I Am Not An Island:

How Mainstream Mental Health Care Fails Low-Income Women



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Abstract

This paper explores how low-income women are not adequately served by the mental health care system and explores potential new approaches to mental health care that can better serve those women. First, I review how psychological treatment came to be both individualized and based on sick care rather than preventative care. Then, I will explain how women are disproportionately poor and how poverty influences mental illness. Low-income women experience poverty differently than men and therefore have specific barriers to accessing effective treatment. This problem of low-income women not receiving adequate mental health care will be put in the context of potential shifts in the field of psychology. Specifically, some psychologists are now claiming that the traditional therapy model is unsustainable for all Americans. Finally, I will explore how new approaches to mental health care can incorporate the needs of low-income women.

I Am Not An Island: How Mainstream Mental Health Care Fails Low-Income Women

Low-income women in the United States are in no way a group with identical experiences. As feminist theorists have articulated, there are countless factors that influence a woman's life beyond her socioeconomic status and gender, including but not limited to race, nationality, disability status and sexual orientation (hooks, 2000; Lorde, 1984). In fact, feminist theorists claim that there is no essential 'women's experience' (Baca Zinn & Thonton Dill, 1996). When feminist activists have historically tried to articulate experiences of women's subjugation, the experiences have often been only those of the women who best fit the hegemonic societal norm – white, heterosexual, able-bodied women (Lorde, 1984). By excluding the experiences of women whose lives are uniquely affected by the intersection of race and gender, feminist activism has replicated existing systems of hierarchy and marginalization (Lorde, 1984). For instance, many white women see rape culture and objectification of women as the cause of sexual violence and subsequently organize resistance strategies based around those causes. However, for many women of color, sexual violence takes place due to the intersection of racism and sexism, as it is often a type of racist oppression (A. Smith, 2005). Therefore, ending rape culture would have little effect on sexual violence against women of color. Grouping the experiences and needs of women in any way has the potential to erase the experiences of women with multiple, intersecting identities (Lorde, 1984). However, in practice, all women have multiple identities that shape their lives, so any grouping of women is misleading. However, functionally, if women's problems cannot be somewhat clustered together and addressed simultaneously, there is little hope for change for women's lives. Therefore, with the knowledge of the potential limitations of grouping experiences as a basis for naming a problem, this examination will strategically essentialize low-income women, recognizing that all

women have other factors in their lives that affect their experiences. Income is an influential and often ignored factor in women's lives, particularly their mental health status and if and how they interact with the mental health delivery system.

The goal of this paper is to show that 1) low-income women are disproportionately negatively affected by the inadequacy of the mental health system, 2) low-income women are more likely to be in need of mental health care *because* of the intersection of being low-income and female, 3) the existing hegemonic approach to mental health care is, from an epidemiological perspective, unsustainable for all Americans, and 4) to briefly review existing alternative models of care that would better serve larger portions of the community, focusing on approaches that would affect low-income women.

However, before examining the current status of low-income women's mental health and their access to mental health care, it is important to review the basic history of the development of mainstream clinical psychology and psychotherapy, and how psychologists have historically interacted with marginalized groups. The parts of history that are particularly relevant to this examination are: 1) how therapy became individualized; in other words, how psychological treatment came to be about getting rid of one person's mental illness rather than building mentally healthy communities; and 2) adjusting people to the status quo rather than challenging existing structures, and therefore pathologizing marginalized communities and normal reactions to difficult circumstances rather than challenging structural inequality. This piece is not intended to be comprehensive, but rather is meant to give basic information that will place this inquiry in historical context.

Historical Context

The Origins of the Individual Therapy Model

Individual and group therapy is the primary mode in which clinical psychologists treat mental illness. According to this model, a mental health care provider meets with an individual or a group of people who are experiencing mental distress for a set amount of time on a regular basis. Although the techniques and stated goals of these sessions vary according to the theoretical orientation of the therapist, the model of meeting with a mental health care provider in a therapeutic setting continues to be the primary way that mental health interventions are executed. However, as will be explained later in this paper, due to the small-scale nature of this type of therapy as well as the fact that it focuses on sick care rather than preventive care, individual and small group therapy are not sufficient to meet the need of all of the people who are experiencing mental illness in the United States. Why, then, is this individualistic, sick care method the primary way that clinical psychologists deliver mental health care services? Although there is not a decisive answer to why this is the primary form of treatment, the historical development of clinical psychology suggests several influencing factors.

