described themselves as unaffiliated and 3.2% (n=5) as "other." 48.7% (n=76) indicated working

full time and 9% (n=14) reported having multiple jobs. 3.8% (n=6) reported working a part-time job and one respondent indicated not working. 4.5% (n=7) of respondents described themselves primarily as students, with an additional 9.6% (n=15) respondents indicating that they are both students and working. 3.8% (n=6) described being at the beginning stages of a career and 7.7% (n=12) as being established in a career.

### *Semi-structured interviews*

Participants were recruited using social media and snowball sampling (i.e., willing participants reached out to other potentially willing participants). Surveys were conducted with 24 participants. Participants had some familiarity to the researcher, as social networks were used to recruit but family, friends, and well-known acquaintances were excluded from the sample. Participants ranged in age from 20-70. 12 identified as female, 10 as male and 2 as nonbinary. As the majority of participants expressed confusion about class identity or described a dynamic class identity (e.g., fluctuating income due to being a student, or working a low-income job but living with parents who help to meet needs) we did not categorize it as initially intended. Given findings that saturation is reached with 9-17 interviews (Hennink & Kaiser, 2022), we coded 10 transcripts as a team and used rapid qualitative analysis (Lewinski et al., 2021) to consider themes from the remaining transcripts.

## Procedure

### *Pre-survey*

We shared the link to Qualtrics on social media. Participants who clicked on this link were directed to an informed consent (see appendix A) and were prompted to input their initials

to acknowledge consent before beginning the survey. Initials were replaced with a study ID number before data was analyzed.

Respondents were then asked to rate themselves on questions designed to reflect the themes of working class posited in the literature: an emphasis on hard work (e.g., “How much effort do you put into your work (or finding work)?”; “How do your efforts compare to others?”), the fear of falling (e.g., “how many paychecks could you could go without going into crisis”), and feeling unfairly judged by others (e.g., “I feel unfairly judged by others"; “I feel blamed for problems outside of my control”). To our knowledge, no construct measure exists to assess the emotional components of class identity in the literature. For this reason, we designed our own survey questions (see appendix B).

Participants were given a range of options for the number of paychecks they could miss without crisis (e.g., zero, 1-2,3-4, more than five) and were asked to rank their attitudes about feeling judged and about work satisfaction and effort on a scale from 0-100. Given the central focus on hard work and stated commitment to a merit-based society the working-class often uses to define themselves, we expected to find that working-class individuals rated themselves higher on their efforts at work and lower on their work satisfaction. We expected to find that working-class participants felt more unfairly judged than middle-class participants, given the existent literature about the scapegoating of the working-class by the narrating middle-class. Finally, we expected to see a significant difference in the number of paychecks the working-class felt they could miss without going into crisis as compared with their working-class counterparts in a way that indicated a “fear of falling.”

Finally, we sought to consider the role of class mobility on attitudes. The *Cantril Self-Anchoring scale* was used as a visual to ask participants to consider their life satisfaction. This visual (a photo of a ladder with 10 rungs with the first rung representing the worst possible life and the 10th rung representing the best possible life) was presented and participants were asked to rate their current satisfaction with their lives, how satisfied they imagined they would be in 5 years, how satisfied they believe their parents and grandparents would have rated their lives, and how they imagined their children, future children, or important next generation members would rate their lives. We expected to find that working-class respondents reported increased life satisfaction between generations in a way that supports the "American dream" social mobility narrative.

In order to contextualize responses, optional open-ended responses were included as a chance for participants to elaborate on their answers (e.g., "What kinds of things do you feel judged about?"; "The world would be a better place if…").

### *Survey*

We shared the link to the Qualtrics survey on the same platforms as our pre-survey. Similarly, respondents were directed to an informed consent that asked for initials to be input before beginning the survey and initials were replaced with study ID numbers before data analysis.

#### Measures.

***Kessler Distress Scale:*** (appendix C) The Kessler Psychological Distress Scale is a 10-question screening scale of psychological distress (K10) and a six-question short-form scale

embedded within the 10-question scale (K6). Both the K10 and the K6 demonstrated good precision in the $90^{th}$-$99^{th}$ percentile range of the population distribution, with standardized error scores in the range of .20-.25 (Kessler et al., 2002). The measure demonstrated high internal consistency [$\alpha = .84$; 42] and predictive validity [predictive accuracy = 76.7%; 42] (Clough et al., 2017). The internal psychometric properties demonstrated consistency across major sociodemographic sub samples including aboriginal peoples (Bougie et al., 2016) and some American Indian communities (Mitchell & Beals, 2011). Given its applicability across populations and its sensitivity in identifying psychological distress, the K6 has been translated into 14 languages and included in surveys distributed by the World Health Organization (Kessler et al., 2002). The K10 posed 10 questions about the participants experiences in the last 30 days (e.g: "In the last 30 days, how often did you feel nervous?") and asked participants to rate their experience on a 1-5 scale (all of the time, most of the time, some of the time, a little of the time, and none of the time). A score of 50, then, indicated severe distress while the minimum score of 10 indicated no distress (Andrews & Slade, 2001).

***Milwaukee Psychotherapy Expectations:*** (appendix D) The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) was developed to measure clients' expectations about the mechanisms and impact of therapy. An exploratory factor analysis revealed a 2-factor solution which consisted of Process Expectations and Outcome Expectations. This was supported by confirmatory factor analyses in three additional samples. The measure demonstrated good internal consistency and test-retest reliability, along with support for convergent, discriminant, and predictive validity (Norberg et al., 2011). The questionnaire has demonstrated good internal

consistency [$\alpha > .85$; 33] and strong test-retest reliability over a one-week test period [$r = .83$; 33]. The 13 items on the scale asked questions to measure patient expectations about the components and the outcomes of therapy (e.g., "my therapist will be sympathetic") and asked participants to rate each item on a 10-point Likert scale (0= not at all 10=very much so) (Clough et al., 2017). Total scores could range from 0-130 points, with higher scores indicating more positive expectations for the process and outcomes of psychotherapy (Rahimian et al., 2020). In order to effectively assess individuals who may have never accessed therapy, questions were framed as "If you were to attend psychotherapy, do you imagine…"

Questionnaire was followed by three questions posed in a psychiatric study examining trends in attitudes of Americans toward treatment seeking for mental health concerns and beliefs around the effectiveness of professional mental health services. Questions asked how much improvement in problems participants expected to see at the end of a therapy period, how satisfied they imagined they would be with treatment results, and how much better they expected to feel as a result of this treatment. Answers were rated on a scale of 0-100% (Mojtabai, 2007).

***Alternate Sources of Support:*** (appendix E) Participants were asked how likely they would be to turn to sources of support other than talk therapy (i.e., church or a faith community, neighbors, friends, family, colleagues, mentors, online forums/groups, etc.). Ratings for each were given on a 5-point Likert-scale (from "very unlikely" to "very likely").

***Cantril Self-Anchoring Scale:*** (appendix F) The Cantril Self-Anchoring Scale is a 10-rung ladder upon which individuals placed themselves to reflect how they saw their social class. This scale has been used extensively in social and psychological research (Trott & Reeves,

2018). The Cantril scale has adequate reliability and validity (Beckie & Hayduk 2007; McIntosh 2001). Kapteyn et al. (2015) found that rating scales that allow for more nuanced answers offer more reliability. In order to contextualize the ladder suggested by Cantril (1965), Gallup (2011) suggests asking participants to imagine a ladder with 10 steps, where the top step represents the best possible life for them. They then ask participants to choose which step of the ladder best represents how they feel right now, which represents how they felt 5 years ago, and which represents how they imagine they will likely feel in 5 years. Given the fact that generational influence impacts participation in education and in politics (Lahtinen et al., 2017; Nichols & Islas, 2016; Verba et al., 2003) it seemed likely that this would influence participation in mental health services. We included questions asking participants to imagine a rung of the ladder for their parents and grandparents and for their children or important next generation members.

***Qualitative Interview***

Recruitment flyers for qualitative interviews (see Appendix G) were shared on social media and with members of our networks with access to individuals of diverse class statuses. Individuals who responded to this flier were emailed an informed consent as part of an email highlighting that interviews were to be conducted on zoom and would be recorded and transcribed. Transcripts were de-identified through use of study ID numbers and the removal of any identifying information during transcription.

We developed survey questions (see appendix H) using the narrative inquiry approach detailed by Clandinin (2006) and colleagues, as this approach offers an opportunity to study lived experience. Interview questions were developed using the three themes identified by

Clandinin and Connelly (2004) as creating the narrative inquiry framework: interaction (e.g., "Do your attitudes about therapy differ from your friends and family?"; "What does or would make you feel connected with a therapist?"), continuity (e.g., "what would motivate you to stay engaged in therapy?"; "Have your educational/work experiences influenced your attitudes about therapy?"), and situation (e.g.., "what kinds of things do/would you talk about in therapy?"; "what would you want to see change in your life to feel like therapy was working?"). Demographic questions were included at the beginning of the interview to add context to responses as they related to identity. These questions were updated to include findings from the pre-survey that speak to class identity (e.g., "How do you feel about your work?"; "what sources do you use to consume news?").

## Data Analysis

### Pre-survey

Independent samples t-tests and chi-squared independence tests were used to determine whether there were any meaningful differences in demographics (i.e., gender, age) between respondents that identified as working-class and those that identified as middle-class. Demographics that were not normally distributed (i.e., age) were normalized using a square root transformation. Chi-squared independence tests were also run to determine whether differences existed between these two groups in regard to income and perceived sense of stability (i.e., how many paychecks could be missed before a crisis) and education level (i.e., highest degree achieved).

Independent samples t-tests were conducted to determine whether statistically significant differences existed in responses between working- and middle-class respondents in regard to their attitudes about how hard they work, how much they enjoy their work, and their sense of being judged unfairly by others. Additionally, a one-way between-groups multivariate analysis of variance (MANOVA) was used to investigate differences between working and middle-class responses to the Cantril Self-Anchoring scales.

**Survey**

Independent samples t-tests and chi-squared independence tests were used to assess whether the demographic differences between working- and middle-class respondents found in the pre-survey existed in main survey responses. Demographics that were not normally distributed (i.e., age) were normalized using a square root transformation. We assessed for differences between working- and middle-class by excluding respondents who identified otherwise (i.e., as wealthy or as low income).

Independent samples t-test were conducted to assess for differences between working- and middle-class respondents in regard to experiences of distress, willingness to access therapy, use of alternate sources of support and expectations for therapy process and outcomes. Like in our pre-survey, a multivariate analysis of variance (MANOVA) was used to assess differences between working and middle-class in their self-reported satisfaction currently and in the future as well as their imagined satisfaction of their parents, grandparents, and important future generation members.

Finally, PROCESS (Hayes, 2012) was used to create a serial mediation model. This model was designed to consider whether class predicts attitudes toward therapy and whether these attitudes, in turn, predict levels of distress. We sought to understand whether attitudes and distress influence the impact of class identity on help-seeking behavior.

**Semi-structured interviews**

The Consensual Qualitative Research (CQR) method (Hill, 2012) was used to conduct a thematic analysis (Braun & Clarke, 2006) of interview transcripts. The CQR method calls for multiple researchers, a process of reaching consensus, and a systematic approach to assessing the representativeness of results across cases (Hill, Thompson, & Williams, 1997). CQR draws from the concept of grounded theory, an inductive approach that begins with the systematic collection of data pertaining to the phenomenon in question. In this framework, patterns, themes, and categories of analysis are sought within the data rather than being imposed on the data through a set of predetermined research questions and subsequent assumptions (Bowen, 2016; Glasser & Strauss, 1967; Strauss & Corbin, 1997).

Central to this approach is the use of sensitizing concepts, or overarching ideas that inform the project and the questions of interest. Unlike definitive concepts, which rigidly define the commonalities existent to a class of objects, sensitizing concepts provide a general framework to approach empirical instances (Blumer, 1956; Bowen, 2016 Charmaz, 2006). As such, sensitizing concepts offer a framework for observing and understanding experience as it actually is rather than as we wish to categorize it. This approach was chosen for our interviews, given our use of narrative inquiry to inform interview questions. Narrative inquiry's commitment

to making space for the unique and intersectional experiences of every person means that it is better operationalized in terms of apparency, verisimilitude and transferability than in terms of validity, reliability and generalizability (Connelly & Clandinin, 1990).