Historical Basis for the Individual Model. Psychology as a field was developed in the late 19th century, although clinical psychology as it is known today did not emerge until World War II. For decades, treatment of the mentally ill was left to psychiatrists. The term "clinical psychologist" was coined in 1907. Since then, however, the meaning of the word has changed significantly. In the early 20th century, the main role of so-called clinical psychologists was to administer psychological tests (Hilgard, 1987; Leahey, 2013). These psychological tests did not identify or categorize mental illness. Instead, the vast majority of them were intelligence tests (Leahey, 2013). For example, intelligence scores were used in public schools to see if children were performing on par with their peers (Hilgard, 1987, p. 446).

However, the Veteran's Administration (VA) during World War II would create and

define a new field in psychology: clinical psychology as we know it today. In World War I, applied psychologists had been involved in the military by testing to see whether recruits were mentally ill or fit to enlist. The psychologists tested soldiers before they returned home to see whether they needed to receive psychotherapy from a psychiatrist before they left (Leahey, 2013, p. 482). Towards the beginning of World War II, though, it became apparent that there would be many "more veterans in need of psychiatric care" than the military had encountered in World War I (Leahey, 2013, p. 482). In fact, in 1946, there were more "neuropsychiatric patients cared for by the Veterans administration" (44,000 patients) than "all other types" of military patients (30,000 patients) (Hilgard, 1987, p.633). In addition to the large number of men who were patients in the hospital, the majority of veterans who had returned home were having a lot of trouble readjusting to post-war and post-military life (Leahey, 2013, p. 482). Thus, the VA did not have enough psychiatrists to meet the need. As a stopgap measure, psychologists who worked for the VA in a testing capacity were suddenly asked to perform similar roles to the psychiatrist – delivering psychotherapy – for the first time (Hilgard, 1987, p. 634).

Even with the psychologists that were suddenly working alongside the psychiatrists, the VA did not have enough trained people to provide therapy. Therefore, they partnered with major universities to set up training programs to "turn out clinical psychologists whose job would be therapy as well as diagnosis" (Leahey, 2013, p. 484). With the Veterans Administration as the largest employer of clinical psychologists, "the number of applied and professional psychologists increased exponentially" (Leahey, 2013, 477).

After the boom period of treatment of World War II veterans was over in the early 1950s, many of these new clinical psychologists went on to treat mental illness through private practice. By co-designing the first clinical psychology programs and training and hiring the first large

wave of clinical psychologists, the Veteran's Administration defined clinical psychology for the second half of the twentieth century: clinical psychologists would treat individuals who were experiencing mental distress in a one-on-one setting.

The VA-established role of the clinical psychologist was based entirely on a sick care medical model. In other words, because clinical psychologists' role was defined in a hospital setting, the development of treatment of the mentally ill followed the norms of the standard treatment of the physically ill. A sick care model is an approach to wellness in which, instead of most resources being put towards keeping people healthy, the majority of resources are placed into treating people who are already sick. For instance, in accordance with the sick care model, when someone comes in to the hospital with a broken arm, the arm is set in a cast and the individual is given pain medication as necessary. This approach to treatment is sensible if the majority of illnesses requiring medical attention are sporadic occurrences due to unusual circumstances, such as broken arms (only 3.6% of people fracture a bone during any given year, and only .012% of people break one of the major bones in their arms or legs) (Donaldson, Reckless, Scholes, Mindell, and Shelton, 2008; Court-Brown, Rimmer, Prakash, & McQueen, 1998). However, if many people started coming into the hospital with broken arms, say, 18.5%, the sick care model would no longer be the most practical approach. Instead, it would make sense to look to environmental causes that were leading to such a large portion of the population having broken arms. In fact, 18.5% of the U.S. population suffers from an anxiety disorder in any given year (National Institute of Mental Health, 2005). Despite that, those many cases of anxiety disorders are largely treated within the same sick-care model that handles broken arms. Of course, many of the physical illnesses that are treated in the health care system today such as type II diabetes and heart disease are quite prevalent in the general population and, like prevalent

mental illnesses, would benefit from better preventative medicine. However, the focus of this inquiry is to show how mental health care in particular became about treating the illnesses rather than preventative medicine and should be focused on preventative care as well. Like other medical care, mental health care is quite inefficient because it is based on the sick care model.

It was within this model that clinical psychologists began working. Similarly to how someone would report symptoms of a broken arm at a doctor's office or emergency room, men would report symptoms of what is now known as post-traumatic stress disorder (PTSD) to clinical psychologists in the VA hospitals. The newly trained clinical psychologist, following the norms of that setting, used a standardized treatment to try to reduce the individual's suffering and make him well again. Based on the earlier mentioned broken arm analogy, in a situation where a multitude of people come in reporting similar distress, it would make sense to try to address the problem at the source. However, that was not the way that medical care was done, so it was not an obvious option for clinical psychologists.

Another way in which clinical psychology emerged in conjunction with World War II where the care was being provided in hospitals was that it followed the medical model in which a sick person is partnered with a professional and the professional provides the necessary treatment. To once again use the broken arm scenario as comparison, within hospitals, professionals do not teach laypeople on a large scale how to splint/cast other people's arms. Instead, a professional performs these tasks for each individual person with a broken arm. The same was true to how clinical psychologists approached the treatment of mental illness; they used their expertise to help heal the person in a one-on-one setting. The model of one-on-one or small group therapy was therefore codified as procedure and was difficult to change. Though there have been many changes over time in terms of understanding the nature of pathology and

orientations towards treatment, the mainstream establishment has built on the roots of the same individualized sick care model.

The third reason that clinical psychologists did not address the source of the trauma was that there was a war on, and keeping people from experiencing trauma in war is impossible. The VA was obviously in no position to call off the war because it was producing too many traumatized people, so the best they could do was promote adjustment for men going into and leaving the military, and individually treat the people who, despite the adjustment support, experienced unmanageable trauma. Because of these specific historical factors, clinical psychologists established a norm of treatment which stressed adjustment to existing circumstances with little to no focus on addressing the roots of the trauma.

To promote adjustment, all military recruits in World War II were given a book, *Psychology for the Fighting Man*, to help them adjust to military life, and then, when a man left the service, he was given *Psychology for the Returning Serviceman* to help him transition back to civilian life (Reisman 1966, p. 298). It was only during the times that an individual failed to adjust that the clinical psychologist was called in for treatment. Therefore, instead of being seen as having a normal response to an incredibly stressful, if not inhumane, circumstance, the soldier was seen as failing to do what is expected of him: i.e. maintain his own psychological health. According to Leahey (2013), "everything in twentieth century psychology has revolved around the concept of adjustment," which firmly places psychological care within the sick care medical model in which the distressed individual is treated rather than the source of the distress (p. 488). Additionally, psychologists had learned to treat the distressed individuals in one-on-one therapy.

Therefore, when psychologists who received schooling in a program developed for the VA and then were given hands-on training in the VA hospitals went out to work in the world,

they had been never been trained to address problems systemically, even when the causes of prevalent mental illnesses were preventable in a way that the war was not. In this way, psychologists approached issues from a position of adjustment; instead of addressing problems that caused soldier's distress, military psychologists were trained to individually help distressed men adjust to their existing circumstances.

In a system that promoted sick-care, treating the individual's symptoms rather than addressing a structural problem, and established the only legitimate way of treatment as one-on-one care with a specialist, it was practically inevitable that today, as will be explained later, there are not enough psychologists to meet the need of all mentally ill Americans.

Ideological Bases for the Individual Model. Mainly because of the specific circumstances of the Second World War, clinical psychology developed as a field to be focused on adjusting the individual to fit circumstances rather than addressing upsetting circumstances. However, the undeniable influence of the American tenet of Individualism cannot be ignored.

De Tocqueville (1840) first identified the United States as an individualistic society, writing that Americans "always consid[er] themselves as standing alone, and they are apt to imagine that their whole destiny is in their own hands" (para. 3). In other words, he claimed that Americans are less inclined to see their problems stemming from societal conditions than from personal choices. Today, individualism has become a much-studied social psychological construct defined as the degree to which individuals view themselves as autonomous. (Hamamura 2011; Forbes et al ., 2011). When individuals see themselves as independent of collectives, they are less inclined to examine wellness in a community as a whole or see how structures can best promote wellness. The United States continues to be perceived today as the world's most individualistic country that values personal responsibility for wellness and health

(Forbes et.al. 2011).