In refining the grounded theory approach, Strauss and Corbin (1990) detailed the constant comparative model, or a continuous cycling between the theory, the data, and the identified categories and themes. CQR deviates from grounded theory in that data is collected using a consistent set of research questions with an identified population of interest, rather than alternating between data collection and analysis. Instead of vacillating between data collection and analysis, a team of coders is used to move through the data: first separating raw data into topic areas (domains), then identifying the essence of what is being said by participants within each domain (core ideas), and finally comparing the data across cases (cross analysis) to assess for consistencies in core ideas within the entire data set.

In order to both honor the uniqueness of participant experience and commit to a standard of rigor in our analysis, we looked to Lincoln and Guba's landmark text *Naturalistic Inquiry* (1985), in which they detailed a set of criteria and techniques to create trustworthiness in qualitative analyses. Lincoln and Guba identified credibility, transferability, dependability, and confirmability as key criteria to demonstrating trustworthiness for the thematic analysis. In order to establish confidence in the legitimacy of our qualitative findings, we committed to prolonged engagement with the data and peer debriefing and triangulation with multiple sets of data. Interviews were transcribed by hand and preliminary notes were taken during the process of interviewing and transcribing (Adu, 2019). In order to triangulate findings (i.e., use of multiple

data sources and methods to develop a comprehensive understanding of phenomena [Patton, 1999]), the team of three coders was involved throughout the process of thematic analysis. Each member of the team independently organized the raw data of several transcripts into domains separately and then came together to discuss domains to consensus. This consensus domain sheet was used to organize the remainder of the transcripts. Each member of the team then independently identified core ideas within each domain for several transcripts and came together to discuss these to consensus and create a code book (see appendix I). Consensus sheet was used to create core idea codes for the remainder of the data that was then used for thematic analysis.

In order to demonstrate that our findings are consistent and reflective of the experience of respondents and not of the opinions and biases of the coding team, an external auditor, who is not part of the project team, was included in the coding process (Miles & Huberman, 1984; Patton, 2001). The auditor reviewed the code book and core concepts sheet once the coding team reached consensus and searched for elements of the data that contradicted themes or patterns. Feedback was provided about any deviations or inconsistencies noted. The coding team incorporated this feedback and then compared the core ideas across cases. This cross analysis was used to develop themes that were shared with the auditor. The consensus process, used throughout the analysis, relied on open dialogue between team members to collaboratively construct a shared understanding of the phenomena being considered. This process deferred to feminist theory (e.g., hooks, 2000, Davis, 1998) as it demanded an openness to all ideas shared by each member of the team and valued the expertise of study participants as it related to their own experience.

Coding team consisted of two graduate school students, one post-doctoral coder and one post-doctoral auditor. Coding team members began the process of coming to consensus by first bracketing their biases (Adu, 2019). The principal investigator on the team identifies as a white cisgender woman and considers herself a class "straddler" given that she comes from a blue-collar working-class family and is now part of the white-collar world of academia as a PhD candidate and a practicing mental health clinician. Biases identified by the principal investigator on the coding team include: expectations for class-dependent attitudes about therapy informed by significant experience with individuals who self-identify as working-class and have negative views about therapy and a desire to find themes reflective of those considered in the pre-survey.

Another coding team member works as a clinical therapist and reflected on the fact that she would likely have biases from a clinician's lens. Moreover, as a practitioner trained in a field that often has fairly colonial, patriarchal, white-centric, neoliberal views, she indicated a potential bias informed by these influences leaking into her understanding of the therapeutic problem and how individuals approach therapy. She also shared that as a cis straight white woman, she may have biases related to gender/sexual orientation that follow more of a heteronormative view and may overlook or have biases related to other experiences. Finally, she reflected on the fact that as someone raised in a mid/upper-mid class family who is currently in a relationship with a dual income, that she may have biases about class structure and the day-to-day experiences of those from different classes.

Our third coding team member is a clinical psychology trainee and shared that this status primes her to see therapy as a positive/helpful tool. She also reflected on the way that her lived

experiences (e.g., woman of color, cisgender, psychology graduate student of color, growing up in New England) and experiences that are not part of her lived experience (e.g., working-class) may inform biases. Finally, she noticed a strong reaction to the interview item: “Do you think any topics are off limits for therapy?” given a belief that the more important question is not whether a topic is off limits but whether a person trusts that a clinician has done the work to be able to effectively help a person process the topic.

The team’s auditor shared that she is a white, chronically ill, non-binary woman who is comfortably middle class and was raised lower-middle-class. She indicated that she grew up in a middle-class, predominantly white area of New England in the United States where therapy was generally accessed and talked about by peers and adults. She was taught, through socialization from adults in her life who were mental health practitioners and from crisis educators at school, that if you or a friend is struggling you should always "ask for help," but this "help" was never defined, and in practice, she witnessed peers struggle to access support or treatment when they needed it. She went on to share complicated beliefs held about therapy as a practice as a highly educated middle-class person with a background in psychology. She shared a belief that existing psychiatric treatment structures, though critically necessary and often lifesaving for many people under capitalism due to significant gaps in community care, are inherently oppressive, especially for poor people, people of color, and people with so-called serious mental illness (SMI). She went on to share that she believes that while mental health care and psychotherapy are critical for many people to maintain their humanity, dignity, and psychological safety under capitalism, this need arises partly from structural shortcomings.

The domains used to organize the interview questions (e.g., identity, beliefs, experiences) were used to create a start list (i.e., list of initial domains). Team members independently organized identified codable chunks of data for 5 interview transcripts to one of the domains on the start list or added/changed domains as the data called for. The team then came together to reach consensus. A consensus version was created and used as a guide to organize the remaining transcripts into domains. Next, team members independently read the raw data for each domain for several transcripts and summarized each segment of data into its main components. This was used to create a code book that was discussed to consensus. The code book was used for several additional transcripts that were also discussed to consensus. The remainder of the transcripts were then coded and a list of codes and core ideas for each code were shared with the auditor. The auditor determined whether the codes and core ideas used accurately reflected the raw material. This feedback was reviewed by the team. The core ideas for codes across cases were then compiled into a single spreadsheet that was used by the team to consider how core ideas cluster into themes. Themes were discussed to consensus and then given to the auditor for final feedback.

## Results

### Pre-survey

To examine differences in demographics between respondents that identified as working-class and those that identified as middle-class (e.g., gender, age) we conducted independent samples t-tests and chi-squared independence tests. As expected, we found no statistically significant differences in the ages of working-class (M= 1.55, SD=.14) and middle class (M=

1.57, SD=.15) respondents nor in the endorsed political affiliation between the two groups *($\chi^2$ = 1.97; df = 3; p = 0.579).* Surprisingly, though, a statistically significant difference was found in regard to self-reported gender, with more working-class respondents identifying as male than would be expected *($\chi^2$ = 7.18; df = 2; p = 0.028).*

Independent samples t-tests were used to assess for differences in reports around attitudes toward work. Surprisingly, we found no statistically significant differences in self-reports from working-class (M=82.12, SD=18.67) and middle-class (M=85.25, SD=20.44) respondents in regard to how hard they feel they work. Similarly, no meaningful differences were found in self-reports regarding how much effort working-class (M=71.37, SD=20.95) and middle-class (M=72.46, SD=19.24) respondents felt they put into their work as compared to others. Statistically significant differences were found, though, in self-reports about job satisfactions between working-class (M=67.04, SD=26.52) and middle-class (M=76.27, SD=18.91) respondents t(89)=[-2.32], p=[.023], Cohen's d=0.40, with working-class respondents reporting less satisfaction than middle-class respondents, as expected.

Next, chi-squared independence tests to determine whether differences existed between these two groups in regard to income and perceived sense of stability (i.e., how many paychecks could be missed before a crisis) and education level (i.e., highest degree achieved) revealed expected results. Working-class respondents were more likely to indicate that they could not miss more than one paycheck while middle class respondents indicated that they could miss more than five paychecks before entering a crisis *($\chi^2$ = 13.2; df = 5; p = 0.022).* Also, in line with expectations, significant differences in the educational achievement of both groups were

indicated, with working-class respondents more likely to report having a college degree and middle-class respondents more likely to report having more advanced degrees (e.g., masters, doctorate) *($\chi^2$ = 9.22; df = 2; p = 0.01).*

Independent samples t-tests to assess differences in reports around feeling judged by others revealed no meaningful differences in the self-reports of working-class (M=30.7, SD=26.58) and middle-class (M=24.97, SD=25.03) respondents with regards to how judged they felt by others. Statistically significant differences were found, however, in self-reports regarding feeling blamed for problems outside of one's control between working-class (M=26.88, SD=26.53) and middle-class (M=18.47, SD=23.64) respondents t(155)=[2.05], p=[0.042], Cohen's d=.33, with working-class respondents reporting more feelings of being judged for things outside of their control than middle-class respondents, findings also in line with our expectations.

Finally, a one-way between-groups multivariate analysis of variance (MANOVA) to investigate differences between working and middle-class respondents in regard to their current life satisfaction, how satisfied they imagined they will be in 5 years, and how satisfied they imagine the generations before them (parents and grandparents) and the one after them would rate themselves revealed mixed findings.

Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity. Our Mahalanobis distance test indicated a violation of the assumption of multivariate normality due to outlier responses. We addressed this by excluding responses with

distance values that exceeded the critical value for our 5 dependent variables. After this adjustment was made, no serious violations were noted.

As expected, there was a statistically significant difference between working- and middle-class respondents on the combined dependent variables [F (5, 124) = 2.61, p = .028, Wilks' Lambda= .91, $\eta^2_p$= .095]. When the results for the dependent variables were considered separately, the only difference to reach statistical significance using a Bonferroni adjusted alpha level of .01 was current level of life satisfaction, [F (1, 124) = 9.72, p = .002, $\eta^2_p$ = .071, Cohen's d=.54], with working-class respondents reporting lower current life satisfaction (M = 6.94, SD = 1.23) than middle-class respondents (M = 7.66, SD = 1.30).

As expected, there was no statistically significant difference in reports from working-class (M = 8.31, SD = 1.15) and middle-class (M = 8.45, SD = .96) in regard to their imagined life satisfaction 5 years from now, in spite of differences in current satisfaction. Also, in line with expectations, self-reports for expected satisfaction for the next generation showed increased scores that were not statistically different between working-class (M = 8.06, SD= 1.58) and middle-class (M = 8.12, SD = 1.39). There was no statistically significant difference in self-reports of imagined satisfaction of parents for working-class (M = 7.49, SD = 1.97) and middle-class (M = 7.43, SD = 1.74) respondents or for self- reports of imagined life satisfaction of grandparents for working-class (M = 7.45, SD = 1.79) and middle-class (M = 7.79, SD = 1.58) respondents. Notably, working-class participants rated their imagined life-satisfaction of their parents as higher than their current life satisfaction, but this difference was not statistically

significant when compared with middle-class respondents, who reported their current satisfaction as being about the same as their parents, on average.

**Survey**

We assessed for any meaningful associations between class and age using independent samples t-tests. As expected, no significant differences were found for ages of respondents who identified as working-class (M=5.57, SD=.82) and those who identify as middle-class (M=5.68, SD=.87). We also found no significant difference between political affiliation and class ($\chi^2 = 2.94; df = 4; p = .569$) which was in line with the findings from our pre-survey. Unlike in our pre-survey, we did not find any meaningful differences in self-reported gender between respondents that identified as working-class and those that identified as middle-class ($\chi^2 = 1.290; df = 2; p = .525$).

Significant differences in education level that were partially in-line with our pre-survey were also demonstrated between respondents who identified as working-class and those who identified as middle class ($\chi^2 = 12.37; df = 2; p = .002$), with working-class respondents being more likely to report having a college degree and middle-class respondents demonstrating an equal split between respondents with college degrees and those with advanced degrees. The majority of respondents from both groups reported working full-time and no significant differences were found between groups in regard to respondents who identified as students ($\chi^2 = .579, df = 1; p = .447$).

***Distress***

While 59% of participants reported feeling dissatisfied within the last two weeks, no meaningful differences were found between working-class and middle-class respondents reporting distress. Working-class respondents did indicate higher levels of dissatisfaction (M=4.32, SD=2.19) than did middle-class respondents (M=3.27, SD=2.66), t(118)=[2.22], p=[.022], Cohen's d=.43. 56% of respondents indicated that they considered seeing a therapist because of their dissatisfaction. Of these respondents, 77% (n=68) indicated they experienced dissatisfaction in the last two weeks and 22% (n=20) indicated they had no experience of dissatisfaction in the last two weeks. Of the 42% (n=65) respondents who indicated never considering seeing a therapist for dissatisfaction, 35% (n=23) reported experiencing dissatisfaction within the last two weeks while 64% (n=42) reported no dissatisfaction within the last two weeks. The majority of respondents who indicated that they had experienced distress also indicated that they would consider seeing a therapist, with no meaningful difference observed between working- and -middle class respondents ($\chi^2 = .20; df = 1; p = .788$). Working-class (M=4.30, SD=2.60) and middle-class (M=4.58, SD=2.29) respondents who indicated willingness to see a therapist reported average expectations that they would feel slightly less dissatisfaction in response to this process and no significant difference was observed between these two groups (Cohen's d= .11).