Although psychology has claimed to be free from culturally-based moral values, Leahey (2013) points out that the field has been deeply tied to the tenet of Individualism from the beginning. Based on this philosophical orientation, he writes, "Psychology's…became encouraging the never-ending growth of individuals, furthering the tendency among Americans to set personal concerns above public ones" (p. 487). Therefore, psychology not only reflected individualistic American values, but also served to maintain and replicate them by reinforcing that individuals experiencing distress are experiencing that stress in isolation.

Although it might seem that people from a more individualistic society would be more likely to challenge psychology's narrow approach to treatment, this is not the case; according to Kemmelmeier et al. (2003), there is "no clear relationship between individualism and authoritarianism" (p. 317). In other words, how individualistic a person is does not predict whether or not a person will question or submit to authority, and, therefore, American individualism will, counterintuitively, not support challenging convention.

Another philosophical basis for psychology being focused on adjusting the individual to existing circumstances rather than challenging larger structures was that, in the early 20th century, American psychologists, like others in American academia, believed that the role of the mind was to adjust the behavior of the individual organism to the environment. This theory of adjustment was based in Darwin's notion of "survival of the fittest." Early American Psychologists such as William James saw the role of the mind to be to help adjust the organism (in this case, the person), to existing circumstances (Leahey, 2013, p. 334). Basic Darwinian theory is based on the notion that, in order to survive, a species must adapt to the existing environment, not on how the species can change or build the environment to better suit its needs.

"Naturally, then, psychologists would come to be interested in how the process of adjustment played itself out in American life, and they would then move to improve the process of adjustment to make it more efficient and to repair it when it went awry." (Leahey, 2013, p. 451). This philosophical approach that emphasized adjustment of the mind was exacerbated by American individualism being connected to American exceptionalism; Americans believed that a core piece of being American was the capacity for personal growth and change, embodied in the American Dream. Therefore, they believed that personal growth was especially possible for them (Leahey, 2013, p. 315).

Based in part on these philosophical origins, the psychological establishment has focused on how an individual should better suit herself to the environment. Therefore, when people experience distress, the cause of that distress is seen as a problem with the individual rather than the individual's circumstances.

Maintenance of the Individual Therapy Model

Clinical psychology as it is known and practiced today can be traced back to the VA's needs which created the field in the first place. However, it has been over sixty years since the VA set out to define that new profession, yet the profession has changed very little. Theoretical approaches to treatment have progressed and become more varied, but treatment itself continues to almost always be one-on-one or small group meeting with a psychologist. Despite this practice being inefficient and unsustainable, this treatment has stayed the same in large part due to clinical psychologists protecting their own professional and financial interests via program accreditation through the APA and licensing laws.

It is counterintuitive that the APA would have played a large role in keeping clinical psychology as it is, even when the system is not in the best interest of mentally ill people,

because one of the APAs guiding goals is to "promote human welfare." During World War II, the APA changed its purpose from "advance[ing] psychology as a science" to "advance[ing] psychology as a science and as a means of promoting human welfare" in order to make the APA relevant to practicing clinical psychologists (Reisman, 1996). The APA would go on to promote human welfare only in a very narrow sense, however, in their guidelines for how clinical psychologists should be trained and their accreditation process for legitimate PhD programs.

The APA worked in conjunction with the VA to develop guidelines for PhD training in clinical psychology (Hilgard, 1987) and then a huge number of clinical psychologists were churned out of new programs based on those newly-formed guidelines. These new experts also did much of their hands on training in VA hospitals. However, as the war became a more and more distant past, there were no longer jobs for these people at the VA hospitals so, with their VA – theoretically oriented approach to care, they set out to establish private practices all over the United States. "When [PhD] programs and trainees multiplied many times over, it soon became evident that private practice would provide the greater number of opportunities" (Hilgard, 1987, p. 636).