The Kessler Distress scale (K10) was used to consider participants' endorsed level of distress over the past month using 10 items. Independent sample t-tests indicated some meaningful differences between working-class and middle-class respondents, both in terms of the total score on the scale and on some individual items. Working-class respondents had higher

scores (M=23.84, SD=6.21) than did middle-class respondents (M=21.35, SD=6.73) on the full measure, t(133)=[2.15], p=[.033], Cohen's d=.38. Notably, both total scores fell within the range of "likely to have a mild disorder" as identified by the scale, with working-class average scores falling closer to the upper end of that range. Of the individual items, a statistically significant difference was found in average scores for working-class (M=2.27, SD=1.08) and middle-class (M=1.81, SD=.88) respondents in regard to how hopeless they have felt within the last month, with working-class respondents indicating more experiences of feeling hopeless than middle-class respondents, t(133)=[2.72], p=.007, Cohen's d=.47. Working-class respondents also reported having more experience of feeling unable to sit still within the last month (M=2.22, SD=.94) than did middle-class respondents (M=1.85, SD= .91) t(133)=[2.26], p=[.026], Cohen's d=.40. Additionally, working-class respondents indicated more experiences of feeling like nothing could cheer them up in the last month (M=2.12, SD=.99) than did middle-class respondents (M=1.61, SD=.84), t(133)=[3.20], p=[.002], Cohen's d=.56.

Finally, there was a statistically significant difference in responses from working-class (M=2.14, SD=.98) and middle class (M=1.67, SD=.95) participants in regard to feelings of self-worth, with working-class respondents reporting more experiences of feeling worthless t(133)=[2.76], p=[.007], Cohen's d=.49 in the last month. Given that item-level analyses are vulnerable to family wise errors, we considered both statistical significance of >.05 as well as effect sizes above small (>.30). As this study is exploratory in nature, we believe that each of these items deserves consideration as being of potential significance. Of note, if we were to apply a Bonferroni correction to account for potential family-wise errors, differences between

working-class and middle-class responses in regard to how often they felt that nothing could cheer them up within the last month would still reach statistical significance and differences in answers regarding experiencing hopelessness would be approaching significance.

Differences in responses between working class (M=2.78, SD=.97) and middle-class (M=2.50, SD=1.01) in regard to how often they felt restless or fidgety approached significance when using a one-sided p value t(133)=[1.61], p=[.055] and fell just below our effect-size cutoff (Cohen's d=.28.) No statistically significant differences were found between working-class (M=2.75, SD=.89) and middle-class (M=2.70, SD=.97) in regard to how often they felt tired. Similarly, responses from working-class (M=2.75, SD=.90) and middle-class (M=2.65, SD=.89) around how often they felt nervous showed no meaningful difference. Working-class (M=1.88, SD=.99) and middle-class (M=2.02, SD=.86) also had responses to how often they felt they could not calm down that did not demonstrate any significant difference. Similarly, there was no significant difference between working-class (M=2.33, SD=.91) and middle-class (M=2.11, SD=.97) in responses to how often they felt depressed or between working-class (M=2.57, SD=.88) and middle-class (M=2.49, SD=1.05) in regard to how often they felt like everything is an effort. Effect sizes for each of these items were .23 or below.

***Expectations***

The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) was used to consider expectations around therapy activities and expectations about the therapeutic alliance—both subscales of the full measure. Working-class respondents indicated having lower expectations for therapy activities (e.g., "I expect my therapist will provide support") [M=57.92, SD=18.53] than

did middle-class respondents [M=65.33, SD=13.87], t(130)=[-2.62], p=[.010], Cohen's d=.45. Notably both groups had average scores of above-average expectations. Working-class respondents indicated lower expectations in regard to expectations about the therapeutic alliance (e.g., "my therapist will be sympathetic") [M=26.34, SD=8.12] than did middle-class respondents [M=29.54, SD=6.08], t(130)=[-2.57], p=[.011], Cohen's d=.45. Notably, average scores for both groups indicated above-average expectations on this 4-item subscale. The full MPEQ consists of 4 subscales. Using a Bonferroni correction to account for any potential familywise errors, both of these findings still reach statistical significance when using the adjusted .012 alpha value.

In addition to the identified subscales, we identified items that seemed to ask about expectations about the therapist or the process of therapy (e.g., "my therapist will provide me feedback"; "therapy will provide me with a better understanding of my problem") and items that seemed to ask about respondents expectations of themselves as part of the therapy process (e.g., "I will be able to express my true thoughts and feelings"). When items asking about expectations of therapist were considered in combination, working-class respondents [M=57.18, SD=16.97] reported lower expectations than middle-class respondents [M=65.60, SD=13.11], t(130)=[-3.19], p=.002, Cohen's d=.56. Expectations expressed by both groups were above average on this 9-item measure. Responses to items asking about expectations about self in therapy indicates a smaller, though still statistically significant difference with working-class respondents reporting lower expectations [M=53.66, SD=15.13] than middle-class respondents [M=58.63, SD=12.61], t(130)=[-2.04), p=.044. Cohen's d=.36. Notably, expectations on this 8-item measure

are both still above average. Conclusions cannot yet be drawn about differences for either of these measures as these item groupings are not validated subscales of this measure. Rather, we sought to explore these differences as part of our exploration into the impact of expectations of self as compared with expectations of the process of therapy.

Two additional questions asked participants to rate their imagined improvement and their imagined satisfaction at the end of therapy on a scale from 0-100. Though mean scores for working-class participants in regard to their imagined improvement were lower [M=58.38, SD=25.91] than average scores for middle-class respondents [60.54, SD=20.58], this difference did not reach statistical significance (p=.681) and effect size was below small (Cohen's d=.09). Average scores for working-class respondents in regard to how satisfied they imagined being at the end of therapy [M=60.52, SD=25.22] were lower than those of middle-class participants [M=68.16, SD=22.52] and reached significance when using a one-sided p-value t(130)=[-1.91], p=.037. Notably, the effect size for this difference is above small (Cohen's d=.32). A third question asked participants to rate how they expected to feel on a scale from 0 ("I expect to feel worse") to 10 ("I expect to feel completely better"). Average responses from working-class respondents were slightly lower [M=6.20, SD=1.87] than for middle-class respondents [M=6.70, SD=1.68] and was approaching significance when using a one-sided p-value t(130)=[-1.57], p=[.059]. Notably, effect size was just below our cutoff (Cohen's d=.28). Importantly, responses from both groups indicated an average belief of expecting to feel somewhat better after therapy.

***Alternate Sources of Support***

Important differences emerged in regard to reports from respondents around who they would turn to for support when in distress. Working-class respondents (M=2.45, SD=.96) reported being more likely to use church for support than middle-class respondents did (M=1.93, SD=.96) t(127)= [3.00], p=[.003], Cohen's d=.54. Working-class respondents (M=2.59, SD=1.02) also reported being more likely than middle-class respondents (M=2.14, SD=.91) to turn to neighbors for support t(124)= [2.57], p=[.011], Cohen's d=.45. Working-class respondents (M=3.43, SD=.69) and middle-class respondents (M=3.45, SD=.86) reported being equally likely to reach out to friends for support. Similarly, no meaningful differences were observed in reported likelihood from working-class respondents (M=3.32, SD=.64) and middle-class respondents (M=3.41, SD=.74) in regard to turning to family for support. Working-class (M=2.94, SD=.96) and middle-class respondents (M=2.90, SD=.96) also demonstrated no statistically significant differences in their reported likelihood of reaching out to colleagues. Finally, no meaningful differences were found in reported likelihood of reaching out to mentors between working-class (M=3.04, SD=.97) and middle-class (M=2.92, SD=1.03) respondents.

***Life Satisfaction***

As with our pre-survey, we performed a one-way between-groups multivariate analysis of variance (MANOVA) to investigate differences between working and middle-class respondents in regard to their current life satisfaction, how satisfied they imagine they will be in 5 years, and how satisfied they imagine the generations before them (parents and grandparents) and the one after them (children, future children, or other important next generation members) would rate themselves. Our Mahalanobis distance test indicated a violation of the assumption of

multivariate normality due to outlier responses. We found that only 3 cases exceeded the critical value for our 5 dependent variables and these cases were excluded from our analysis. After this adjustment was made, no serious violations were noted. Unlike with our pre-survey, there were no statistically significant differences observed on the combined dependent variables. Differences between imagined satisfaction of respondents in 5 years and differences in imagined satisfaction for important future next-generation members were approaching significance but did not meet our Bonferroni adjusted alpha value of .01. We ran an independent sample t-test for each of these differences and found that working-class respondents reported an imagined life satisfaction that was slightly lower [M=7.29, SD=1.34] than did middle-class respondents [M=7.82, SD=1.32]. This difference was approaching significance t(106)=[2.0], p=[.048] but did not meet our Bonferroni adjusted alpha level of .01. Effect size was above small [Cohen's d=.40]. We also found that working-class respondents [M=7.34, SD=1.91] imagined less satisfaction for their children or important next generation members than did middle-class respondents [M=8.06, SD=1.45]. A Levene's test indicated that the assumption of the homogeneity of variance was violated. The adjusted p-value used was approaching significance t(68)=[2.08], p=[.042] but did not meet our Bonferroni adjusted p-value of .01. Notably, effect size was above small [Cohen's d=.42].

***Class, distress, expectations, and help seeking***

In order to assess the influence of class on attitudes toward therapy, levels of distress, and willingness to help-seek, PROCESS was used to create a serial mediation model. PROCESS uses listwise deletion prior to analysis, meaning that any cases with missing data were excluded from

the model. Our sample size after this listwise deletion was 132. The outcome variable was help-seeking, as measured by participant's answer to the question "have you ever considered seeing a therapist because of dissatisfaction?" The predictor variable was class, as measured by participants self-identification of class status (outlier participants who self-identified as "low-income" or as "wealthy" were excluded from analysis). Mediator variables were attitudes toward therapy, as measured by the expectation of therapist alliance subscale of the MPEQ, and distress level, as measured by total score on the K10. Class was significantly associated with attitudes toward therapy, such that working class membership was associated with less positive expectations for therapy relative to middle class membership, b = -11.22, SE = 3.82, p =.004, 95% CIs [.-18.79, -3.64]. Less positive attitudes were, in turn, associated with more distress, b=-.08, SE=.03, p=.004, 95% CIs [-.13, -.02]. Class was not associated with distress while controlling for attitudes, b=1.56, SE=1.119, p=.19, 95% CIs [-.80, 3.91]. Both distress [b=.17, SE=.04, P=.000, 95% CIs [.10, .25]] and attitudes [b=.03, SE=.01, p=.003, 95% CIs [.01, .05]] were significant predictors of help-seeking behavior, with higher levels of distress and more positive attitudes both associated with more help-seeking. Class, however, was not a significant predictor of help-seeking behavior when controlling for distress and attitudes, b=.17, SE=.43, p=.704, 95% CIs [-.69, -1.02]. Finally, the indirect effect of class on help-seeking behavior through distress and attitudes was significant, [b=.15, SE=.08, 95% CIs[.03, .35]].

**Semi-structured interviews**

Each member of the coding team began by reviewing transcripts independently and organizing chunks of raw data into domains, using interview questions as a start list. The team

then came together to discuss identified domains and reached an agreement that the domains that best fit the data were: identity, beliefs, and experience. Coders then reviewed several more transcripts using these domains to organize raw data. This was discussed to consensus. During this process of reaching consensus, it was determined that the "identity" domain was largely captured by the "experience" and "belief" domain and so data assigned to this domain was reassigned to one of these two. It was noted that respondents often expressed a lack of certainty in responses to identity questions. Concrete responses to questions about identity (e.g., "I am a registered republican") were added to the experience domain and responses that were posed as questions or that indicated a lack of certainty (e.g., "I don't know, I guess middle class?") were added to the beliefs domain. Coders then revisited organized data and assigned initial codes independently. Codes from each team member were used to create a code book (see appendix I) that was discussed to consensus. Codes identified for the code book included: therapy process, therapy content, therapist traits, therapy outcomes, therapy engagement, therapy system, sociopolitical context, work, alternative forms of therapy, and relationships. Each code assigned to raw data was tagged with an agreed upon theme (e.g., "Therapy process: Therapist providing long term access"). Qualifiers used to contextualize codes when necessary, included: self, other, desired, and undesired (e.g., "Therapist Trait: (undesired) shift from helpful to blurred boundaries).

Coders then independently created 1-2 sentence summaries for the tags under each code for several transcripts and came together to discuss a list of categories to consensus. Categories identified included engagement in various modalities of therapy throughout the years, the use of

social media to normalize therapy, generational changes in openness to therapy, confusion about class status, beliefs that therapy is for people who are struggling, a desire for increased self-understanding and self-regulation, a desire to engage in more goal-directed behavior, the importance of therapists creating safe space for disclosure, a desire for shared experience/background, and concern about the limitations insurance poses on access to therapy.

These categories were used to consider overarching themes of our data. Given the responses from our pre-surveys pointing to a lack of clear-cut boundaries around class, we were unsurprised to find that one overarching theme identified was confusion and lack of certainty about class identity. On the other hand, we were somewhat surprised to find an overarching theme of feelings that a two-party system does not provide candidates that align completely with interests of voters, even for those who expressed skepticism about the value of help-seeking and who identified as conservative-leaning. This was unexpected given the research connecting feelings of hopelessness and dissatisfaction to polarized political beliefs and strengthened commitment to right-wing nativist politics.

We were unsurprised to find that the theme of therapy as a valuable resource for those who can afford to access it extended across interviews and were similarly unsurprised by the theme of a generational shift in use of social media for accessing current events and normalizing therapy, given our own lived experiences and participation in social media platforms and the field of therapy. We were interested to see that many participants endorsed both a belief that therapy is for people who are really struggling and who are looking to be proactive, resulting in an overarching theme of therapy as an important intervention to reduce acute distress and to

increase goal-directed behavior. This commonly expressed dichotomous belief about the motivation for therapy engagement was incongruent with the various reasons participants indicated for engaging in therapy themselves or for seeing others participate in therapy. This incongruence was further underscored with an additional overarching theme of participant belief that therapy is for anyone. This expressed belief was held by the majority of respondents, regardless of their own engagement in therapy or their expressed willingness to consider using therapy as a resource. Given this incongruence, we noted an overarching theme that aspirational beliefs about therapy are often not in line with lived experiences. Interestingly, we noticed that some respondents (primarily those working jobs traditionally considered working-class) endorsed the importance of therapists with shared lived experience while others (generally those who endorsed consistent engagement in therapy throughout their lives) saw over-familiarity as a barrier to effective therapy. Finally, the majority of participants indicated some kind of concern that therapy is not responsive to the holistic needs of all people. This felt particularly salient, as it speaks to our hypothesis about the disconnect that exists between experiences of distress, attitudes about therapy, and accessing of services.

## Discussion

Our pre-survey findings support some of what previous literature suggests about defining the working-class, both in terms of ways to differentiate this group and in terms of distinguishers that draw arbitrary boundaries and conflate groups who hold various identities. In terms of demographics, our findings are in line with warnings in the literature that conflating class with political affiliation is a misconception that overlooks the nuanced and complex aspects of both

class and political identity. Our finding that working-class respondents were more likely to identify as male is one not discussed in the literature to date. Given findings that women, in general, are more likely to respond to surveys than men (Smith, 2008), we have reason to believe that our gender breakdown is in line with average response rates for surveys like ours and that our chi-squared goodness of fit test indicates a potentially meaningful connection between gender and class that should be further explored. We suspect that there might be some overlap between values often associated with the working-class (e.g., engaging in labor with one's own hands, skepticism toward social services) and values (e.g., self-sufficiency, stoicism) socially understood as traditionally masculine. These findings are also in line with our interview data, where several participants indicated a belief that women were more likely to use therapy and that white women were more socialized to see therapy as an appropriate resource for trivial problems.

The lack of significant findings in self-reported beliefs around how hard respondents understand themselves to work or how much effort they feel they put into their work in comparison with others suggests that both working-and middle-class individuals consider themselves hard workers and see their work ethic as being comparable to or better than their counterparts. Significant findings around job satisfaction, though, suggest that while both groups seem to define themselves as hard working, the working-class find less satisfaction and fulfillment in this work. Responses to open-ended questions provide some potential context for this difference. Middle-class respondents indicated working jobs that seem to lend themselves to more creativity (e.g., musician, graphic designer, policy advisor). This is also reflected in some of the terms middle-class respondents used to describe their identities (e.g., "fun, optimistic,

always curious"; "hard worker, creative"; "Introverted empath, healer"). Working-class respondents indicated working jobs that have more defined requirements and expectations (e.g., teacher, mental health counselor, carpenter) and demonstrated a focus on their hard work when asked about their identity (e.g., "hustler, goal oriented"; "permanently exhausted human"; "hardworking teacher").

Differences in findings between reports about feeling judged and reports about feeling blamed for problems outside of one's control provides important context for the literature suggesting that the middle-class uses the working-class as a scapegoat for social ills. While no meaningful differences were found between groups in regard to how judged they feel by others, working-class respondents indicated that they feel more blamed for problems outside of their control than middle-class respondents. Open-ended responses indicate that both groups feel judged about things like their appearance (e.g., "my appearance"; "age, weight"; "looking younger than I am") and their beliefs (e.g., "religion, political views"; "opinions expressed"). In regard to feeling blamed for things outside of one's control, both groups also indicated similar experiences of feeling blamed for problems at work (e.g., "people passing the buck [at work]"; "work issues usually"). The statistically significant difference in amount of blame felt between the two groups, though, suggests a meaningful difference in the internalization and interpretation of this blame. Notably, some open-ended responses point to understanding this blame as a consequence of being seen as benefiting from white privilege (e.g., "In general terms, that due to the color of my skin I owe reparations or should apologize for my lifestyle"). These findings are in line with existing literature on the cultural inertia model (Zárate et al., 2019) that identify

national nostalgia (i.e., a longing for the country's past and a belief that social change threatens cultural norms and values) as a psychological anchor for resistance to social change (Armenta et al., 2021) and, as such, contribute to the understanding of backlash to movements like *Black Lives Matter* that seek to challenge and change systemic inequity.

Our findings also support the "fear of falling" detailed in Ehrenreich's (1990) work exploring the influence of anxiety and ambition on class status. Unsurprisingly, the difference seen in reports from middle- and working-class respondents in regard to how many paychecks they could miss before going into crisis points to the experience of having an economic buffer as a defining difference between working- and middle-class respondents, given that middle-class individuals were more likely to report that they could miss as many as five paychecks or more without going into a crisis and working-class respondents were more likely to report that they were only one missed paycheck away from falling into crisis. Future studies should consider the relationship between this perceived buffer and actual assets and earned income.

Our findings also add some context to the criticism in the literature that differentiating the working-class as individuals not accessing higher education draws an arbitrary distinction that conflates individuals with various jobs, incomes, and value systems. While almost a third of our working-class respondents indicated having no college degree (as compared with only 12% of middle-class respondents) our analyses indicate that a disproportionate number of respondents indicated having a college degree when compared with middle-class respondents. Middle-class respondents, though, disproportionately reported holding higher degrees (e.g., masters, doctorate) as compared with working-class respondents. This suggests that our understanding of

post-secondary education as a distinguishing factor merits more granularity. This likely reflects the fact that enrollment in post-secondary programs generally increased throughout the years (Duffin, 2022; Nietzel, 2021) and the requirement of increasingly higher degrees for jobs that are typically considered middle-class. This is consistent with the reports from the federal government that about 30% of all enrolled college students receive a need-based Pell grant (Duffin, 2022) and with studies that suggest that lower-income students account for much of the increase in the overall number of students attending college over the last 20 years (Smith, 2019). We recognize that individuals with higher levels of education are more likely to complete surveys (Smith, 2008) and that the state in which we've conducted our research is one with the highest number of college degree holders as compared with the rest of the country (Bryant, 2021). We caution that these results should be understood in light of this potential skewing of participant education level. Given findings around the increased number of Americans attaining higher degrees (Nietzel, 2021), and the fact that our survey was conducted online and accessible throughout the country, we believe that our findings may point to an important shift in the relationship between higher education and class status.

Our findings on the Cantril Self-Anchoring Scale indicate, unsurprisingly, that differences in class influence current life satisfaction. Notably, our findings indicate that these differences in current life satisfaction do not extend to differences in imagined satisfaction five years from now. This is in line with assertions made in the literature that working-class individuals are driven by a belief in an "American Dream" that they bend as needed to reflect their own experience (Gest, 2018). This narrative is further supported by the lack of statistically

significant differences found in regard to imagined life satisfaction of important next-generation members in spite of the meaningful differences in current life satisfaction. These findings, in combination, point to a sustained belief in class mobility despite the economic realities of a country with a well-documented history of class stratification and ever-increasing distance between class groups (Gest, 2018; Massey, 2007; Perrucci & Wysong, 2008; Reich, 2016). While the difference between current satisfaction and beliefs about parents' satisfaction reported by working-class respondents did not reach statistical significance, we believe that it could reflect the theme of nostalgic deprivation put forth in the Sociology literature. Importantly, this literature suggests that a sense of nostalgic deprivation (i.e., a belief that one has less capital than in the past) is connected with recent rises in the support for radical right politicians and policies (Gest et al., 2018).

Notably, both groups had several open-ended responses highlighting a good nature and a desire to care for those around them (e.g., "My core values include loyalty, love, compassion and kindness"; "caring and compassionate and always willing to help whoever needs it"; "Pleasant and easygoing"). Several working-class responses to open-ended questions seemed to reflect a connection between hard work and care for others (e.g., "A homebody and a caretaker…I tend to take care of those around me"; "generally happy, family oriented, and hardworking") while some middle-class responses to the same open-ended question indicate a desire to live by values that are separate from work (e.g., "I try to identify more with my values than with a job"; "a young man who strives for life"; "community member passionate about doing better for families"). These differences are particularly poignant given the literature that white working-class

individuals are more likely to organize around their whiteness, as jobs that are traditionally considered working-class are less likely to provide a sense of identity than jobs that are traditionally considered middle-class. Consequently, working-class individuals are more likely to be invested in ethnic and racial distinctions that allow them membership to an in-group than are middle-class individuals who are able to identify, at an individual level, with an achieved social status. As our population continues to diversify, whiteness is increasingly created in response to a sense of threat against this in-group identity status (Gest, 2018).

Understanding the sense of belongingness and threat experienced by different class groups helps us to consider the needs they are trying to meet. Maslow's hierarchy of needs (1943) suggests that we cannot attend to needs of self-actualization (e.g., creativity, purpose) until our needs of safety and security (e.g., employment, social stability) have been met. Moreover, needs of self-esteem also precede needs of self-actualization in the hierarchy, suggesting that working-class respondents who report being less satisfied at work are likely trying to attain a sense of achievement and respect rather than a sense of creativity and purpose. When we consider these differences in the context of Terror Management Theory (Greenberg et al., 1997; Greenberg et al., 2008), it follows that when needs of safety and stability are met, awareness can expand beyond day-to-day wellbeing to consider the scope of one's life and inevitable mortality. This awareness may, in turn, inform existential questions around one's purpose and legacy in life and sustain a drive to be creative and make meaning of one's life. This difference in the perception that one's needs are being met appears to lay at the heart of the distinction between working and middle class. Importantly, this difference seems to inform the

attitudes and anxieties associated with each group: for the middle class, a desire to find meaning and purpose and for the working-class a desire to feel a sense of stability and self-sufficiency.

Results from our main survey highlight class as an aspect of identity that intersects with many other identities. Survey demographics support our initial findings that class distinctions should not be made in terms of age or political affiliation. Notably, our full survey did not find any meaningful differences in gender identified between respondents from different class groups. This initial finding around association between gender and class membership should be further assessed. Findings from the main survey also support our initial findings around differences in education level, with working-class respondents being more likely to report having a college degree and middle-class respondents being equally likely to report having a college degree or an advanced degree. Also, in line with our initial findings that both working- and middle-class respondents understood themselves to work equally as hard, most respondents indicated working full-time regardless of identified class identity.