As they developed as professionals, they joined the APA, and soon the majority of APA members were clinical psychologists. As they were then in control of the APA, they could control the future of the field in several ways. They decided which programs could be allowed to receive accreditation. And they would accredit fields that were in line with the way they had been taught. It would benefit them to do this because it added to the legitimacy and prestige of the way they worked. Not only did they believe in making other training programs like theirs, but they had a financial interest in minimizing competition, which maintained their elite status as a field and therefore made them more money.

To further improve their professional prospects and "protect their role in society," psychologists established licensing laws (Leahey, 2013, p. 439). People who have licenses would have to have gone to the accredited programs – accredited by the APA. In this way, accreditation and licensing laws have kept alternative approaches to care from being recognized as legitimate. Although there are other mental health degrees in the United States such as master's degrees in counseling psychology and social work, the PhD psychologists are the most prestigious and highest-paid positions. Therefore, they set the standard for theoretical approaches to care.

In this way, band-aid, sick care approaches to mental health have stayed the unquestioned norm for mental health in the United States for the last 75 years.

Psychology's History of Participation in Structural Violence

The development of clinical psychology as a field informs the inadequacies of modern therapeutic practices. Similarly, psychology's historical pathologization of marginalized communities informs the contemporary tension between disenfranchised groups and clinical psychologists: namely, that marginalized communities distrust clinical psychology (Anderson et al., 2006; Esser-Stuart & Lyons, 2002). It is perfectly reasonable that marginalized communities would resent or distrust clinical psychologists and other mental health care workers because, through history and up until the present day, clinical psychology has both supported existing cultural norms about marginalized groups and medicalized and therefore further normalized ongoing marginalization and oppression. Instead of addressing circumstances that lead to distress or differences, psychology has tried to either treat the symptoms (in the case of distress), or attempt to make people more mainstream (in the case of difference). These practices function to put blame on the individual people rather than the structures that demand rigid role performance or place extreme stress upon that individual. As Leahey (2013) puts it, "by offering tools for

social control and by stressing adjustment, it [clinical psychology] placed itself on the side of conformity" (p. 488)

When an individual reasonably expresses distress due to stressful life circumstances, psychologists label the person as having a mental illness rather than having a reasonable reaction to stress. In treating the so-called mental illness, the psychologists encourage individuals to adjust themselves to the existing way of life. Through emphasizing adjustment, psychologists turn attention away from the unjust circumstances, inadvertently framing those circumstances as unchanging, and blaming the victim of unfair life circumstances. For instance, many middle-class white women in the mid-twentieth century were, according to Phyllis Chesler (1972), taught by psychoanalysts to channel their anger at their life situation – a situation in which they were subjugated by men, denied fulfilling work, and isolated from other women – into "hysterical symptoms: frigidity, chronic depression, phobias, and the like"(p. 140). Therefore, instead of recognizing that she was being unfairly treated by society, a woman was trained by psychologists to think that her distress was due to her personal impairment or inadequacy that she needed to overcome.

Chesler (2005) claims that not much has changed; psychologists continue to pathologized people for what are actually reasonable responses to trauma that they experience as members of a marginalized group. For example, she points out that "women who have been repeatedly raped in childhood…are traumatized human beings; as such, they are often diagnosed as borderline personalities" (p.18). When these women are diagnosed with borderline personality disorder, already one of the most stigmatized mental disorders, most clinicians treat them as liars and manipulators rather than as victims (Chesler, 2005, p. 19). By diagnosing survivors of sexual violence with a stigmatized mental illness, little attention is paid to the society-wide problem of

the violence itself. Instead, psychologists frame the traumatized woman as having something fundamentally flawed with her personality, and her ability to react, respond, and get well, regardless of her circumstances.

By teaching women to look within for solutions to their trauma, psychologists have inadvertently obstructed collective organizing against injustices. Similarly, the rare male perpetrator of sexual violence who is incarcerated by the criminal justice system is framed as being mentally ill – a societal outlier – rather than as someone who was trying to obtain power through violence that, based on his race or class status, is denied to him elsewhere. bell hooks (2000) claims society teaches men that power can only be gained through violence, but that structural inequalities lead to some men being denied power elsewhere, so the only way they can feel powerful and therefore worthwhile is through violence against women (p.121).