Our finding that over half of our respondents indicated experiencing distress within the last two weeks is in line with findings from the Pew Research Center indicating that 41% of Americans report a belief that life is worse now than in the past (Poushter, 2017) and a COVID Response Tracking Study that found that Americans are reporting the lowest levels of happiness in 50 years (Lush, 2020). Moreover, the fact that working-class respondents indicated higher levels of dissatisfaction than middle-class respondents is in line with findings from global research organization Gallup, who has been measuring employee engagement in the US since 2000, that 51% of workers indicated not feeling engaged at work. This may be particularly

poignant in our current sociopolitical context, as disengagement at work is coupled with relatively flat wages (Wilkie, 2017). This suggests that workers are feeling a lack of value in their work, both in the sense of purpose and of compensation. Given our pre-survey findings that working-class individuals are more likely to report lower levels of satisfaction at work and to indicate less financial stability (i.e., the belief that fewer paychecks could be missed before a crisis), their higher levels of dissatisfaction make sense within this context.

While we recognize that doing item-level analyses can lead to a higher potential for familywise errors we believe that the exploratory nature of this study and its emphasis on lived experience justifies considering response styles to the different aspects of distress used by the K10. Our findings that working-class respondents indicate a greater sense of hopelessness than do middle-class respondents may reflect responses to wages that remain relatively flat as individuals continue to feel increasingly disengaged from work. Moreover, the COVID-19 pandemic increased joblessness and income instability. We know that the pandemic had a differential impact on marginalized communities (Graynor & Wilson, 2020) in terms of exposure, severity of illness, long-term consequences (CDC, 2020) and in terms of compounded impact on communities already facing social vulnerability due to factors like poverty and limited infrastructure (e.g., affordable housing, transportation) (CDC, 2018). It seems to follow that the loss of jobs and income resulting from COVID-19 also compounded the feelings of resentment and hopelessness expressed by individuals impacted by the economic trend in the United States beginning in the 1970s of shrinking opportunities for well-paid blue-collar work as the country became increasingly beholden to global corporations (Putka, 2021).

Our finding that working-class individuals report more experiences of feeling worthless than do middle-class workers lends more support to this narrative, particularly given research demonstrating that white Americans (in particular those who are poor and live in rural areas) report more pain than do poor individuals who hold minoritized identities (Blanchflower & Oswald, 2019). White individuals have been found to endorse more chronic pain (NHIS). Notably, research coming out of Princeton University and the University of Southern California indicates that acute and chronic pain is rising in working class and less-educated Americans under the age of 60 (Anson, 2020). Given the well-documented hardships faced by minority individuals throughout the history of the United States, this difference in reporting suggests that lower-income white Americans (or those who see themselves as having less than they need or deserve) may be pointing to experiences of increased psychological pain. When considered within the social hierarchy of the United States, an experience of differential psychological pain by those benefiting from white privilege likely points to differences in an understanding of self-worth. These findings are also supported by our pre-survey findings that working-class respondents were more likely than middle-class respondents to report feeling judged for problems outside of their control. Research demonstrating the connection between a person's sense of being meaningfully employed and their overall wellbeing and personal satisfaction (Blustein, 2008) further supports this connection between meaningful employment and feelings of self-worth.

Notably, the only difference to reach statistical significance was the higher likelihood that working-class respondents would indicate more instances of feeling like nothing could cheer

them up. This seems to reflect the despair resulting from feelings of hopelessness and worthlessness and suggests that working-class individuals are less likely to see their situations as able to improve. This is borne out in research demonstrating that poor individuals who hold minoritized identities report greater optimism than their white counterparts (Graham, 2021; Putka, 2021) and that these marginalized individuals actually indicate more positive attitudes about the mental health field than the general public (Diala et al, 2001; Mojtabai, 2007). This may be a consequence of white working-class individuals organizing around their whiteness. Organizing around privilege, particularly for those who do not share in many of the benefits of this privilege, likely leaves individuals vulnerable to feeling that lack of satisfaction is the result of personal failure. Ironically, an unexamined belief in meritocracy seems to remove the protective factor of awareness of external factors (e.g., racism, classicism) that can help to depersonalize distress and instill hope for change.

Findings that working-class respondents are more likely to report challenges sitting still as compared with middle-class respondents seem to reflect a capitalist narrative that worth is best measured by productivity and output. This finding feels particularly poignant in the context of Audre Lourde's (2017) assertion that the cruelty of capitalism lies in its use of people's desires against them. The same group of people more likely to report feelings of hopelessness and worthlessness are also the ones indicating difficulty sitting still, suggesting that they are looking to productivity as a solution to this lack of purpose and fulfillment. Findings that the US has fallen from 11th to 19th place in the World Happiness Report (Putka, 2021) and well documented findings that income does not improve emotional well-being (Dahneman & Deaton,

2010) illustrate the painful loop working-class individuals indicating both higher levels of dissatisfaction and of challenges with stillness and rest seem to be caught in.

Responses to the Milwaukee Psychotherapy Expectations Questionnaire indicate that working-class individuals have lower expectations both for the process of therapy, as measured by their expectations of therapeutic activities, and for the value of a therapeutic relationship, as measured by expectations of the therapeutic alliance. Importantly, working-class respondents also indicated having lower expectations about themselves as part of the therapy process. Importantly, both groups reported expectations of therapy that were above average, which may point to a generational shift in attitudes toward therapy given that our respondent's ages, ranging from 19-79 were significantly skewed to the left and were largely concentrated between 25 and 35.

Notably, while differences in reports between working- and middle-class respondents in regard to expectations around improvement from therapy were not statistically significant, expectations of level of satisfaction following a therapy process and of expectations for feeling better demonstrated notable effect sizes. These findings further support an understanding of working-class individuals as having less optimism and more skepticism that their emotional well-being can improve. Importantly, this distinction seems to speak to lower attitudes about therapy reflecting a belief that it will not make a meaningful change on life satisfaction than a belief that it is not an effective practice in its own right.

Differences observed in responses between working- and middle-class respondents in regard to the likelihood that they would use alternative sources of support add further context to

this understanding of working-class individuals as potentially more distressed and less hopeful. Working-class respondents' increased likelihood to turn to the church and neighbors than middle-class respondents seems to reflect an ongoing desire for the kind of support and understanding provided by the kind of "small republics" Robert Weibe (1967) describes as being erased by capitalism in his *Search for Order*. It also suggests that this group may be more likely than middle-class individuals to look for safety and understanding in communities that they perceive as understanding them, as opposed to with largely middle-class professionals who are disconnected from the aspects of life (e.g., dissatisfaction at work, financial instability) that inform and maintain their sense of dissatisfaction and hopelessness.

The mixed findings on the Cantril Self Anchoring scale between our pre-survey and our survey suggest that this is an area in need of further exploration. Notably, both surveys pointed to some evidence that working-class individuals report less current life satisfaction than do middle-class respondents. These findings are in line with results on the MPEQ and the K10 that identify meaningful differences between working-and middle-class respondents that point to higher levels of distress, lower levels of satisfaction, and less optimism in the working-class as compared with middle-class individuals. Notably, lower expectations for the satisfaction of important next-generation members endorsed by working-class respondents as compared with middle-class respondents was approaching significance. The difference in these findings and our pre-survey findings that no meaningful difference in expected satisfaction of next-generation members merits further exploration, as it seems to reflect the instability of the "American Dream" narrative.

Our findings that class influences attitudes toward therapy which, in turn, influence levels of distress and that attitudes and distress levels predict differences between working-class and middle-class groups in regard to help-seeking behaviors reinforce and help to contextualize our findings that working-class individuals have higher levels of distress, dissatisfaction, and hopelessness and lower levels of optimism than do middle-class individuals. It seems that differences in service-utilization cannot simply be explained by class status or background but instead are better considered as being influenced by class-informed attitudes about therapy and subsequent levels of distress. We suggest that these findings lend support to our assertion that discrepancies in service utilization need to be considered not just in terms of logistical access but also in terms of meaningful access, as expectations around the therapy process and the therapeutic alliance appear to be both be influenced by class and to influence level of distress and willingness to engage in therapy.

Our interview data provided important context for our quantitative findings. Importantly, an overarching theme identified was a sense of confusion and/or uncertainty when asked to discuss class identity. Several participants expressed confusion when asked to discuss their identity in general and most expressed some degree of uncertainty when asked about their class status. In some cases, this uncertainty seemed to reflect class as an ill-defined concept (e.g., “I wanna say I’m in the middle of mid and low class?”) or class as a dynamic concept (e.g. “I’m not comfortable with the traditional, you know, working, middle, upper etc. We’re very fortunate but if “rich” means being able to know that you can take care of your needs and the needs of your family for the rest of your lives that’s a very high bar. So, I would say very fortunate but

knowing that in this country that can change."). Notably, some of the uncertainty seemed to arise from discomfort discussing class, particularly from those who identified as middle-class (e.g., "Like poverty level? or? like.. oh! nevermind, I'm sorry, I get it now…like mid to upper class…sorry I'm thinking class like in an airplane. I'm so sorry."). This supports our assertion that class is intentionally ignored as a means to maintain the status quo and that the working-class serves as a convenient scape-goat group for middle-class individuals looking to denounce social ills without surrendering any of their power and privilege.

Another common theme identified across transcripts was discontent with a two-party political system. Expressions of discontent ranged from a desire to avoid conflict (e.g., "I would say [I'm] probably an independent more than anything. I don't vote and politics are another thing that I tried to really stay out of. I would say I'm not a confrontational kind of person."), to beliefs that neither party fully embodies their values and ideals (e.g., "My interests lie more with what the Democratic party has to say. But, on the other hand, I don't particularly identify as Democrat, it's just like, whatever candidate is less likely to bash queer people…I'll vote for that person,"; "I'm unenrolled, but I lean toward conservative."). Notably, almost all participants indicated using social media as their primary news source (e.g., "Facebook and Reddit are probably my big two news sources."). This seems to represent a generational shift (e.g., "my mom asked me this a while ago. She was like 'do you read the newspaper?' and I'm like 'no' and she's like 'well then what are you doing?' and I'm like 'I don't know..memes?'"). Some older participants indicated watching TV news (e.g., "I try, and hit all the channels. But I'm, you know, 70% Fox.") and some younger participants indicated a primary reliance of others for current events (e.g.,

"Sometimes if something is particularly interesting, I like to look for news articles, but most of my news comes from word of mouth.").

Many participants also pointed to a generational shift in attitudes about therapy (e.g., "Because of age differences [in fire department staff] you still have that group that still thinks that you know, we're not supposed to reach out we're supposed to just shut up, keep our mouth shut and keep moving forward"; "nowadays it's like…it's completely the opposite where everyone is very encouraging to go to therapy…the whole attitude about it, the way we'll talk about it has completely reversed in the new decades.") and is being talked about more openly on social media (e.g., "I feel like there's a lot more on social media, too…and I feel like that's been pretty helpful because you start to look at it and you're like 'oh, there's lots of people that have anxiety and depression'...it kind of makes you realize that you're not alone.").

Most participants expressed a belief that anyone can benefit from therapy. Some rejected the idea of a stereotype for a specific image of a person who uses therapy (e.g., "I think it can be any body shape or color. It really doesn't... I don't have a specific stereotype for that.") and others indicated that they think certain kinds of people access therapy more readily than others but that it could be of help to anyone (e.g., "kids…because they're told to go…and females. I think a lot of men probably should be in therapy but don't go."; "It seems just normal that if you're a queer person you also have a therapist. Like it just seems to go hand in hand."). Most participants also stated a belief that nothing in therapy should be off limits. Some indicated that content should depend on the comfort level of the participant and the kind of space created by the therapist (e.g. "I think if you have a good therapist [nothing should] necessarily [be off

limits].” and others expressed a belief that topics viewed as off limits may be the most important ones to discuss in therapy (e.g., “I don’t think anything should be off [limits]. Because if something’s off limits, then that may be the thing that’s the catalyst.”). Notably, several participants indicated both a belief that nothing should be off limits in therapy and a discomfort talking about certain topics in their own therapy process.

Several participants also described a belief in the value of therapy that did not match their lived experience in individual therapy (e.g., “It felt sort of like a waste of time, but like, I think, that might have been like these particular ones didn't match me, because, like I feel like I have like something to gain from therapy. But from the therapist I've gone to I haven't really found what I’m looking for or need, you know?”). Many participants indicated a belief that this was because resources are hard to find and navigate (e.g., “maybe like, make [therapists] easier to find, because at the moment, it takes like an afternoon of research, just to find like a couple of potential therapists. As is, it's just like, there’s too much…the information is spread out too much, and, like you'll go to like different sites and then find like different information about the same therapist and stuff and like at the moment like my main difficulty with like finding a therapist is literally the finding part.”). Others described feeling like they had not experienced a “good fit” with any therapist (e.g., “conceptually I know it is a good thing to try a whole bunch of different therapists, but so far, all my experiences with them have been very uh…like, neutral. Like I didn’t really get anything from it.”; “I have not figured out [what would make me feel connected to a therapist] yet. If I did, I would probably actually be in therapy at the moment.”). Some participants also expressed feeling like techniques used in therapy were things they already

knew (e.g., “I don’t wanna say [not] helpful because it’s obviously helpful in many ways…[but] it didn't’ seem like anything that I haven't already done…like self-soothing if that makes sense.”) or that they felt able to anticipate what therapists were doing (“I've been like I should probably go [back] to therapy, and then I've been like, I already know what they're gonna say so I’m not gonna go.”) or that they believed therapy techniques were things they should be able to do on their own (e.g., “I wouldn’t talk about much [if going back to therapy] I just think I can Google it and figure it out.”). Notably, several participants indicated a belief that the field over-relies on medication while also indicating benefitting from medication themselves.

Several participants expressed a belief that specialists are particularly hard to find, even with good insurance, (e.g., “I saw like a psychiatrist most recently, not a psychologist and you know, both of them were recommending DBT therapy for me. And maybe I should have sought that out. It's just a little bit more difficult to find something like that than just like a talk therapy.”) and some drew comparisons between the field of psychology and the medical field, highlighting how much easier it is to find a medical specialist than a mental health specialist (e.g., “If I was to Google it [therapy resources] right now, it would bring me to the suicide help line as opposed to a therapist, whereas if I, Google a dentist, I as a gives you 20 of them.”). Several participants also expressed a belief that everyone could benefit from therapy, but that therapy is not accessible to everyone (e.g., “So, you know, theoretically everybody should go to therapy, but, like I know, it's not really an option, for a lot of people, so it's like if they can get it, that's great like…if it is within your means, go for it.” ).

## Implications

Our study provides important implications for clinical practice, research, and theory. Clinically, our findings support our proposed use of a critical narrative humility model (see appendix J). Our findings that point to the influence of class on expectations of therapy, and on confidence in the ability of the therapist to establish an alliance in particular, suggest that therapist self-reflection is a crucial first step in creating a therapeutic environment that feels safe and collaborative. We suggest that our model of critical narrative humility provides a concrete framework through which to consider personal commitment to the hegemony as a practitioner of the field of psychology. We propose that in reflecting on our buy-in to the hegemony, our commitment to maintaining the status quo, the benefits we receive from capitalism, our positionality on the social ladder, and our training biases, that we can dismantle our own commitment to maintaining a capitalist social hierarchy and convey an authentic readiness to clients to listen to their experiences openly and without judgment.

This self-reflection puts us in a position to consider the messages our clients have received about help-seeking, the kinds of oppression they may have internalized, the impact a sustained status quo has on their wellbeing, the role capitalist values play in their distress, and any discrepancies that exist between our positionality on the social ladder and theirs. This ability is particularly important for effective service delivery to working-class clients, given that this group was more likely to indicate a desire for therapy to be a space where they can speak freely about their experience without misunderstanding or judgment. When we as clinicians deconstruct our own stories, we begin to understand our blind spots and assumptions and become able to

bring an awareness of our biases and personal contexts into our therapy practice that allows us to communicate the kind of authenticity valued and desired by working-class respondents.

We also encourage the use of this model to consider the realities of a field that largely does not match the demographics of the population it purports itself to serve. While most of our interview participants expressed a desire to have a therapist create a safe space for them, several working-class respondents indicated a desire for a therapist with a similar background of lived experiences. Our findings suggest that education level is a meaningful differentiating factor between the working- and the middle-class and this discrepancy is likely present in most therapeutic relationships, given the requirement of higher education to practice therapy. Moreover, many interview participants identified a willingness to understand personal limitations and to refer out if client needs fall outside of a provider's capacity or best practice as a desired therapist trait. This is in line with research demonstrating that effective match between patient presenting problem and therapist expertise leads to better outcomes, particularly for ethnic and racial minoritized populations (Boswell et al., 2022). Our reflection as clinicians must not end with what we can do differently in our own practice but must extend to a consideration of systemic changes in regard to clinical practice. Increasing the diversity of our practitioners and our leadership increases the probability that all people seeking help will be able to find the kind of "good fit" many of our respondents who fell outside of the "default body" (i.e., white, middle-class) felt unable to access. Moreover, meaningful diversification of leadership will allow our field to challenge assumptions about our understanding of "meaningful" and "effective" services to reflect the diverse lived experiences and values of our intersectional population as

they actually exist rather than as our WEIRD-centered system of categorization and classification suggests it should be.

Making space for our client's truths and larger truths of our field allows us as clinicians to speak truth to power. Interview participants across the board expressed their concern for the accessibility of services both in terms of logistical access (e.g., having the right insurance, locating a specialist with availability) and practical access (e.g., knowing where to find the right information, navigating systems that are not streamlined and are often not up to date). Our field cannot make meaningful changes around equity and access to clinical care until we are willing to make changes at all levels: managed healthcare, training programs, and professional organizations as well as the individual practices developed and maintained within these systems. In speaking this truth to power, we can not only demand change but create space for the beauty of healing not just for our clients but for ourselves as clinicians and for our field of Psychology.

In regard to research, we suggest that our findings around differential levels of hopelessness, worthlessness, and optimism between class groups is of particular importance given our current socio-political context. Understanding higher levels of hopelessness and worthlessness and lower levels of optimism for working-class individuals is particularly important for the field of Psychology, as the decade preceding the pandemic (2005-2019) saw an average of 70,000 Americans die annually from what researcher Carol Graham describes as "deaths of despair." These deaths are the result of suicide, drug overdose, or alcohol poisoning and are overrepresented in middle-age white individuals with lower levels of education. Notably, low-income individuals and those holding minoritized identities are much less likely to die of

these deaths (Graham, 2021). This difference is particularly poignant given our field's admitted failure to serve these minoritized populations. More research is urgently needed to understand the drivers behind these deaths of despair so that the white working-class can be meaningfully understood as one with risk factors that we as a field of psychology are not effectively addressing.

Given the nature of our study, our findings have implications not only for clinical research but also for policy research. In addition to the impact hopelessness and worthlessness appear to have on one's well-being, a lack of hope that is internalized into a sense of worthlessness seems to motivate the support of harmful social and political policies. The dangerous impact of higher levels of hopelessness and lower levels of optimism on public policy have been painfully demonstrated in the last several years. Areas with higher reports of lost hope in the years before 2016, for instance, were more likely to vote for Donald Trump, a politician with demonstrated commitments to prioritizing only the most wealthy privileged members of our capitalist society (Herrin et al, 2018). This is somewhat unsurprising, as despair among the white working-class has shown to drive nativist politics, vulnerability to inaccurate news reporting, and skepticism about science (Graham, 2021). The election of Donald Trump, a candidate who promised to return America to a state of "greatness," led to a 20% increase in hate crimes– a number that may well reflect an underreporting of violence experienced by individuals holding minoritized identities (Villarreal, 2020). It seems likely that Trump's narrative of an America stripped of its greatness by the undeserving "other" (i.e., BIPOC, immigrants, women and gender nonconforming individuals) gave those struggling with unexamined feelings of

hopelessness permission to scapegoat others in a way that defends against their own sense of worthlessness.

Consequently, in addition to the implementation of harmful policies in regard to environmental protections and immigration, the Trump presidency led to an increase in polarized partisanship, particularly in regard to the news media. Importantly, this led to the emergence of misinformation that influenced the 2020 presidential election and culminated with an insurrection at our Nation's capital (Pew Research Center, 2021). Significantly more research is needed on the impact of media and, in particular, the influence of misinformation on both mental states, meaning making, and subsequent actions. This misinformation in combination with mistrust in science also significantly influenced our country's response to the COVID-19 pandemic. This response, initiated by the Trump team, proved to be much less effective than the response styles of many countries with less resources (Beaman & Davidson, 2020) and led to higher death tolls than in other wealthy countries. Despite having some of the world's best access to vaccines, the US failed to vaccinate as many individuals as other comparable nations and fell even further behind counterparts in administering boosters (Mueller & Lutz, 2022). Research motivated by the COVID-19 pandemic found that measures of trust in the government, interpersonal trust, and government corruption had significant associations with infection rates, such that higher trust and lower corruption was associated with lower infection rates and higher vaccine coverage (Bollyky & Dieleman, 2022). Future research should consider the intersection of class and hopelessness and worthlessness to further explore risk factors that exist for this group, both in regard to their mental health needs and their civic identity and engagement, with

the aim of informing more responsive intervention strategies that more effectively promote their best interests in both domains.

Differences identified between class groups in regard to use of alternate forms of support to seek solace and address distress also have important implications for both clinical and policy research. Clinically, differences in use of church to address distress is likely to influence feelings of disconnect felt between working-class help seekers and primarily middle-class therapists. Research suggests that many patients want spirituality as an aspect of their clinical care and that spirituality can be an important resource for individuals to draw upon as part of recovery (Rosmarin et al., 2019). Some research has already demonstrated the effectiveness of including spiritual psychotherapy as an aspect of clinical care (Captari et al., 2018; Smith et al., 2017; Rosmarin et al., 2021) and even indicates that nonreligious clinicians deliver this kind of care more effectively than religious clinicians due to the tendency of nonreligious clinicians to take a more dialectical approach (Rosmarin et al., 2022). Future research should consider the intersection of class and desire for religion and/or spirituality as an aspect of clinical care in order to allow clinicians to integrate this aspect of care into their training and practice.

These differences in use of church to seek solace and manage distress, though, also provide important context for the impact of class on policy. While involvement in religion has shown to influence positive outcomes at an individual level through social involvement, meaning-making, and values-directed goal setting, it has also demonstrated a significant potential for causing harm when used to make meaning at a systems level (Maton et al., 2005). Early research has found connections between declared attendance at religious services and

COVID deaths (Linke & Jankowski, 2022) and observed connections between religious fundamentalism and ineffective responses to the COVID-19 were demonstrated in differential public health responses across the country (Cole, 2020). Religion has also been used as a kind of justification for harmful public policy in regard to access to safe and legal abortion and gender affirming care, among other critical public health issues. A recent wave of anti-trans legislation aimed at restricting transgender rights at a state level was led by many of the same Christian and conservative groups who lead the charge to dismantle reproductive health rights by challenging Roe v. Wade. These groups (e.g., Alliance Defending Freedom, American Principles Project, Family Research Council) aim to create policy based on theological and religious beliefs around gender, sex, and family (Contreras, 2023). Notably, research has found that religious beliefs, but not religious tradition or behavior are a strong predictor of senator's legislative behavior. This suggests that the influence of religion at a policy level often does not reflect the actual lived values or practices of legislators (Daniel, 2018), as evidenced by much of the disconnect seen between "family values" candidates' rhetoric and their behavior within their own families (Seelinger, 2017). A better understanding of the role of religion in treatment can position clinicians both to support clients in accessing the personal benefits of religion and spirituality as part of effective clinical care and to identify and address disconnections that exist for clients between their lived values and experiences and their use of religion to make meaning of social policy.

Differences identified between class groups in regard to life satisfaction and optimism for the future also has important implications for both clinical practice and policy. Many of the

groups supporting politicians working to dismantle rights around reproductive healthcare and trans rights, among other harmful social policies, use a narrative of returning America to a past "greatness" that appeals to groups struggling with a sense of hopelessness and a lack of optimism for the future. Research on cultural nostalgia, or a longing for past cultural norms, suggests that a belief that social change compromises one's ability to reach life satisfaction and a fear that this will continue to decrease for future generations acts as a psychological anchor for resistance to social change (Armenta et al., 2021). Findings that individuals endorsing higher reports of lost hope were more likely to vote for Trump in the 2016 election should also be considered in light of subsequent research indicating that these same voters reported much more positive views of the United States and its value to "people like you" during the Trump presidency (Pew Research Center, 2017). This increased optimism includes reports from Trump voters that the president's messages made them feel "hopeful, entertained, informed, happy, and proud" (Pew Research Center, 2021). A better understanding of shifting perspectives toward the "American Dream" narrative through comprehensive research is of particular importance for clinicians. The hegemonic explanation for the lack of realized success of individuals willing to work hard is that the country has shifted away from values and norms that serve these individuals and support their success. In order to effectively address the higher levels of distress endorsed by the working-class, Psychology must first work to dismantle its unexamined bias toward the hegemony in order to understand the influence of systemic factors in the maintenance of working-class distress and discontent. Without research aimed at understanding the relationship between working-class distress and their understanding of the unrealized "American Dream,"

any efforts at managing this distress risks reinforcing a nostalgia narrative and the immense harm it causes the marginalized populations these historic "values" were set up to oppress.

In regard to theory, we suggest that our findings support an addition to our critical narrative humility model (see appendix K) that provides a framework for engaging in deconstruction and reconstruction, starting at the individual level and moving to a systems level. Critical self-reflection supports authentic story sharing within the therapeutic relationship. This, in turn, creates a foundation upon which to effect systems change within the field as a whole. In his prolific consideration of the operations of racism in the United States, WEB Dubois came to assert that much of what drives racism is not hatred or even ignorance but rather a commitment to maintain the psychological and economic benefit afforded by white supremacy (Morris et al., 2021; Sullivan, 2003). This assertion is particularly poignant in the case of the white working-class, as white supremacy offers this group a psychological feeling of privilege that allows them to overlook the fact that they are not, in fact, beneficiaries of the economic benefits of this system. Moreover, an ability to unite around whiteness allows the working-class to sustain their belief in meritocracy and the rewards of hard work by blaming those who do not share in this identity rather than confronting the reality of a system is not set up to serve them.

Our model proposes that in order to promote equity and increase access to care, clinicians must begin with a personal process of deconstruction and reconstruction that can then be extended out to the larger field. In starting with personal reflection, clinicians can deconstruct their own story and consider the blind spots and assumptions created and maintained by their socialization and their training. They can then name these biases and address the role of their

own story and its impact in the room with their client. This allows for the creation of space to hear client's truths as they actually are, not as clinicians assume them to be. More importantly, it creates space to consider clients as unique and intersectional individuals rather than as cases to conceptualize and place into diagnostic categories. In sharing our truth, we can begin to acknowledge the truth of our field. We can consider the ways in which our field invalidates the experiences of those who are not benefited by the system of Capitalism that American Psychology works to serve by telling them that their distress is disordered and is their responsibility to fix. With truth telling as a first step, we as clinicians can call our field to engage in its own process of deconstruction and reconstruction. We can call our field to deconstruct its story by reflecting critically on the assumptions inherent in its teaching and training practices. We can demand that blind spots and assumptions in our field be addressed by diversifying leadership to better reflect the population we work to serve so that these perspectives and interests can be included in research, policy, and training initiatives. In naming and addressing these biases and blind spots, our field could begin the process of healing through truth telling that could allow for movement from claims of being of service to anyone willing to change to meet the standards of our field and toward a commitment to be of service to everyone as they authentically exist.

## Limitations and Future Directions

Our study is exploratory in nature and, as such, explores themes that merit further consideration. Our findings raise important questions about the intersection of class and gender, and we hope to further assess the relationship between socialized gender values in a capitalist

society and values associated with different class groups in future work. We also hope to build on our findings around perceived financial instability and a fear of falling by exploring the relationship between perceptions of financial stability and earned income and living expenses.

While we used recommended strategies to avoid inauthentic responses (e.g., bots) we still received many survey responses that appeared to be inauthentic. We used best practices suggested by the Qualtrics platform to identify and remove these responses from our data set but the possibility that some inauthentic responses were not screened out remains. Future studies should consider alternative means to compensate individuals for completing surveys, as offering compensation on the Qualtrics platform itself seemed to leave us particularly vulnerable to inauthentic responses.

Importantly, our coding team was made up entirely of individuals who have had access to higher levels of education and formal training in the field of psychology. We spent intentional time bracketing our biases before the coding process and used practices like triangulation as a way to challenge biases. Future studies would benefit from coding team members with more diversity in education level and who are removed from the field of study. Our hope in addressing the intentionally overlooked theme of class in the therapy space is to shed light on the complexity and nuances of this aspect of identity, particularly as it relates to the field of Psychology. Future studies would benefit from exploring these nuances, particularly as they relate to themes of hope, sense of self, and civic engagement. We offer our model of critical narrative humility as a tool for clinicians looking to dismantle their own commitment to a capitalist social hierarchy and the values central to this social system and hope for the future

opportunity to assess the impact of this tool on clinical practice and on the field at a systems level.

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## Appendix A- Informed Consent

**INFORMED CONSENT TO PARTICIPATE IN RESEARCH**

The following information describes the research study in which you are being asked to participate. You must be 18 years or older in order to participate. Please read the below information carefully and take whatever time is necessary to make your decision. If you have any questions about the study that you would like answered before you decide, please feel free to ask. You should feel fully informed before making your decision. If you decide that you would like to participate in this research study, you will be asked to sign this document and you will be given a copy.

**TITLE OF RESEARCH STUDY:** Turning the Mirror Inward to Dismantle the Barriers of Psychotherapy

**PRINCIPAL INVESTIGATOR:** Dr. Debra A. Harkins, Clinical Psychology, Suffolk University

**CO-INVESTIGATOR:** Lynne-Marie Shea, Clinical Psychology, Suffolk University

**PURPOSE OF RESEARCH:**

The purpose of this research study is to explore the attitudes and expectations of psychotherapy held by individuals from identity groups that have traditionally low rates of utilizing psychological services. This study is intended for a general audience and readability should be at the sixth to eighth grade reading level. It is anticipated that 150-200 individuals will participate in the completion of a survey and that another 20-25 will be recruited for participation in a qualitative interview. You are being invited to participate in this study as a member of an identity group with traditionally low rates of accessing psychological services.

**RESEARCH PROCEDURES:**

If you decide to volunteer for this research study, you will be asked to complete a survey. You might also be contacted to ask for your participation in an hour-long interview. Completion of the survey does not necessitate participation in an interview.

- You will be asked to complete an electronic survey.
- Survey questions are all scale ratings.
- Surveys will consist of both open-ended questions and scale-rated questions.
- You might be contacted to ask for your participation in an hour-long interview.
- Interviews will be recorded and transcribed.

**RISK AND/OR DISCOMFORTS:**

Questions asked in surveys and in interviews address the subject of personal distress and experience with psychological services and, as such, might lead to feelings of discomfort. Otherwise, it is not expected that you will experience any risks and/or discomforts by participating in this research study that are any greater than those normally experienced in everyday life.

**BENEFITS:**

The benefits of participating in this study include receiving a gift card for participation in the survey and the potential for a larger gift card for completion of an hour-long interview. Additionally, the field of Psychology is likely to benefit from this study by hearing your experience and perspective on its available services.

**ALTERNATIVES:**

The alternative is not to participate in this study. Participation in the survey does not necessitate participation in an interview, even if you are recruited.

**PRIVACY AND CONFIDENTIALITY:**

Your privacy will be protected by the direct submission of the surveys to the researchers and by the conducting of interviews in private rooms or with secure technological forums. Completion of surveys does not mandate participation in interviews, even if you are recruited to do so. Any information shared with anyone outside of the investigators will be de-identified.

The confidentiality of the information will be maintained by:

- Using secure Qualtrics platform to collect data.
- Ensuring that surveys data is stored in a password protected account that only the investigators and research assistant have access to.
- De-identifying interview transcripts and survey data.
- Destroying original responses once data has been compiled and de-identified.

**COMPENSATION:**

Participants who complete surveys will be sent a gift card. Participants who complete and interview will receive an additional gift card.

**VOLUNTARY NATURE OF PARTICIPATION/ RIGHT TO WITHDRAW:**

Participating in this research is voluntary. You have the right to refuse to participate. If you decide to participate, you may withdraw your consent at any time and any information collected from you will be destroyed. Your withdrawal will not result in any penalty or loss of benefits and/or services that you might be entitled to receive. The investigator may also determine that it is in your best interest to discontinue your participation at any time.

Your completion of a survey does not in any way confirm your participation in an interview, even if you are recruited. If willing to complete an interview you may still withdraw at any time.

**CONTACT INFORMATION:**

If you have any questions about this study including the purpose, procedures, and/or risks and benefits you may contact:

Lynne-Marie Shea
401.345.9046
Lshea@suffolk.edu

## Appendix B- Pre-survey

1. What is your age:

2. What is your gender:

3. What is your ethnicity:

4. What is the highest degree or level of school you have completed? (If you're currently enrolled in school, please indicate the highest degree you have *received.*)

- Less than a high school diploma
- High school degree or equivalent (e.g., GED)
- Some college, no degree
- Associate degree (e.g., AA, AS)
- Bachelor's degree (e.g. BA, BS)
- Master's degree (e.g., MA, MS, MEd)
- Professional degree (e.g., MD, DDS, DVM)
- Doctorate (e.g., PhD, EdD)

5. What is your current employment status?

- Employed full time (40 or more hours per week)
- Employed part time (up to 39 hours per week)
- Unemployed and currently looking for work
- Unemployed and not currently looking for work
- Student
- Retired
- Homemaker
- Self-employed
- Unable to work

6. If you are working, how satisfied are you with your job?

| **Not at all** | | | | | **Somewhat** | | | | | **Very much** |
|---|---|---|---|---|---|---|---|---|---|---|
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

7. How much effort do you put into your work (or finding work?)

**Very little** **Average amount** **A lot**

**0 1 2 3 4 5 6 7 8 9 10**

8. How do your work efforts compare to others?

**A lot less than others** **About the same as others** **More than most**

**0 1 2 3 4 5 6 7 8 9 10**

9. How many paychecks could you go without before being in a crisis?

- Zero, any missed paycheck would cause a serious problem
- Not more than one
- 2-3
- 4-5
- More than five
- I have other income that would keep me out of crisis even without my paycheck

10. I feel unfairly judged by others

**Rarely** **Sometimes** **A lot**

**0 1 2 3 4 5 6 7 8 9 10**

(Optional: About what kinds of things?:_____)

11. I feel blamed for problems outside of my control

**Rarely** **Sometimes** **A lot**

**0 1 2 3 4 5 6 7 8 9 10**

(Optional: What kinds of problems?:_____)

12. The world would be a better place if:

13. Optional: How would you describe your identity?

## Appendix C- Kessler Psychological Distress Scale



### Kessler Psychological Distress Scale (K10)

| Please tick the answer that is correct for you: | All of the time (score 5) | Most of the time (score 4) | Some of the time (score 3) | A little of the time (score 2) | None of the time (score 1) |
|---|---|---|---|---|---|
| 1. In the past 4 weeks, about how often did you feel tired out for no good reason? | | | | | |
| 2. In the past 4 weeks, about how often did you feel nervous? | | | | | |
| 3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down? | | | | | |
| 4. In the past 4 weeks, about how often did you feel hopeless? | | | | | |
| 5. In the past 4 weeks, about how often did you feel restless or fidgety? | | | | | |
| 6. In the past 4 weeks, about how often did you feel so restless you could not sit still? | | | | | |
| 7. In the past 4 weeks, about how often did you feel depressed? | | | | | |
| 8. In the past 4 weeks, about how often did you feel that everything was an effort? | | | | | |
| 9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up? | | | | | |
| 10. In the past 4 weeks, about how often did you feel worthless? | | | | | |

**Appendix D.- The Milwaukee Psychotherapy Expectations Questionnaire**

In the past two weeks, have you been feeling dissatisfied with life? _____yes _____no

**If yes, how much dissatisfaction have you been feeling?**

**0 1 2 3 4 5 6 7 8 9 10**

**None very much**

**How willing would you be to see a clinician and engage in psychotherapy if you were experiencing distress or satisfaction?**

**0 1 2 3 4 5 6 7 8 9 10**

**none very much**

**If yes, how much dissatisfaction would you expect to feel by the end of therapy?**

**0 1 2 3 4 5 6 7 8 9 10**

**none very much**

*Imagine that you are experiencing a sufficient amount of distress and dissatisfaction with life and are considering seeking therapy (**whether this is true for you or not**.) Please answer the following questions as if you have made the choice to talk with a clinician and engage in psychotherapy:*

**Not at all Somewhat Very much**

**0 1 2 3 4 5 6 7 8 9 10**

**1. I expect my therapist will provide support.**

**0 1 2 3 4 5 6 7 8 9 10**

**2. Therapy will provide me with a better understanding of my problem.**

**0 1 2 3 4 5 6 7 8 9 10**

**3. I will be taught new skills in therapy.**

**0 1 2 3 4 5 6 7 8 9 10**

**4. In therapy I will learn to use skills that I already have to solve my problems.**

**0 1 2 3 4 5 6 7 8 9 10**

**5. My therapist will provide me feedback.**

**0 1 2 3 4 5 6 7 8 9 10**

**6. I will discover different ways to alter my behavior through participating in therapy.**

**0 1 2 3 4 5 6 7 8 9 10**

**7. I will be given new information about myself.**

**0 1 2 3 4 5 6 7 8 9 10**

**8. I will be able to work on my own goals in therapy.**

**0 1 2 3 4 5 6 7 8 9 10**

**9. I will be able to express my true thoughts and feelings.**

**0 1 2 3 4 5 6 7 8 9 10**

**10. I will feel comfortable with my therapist.**

**0 1 2 3 4 5 6 7 8 9 10**

**11. I will learn more about myself.**

**0 1 2 3 4 5 6 7 8 9 10**

**12. My therapist will be sincere.**

**0 1 2 3 4 5 6 7 8 9 10**

**13. My therapist will be interested in what I have to say.**

**0 1 2 3 4 5 6 7 8 9 10**

**14. My therapist will be sympathetic.**

**0 1 2 3 4 5 6 7 8 9 10**

**15. My therapist will be nurturing.**

**0 1 2 3 4 5 6 7 8 9 10**

**16. I will be willing to talk about myself, even if it is embarrassing.**

**0 1 2 3 4 5 6 7 8 9 10**

**17. I expect that I will come to every appointment.**

**0 1 2 3 4 5 6 7 8 9 10**

**At the end of the therapy period, how much improvement in your problem(s) do you think will occur?**

**0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

**By the end of therapy period, how satisfied do you expect to be with the treatment results?**

**0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

**Which of the following best describes your expectations about what is likely to happen as a result of your treatment (Circle only one number)?**

**0 – I expect to feel worse.**

**1**

**2 – I don't expect to feel any different.**

**3**

**4 – I expect to feel a little bit better.**

**5**

**6 – I expect to feel somewhat better.**

**7**

**8 – I expect to feel much better.**

**9**

**10– I expect to feel completely better.**

## Appendix E- Alternate Sources of Support

**How likely would you be to turn to the following for solace/support when experiencing distress?**

**a. Church/faith community**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**b. Neighbors**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**c. Friends**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**d. Family**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**e. Colleagues**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**f. Online forums/groups**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**g. Other:_____**

**0 1 2 3 4 5 6 7 8 9 10**

**Unlikely Somewhat likely very likely**

**Of the support systems you would be likely to turn to in moments of distress, where would you turn:**

**First:_____**

**Second:_____**

**Third:_____**

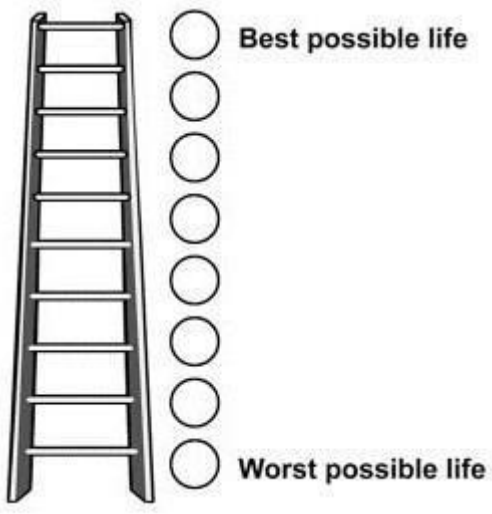
**Fourth and beyond:_____**

**Appendix F.- Cantril Self-Anchoring Scale**

Assume this ladder is a way of picturing your life. The top of the ladder represents the **best** possible life for you. The bottom of the ladder represents the **worst** possible life for you.

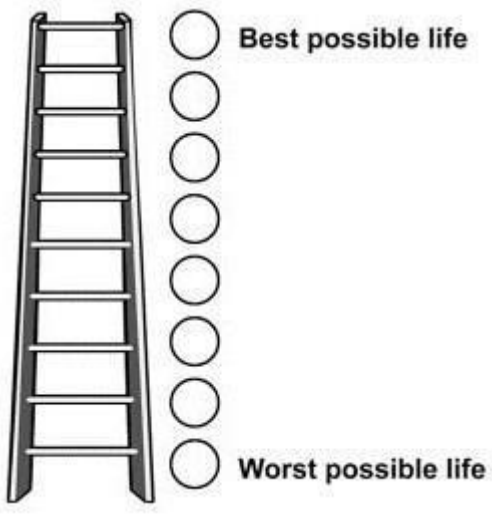
Indicate which step of the ladder you personally feel that you stand **right now**:


Now, indicate which step of the ladder you feel you will *most likely* be standing on **in 5 years**:

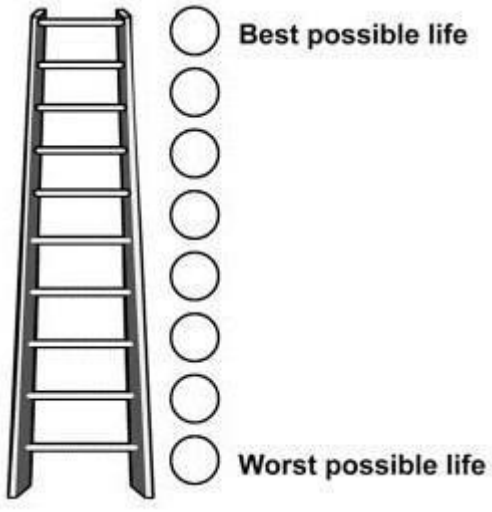



Which step of the ladder do you imagine your parents would rate themselves?


Which step of the ladder do you imagine your grandparents would have rated themselves?




Which step of the ladder do you imagine your children (or future children/important next-generation family members) will rate themselves once they reach adulthood?



**Appendix G- Interview Recruitment Flyer**

## Appendix H- Interview Questions

**Identity:**

1. How would you describe your identity? (age/race/ethnicity/gender etc.)
2. How would you describe your class status?
3. How would you describe your income?
4. What kind of work do you do? (job title/number of hours)
5. How do you feel about your work?
6. What sources do you use to get news/learn about current events?
7. How would you describe your political affiliation?
8. Are there any important parts of your identity that we haven't touched on yet?

**Experience with Therapy:**

**What is your experience with therapy like?**

*Have you ever participated in talk therapy? What kind?*

*If yes: what was this experience like for you?*

*If no: what would make you consider talk therapy, if ever?*

*What has kept you/continues to keep you from using therapy as a resource?*

**Who is therapy for?**

*Who do you think goes to therapy?*

*What do they look like?*

*What do they talk about?*

*Who has the greatest potential to benefit from therapy?*

**Where do your beliefs about therapy come from?**

*What messages have you received about therapy or counseling?*

*Where did these come from?*

*Do your attitudes about therapy or counseling differ from those of your family and close friends? Why do you think that is?*

**What would/do you talk about in therapy?**

*What would you talk about with a therapist?*

*Do you think any topics are off limits?*

**What would make therapy feel like a success?**

*What would make you feel understood by a therapist?*

*What changes would you want to see in your life to feel like therapy was working?*

**How satisfied are you with the field?**

*How close do you think the field of psychology is to meeting your needs?*

*How close is it to meeting the needs of people in general?*

*What changes would you want to see therapists make to better meet needs?*

**Is there anything else that you think is important for us to know about your attitudes about or experiences with talk therapy?**

**Appendix I- Code Book**

**Domains:**

**Experience**- Participant's sharing of things that have happened to them directly. Confined to a specific experience or context. Expressions of reactions to one's own emotional experience. Aspects of identity that feel like lived experience.
E.g., *"[work in] Pharmaceutical biotech."; "I had a very negative experience with one person [therapist]"; "I'm a registered democrat"*

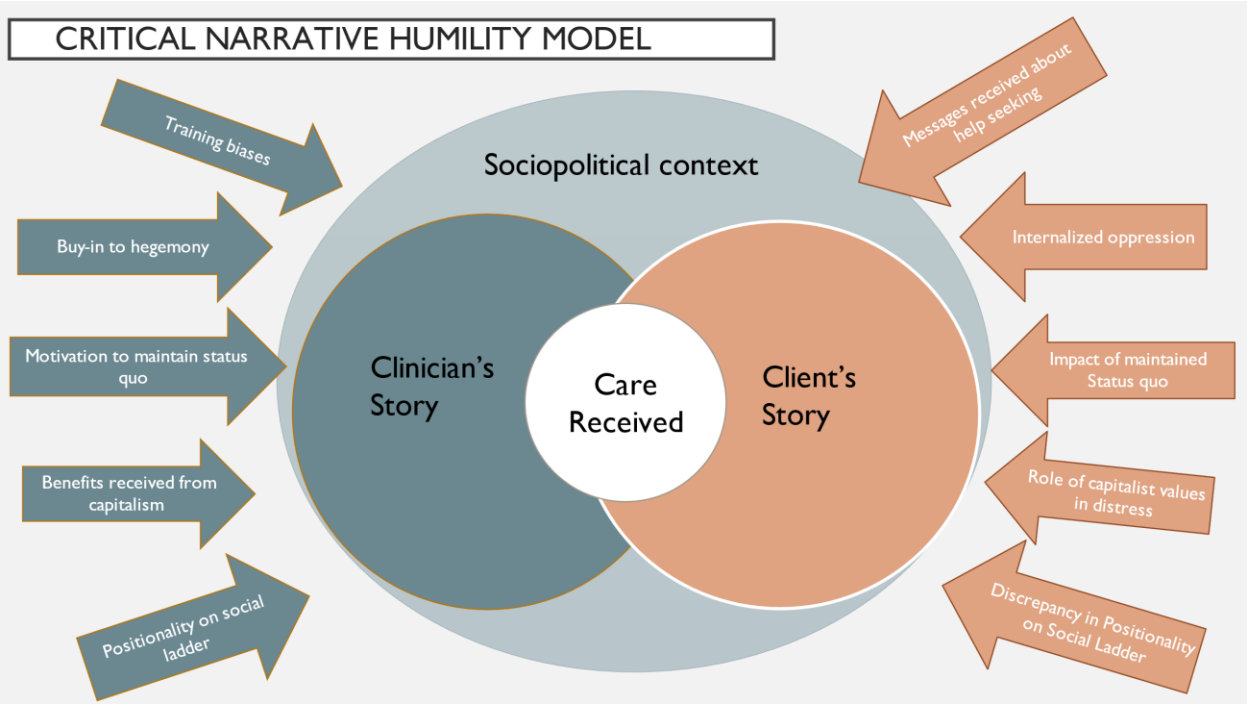
**Belief**- Participant's thoughts about others or about the world. Generalizing, speculating, or drawing conclusion from personal experience. Aspects of identity that are assumptions participants make about themselves or aspects of their identity that they are trying to understand.
E.g., *".I think that therapists shouldn't be very judgmental."; "but he [boyfriend] always he always jokes and he's like I don't need to see a therapist because I have you, which i'm like yeah I mean that's nice but maybe we should have someone else."; "I don't know. Like mid to upper class?"*

Codes:

| **CODES** | Definition | Example |
|---|---|---|
| **Therapy Process** | What therapy looks/looked like (for self or others, specific or general) | *"So I've been to a couple of therapists. once when I was much younger, and then another more recently. They were both talk therapy."* |
| **Therapy Content** | Things that happen in therapy space | *"I think that it's very appropriate to talk about your fears [in therapy]"* |
| **Therapist Traits** | *Qualities of therapist* | *"I think that that's what helps me the most..she [my current therapist] has been giving me a lot of autonomy."* |
| **Therapy Outcomes** | Results of therapy, meaning making from therapy | *"less anxiety, less depression. Generally just feeling happier and better about myself."* |

| | | |
|---|---|---|
| **Therapy Engagement** | Factors that increase or decrease therapy engagement | *"I mean he's got depression, but like we do what we can for him, but he's he doesn't want to see a therapist. It's like he's very stubborn."* |
| **Therapy System** | Thoughts about field of psychology/mental health as a whole | *"I think the field has advanced a lot. I think there's always room for improvement in any field in any aspect."* |
| **Sociopolitical Context** | Influence of outside factors (cultural, political, social, generational, etc.) | *"I wanna say i'm in the middle of mid and low class"* |
| **Work** | Feelings/beliefs about work experience | *"And so the job definitely came with its own struggles. You felt very secluded and not too much a part of a team. Everyone that you talked to was through like email or chat. Never really like well, never face to face."* |
| **Alternative Therapy** | Things other than traditional therapy that is used for similar benefit (e.g., church, meditation) or integration of non mainstream techniques into therapy practice | *"I'm at a point now where I don't physically practice yoga, I wouldn't even say once a month, but mentally I practice yoga meditation."* |
| **Relationships** | Discussion of beliefs/ experience/ influence of friends/family | *"Yeah. And so I got all of that insight [about boyfriends family] very, very recently, and we've been with each other for 10 years."* |
| **QUALIFIERS/ TAGS** | | |
| **Self** | | |
| **Other** | | |
| **Desired** | | |
| **Undesired** | | |

## Appendix J- Critical Narrative Humility Model



**Appendix K- Critical Narrative Humility Model- Deconstructing and Reconstructing**