In addition to pathologizing individuals who were legitimately hurt by their circumstances, psychologists have historically gone even further and supported hegemonic constructions of normalcy through claiming that people who do not fit those narrow constructs are mentally ill or otherwise wrong. For example, when homosexuals were largely shunned, in part because of their challenge to religious doctrine and patriarchal power (Pharr, 1988), homosexuality was listed as a mental illness in the Diagnostic and Statistics Manual, the guiding diagnostic book for psychologists in the United States, until the 1973 update (Hansel & Damour, 2008). Homosexual people, who were perfectly content with being who they were, and whose main distress stemmed from their experience of rejection from mainstream society, were told by psychologists that, by being attracted to people of the same sex, they were mentally ill and required treatment. Although it may seem as if that time has passed, transgendered people are similarly pathologized today. In many ways, psychologists continue to be influenced by cultural

beliefs in their construction of normal and abnormal (Ballou and Brown, 2002) and inadvertently continue to support cultural hegemony by naming a group of marginalized people as "disordered."

The way that low-income people interface with mental health workers differently from middle and upper-class people exacerbates clinical psychology's tendency to maintain cultural hegemony among low-income people. While middle and upper class people often have and continue to go to see therapists when experiencing distress and wanting help, low-income people do not have that opportunity because their lack of resources prevents them from having the time and the money. Instead, all too often their only interactions with mental health care providers – mostly less-trained social workers instead of psychologists – take place within a punitive framework. In other words, mental health care providers become a part of the structures that oppress the poor. For example, many low-income women will interact with social workers from Social Services after a complaint of child abuse or neglect (Brooks, 2002). Once a complaint has been made, however dependable the source, women are made to feel that they must prove to the social worker that they are capable parents or their children will be taken away from them (Anderson et al., 2006). By policing their parenting, social workers are actors in class-based oppression which demands white, American, middle-class parenting styles. Dictating how low-income women should raise their children is nothing new; social workers have been doing this in poor communities for over 100 years, and there is a well-documented history of women of color having their children taken away by Social Services for similarly racist and classist reasons (Ewen, 1985; A. Smith, 2005). Another common way that low-income women will interact with mental health care workers is as a legally mandated treatment for addiction after committing a drug-related crime, for which low-income people are disproportionately convicted (King &

Mauer, 2002).

While middle-class women are given a less stigmatized set of diagnoses and then given loving treatment in order to overcome that diagnosis, low-income women are more likely to receive diagnoses that are perceived as incurable or dangerous. Chesler (1972) explains this disparity in terms of psychology supporting cultural hegemony when she says,

> The *institution* of psychotherapy can also be viewed as a form of social and political control that offers those who can pay for it temporary relief, the illusion of freedom, and a self-indulgent form of self-knowledge; and as an institution that punishes those who cannot pay for such illusions by being forced to label *their* unhappiness as psychotic or dangerous, thereby helping society consign them to asylums (p. 139).

As a partial replacement for poorhouses and prisons, asylums were another way in which society removed unwanted people from mainstream society (Sanz, 1994; Chesler, 1972). Although asylums no longer exist as they did in the mid-twentieth century, the penal system has largely replaced them as a place to store unwanted people (Davis, 2003).

It is with this context of how low-income women and similarly marginalized groups have been historically mistreated by psychology that the current problem of the stress and mental illness experienced by low-income women and how those women are both underserved and disserved by the contemporary mental health care establishment can be explored.

The Emotional Burden on Low-Income Women

Being poor adds tremendous stress to women's lives; a woman living in poverty constantly lives in fear that some unexpected expense will destroy her paycheck to paycheck living situation (Blake, 2014). Research shows that it would be hard to overstate the psychological impact of poverty on women's lived experience. A woman's personal financial

situation, combined with other circumstances that often come along with socioeconomic status, has a profound effect on that woman's well-being. Unfortunately, women are disproportionately poor in the United States, so they are unevenly burdened with the stressors that come with poverty and there are additional stressors that specifically affect women. Before getting into the specifics of the emotional burden on low-income women, it is important to review how the terms "low-income" and "poor" are used in social science literature, and how women are disproportionately economically disadvantaged in the United States.

Defining "Low-income" and "Poor"

Most social science research bases its use of the words "poor" and "low-income" off of the federal poverty guidelines, which are issued each year by the U.S. Department of Health and Human Services (HHS). Every year, HHS calculates what they think is the minimum amount of money that an individual or family needs to meet basic expenses such as food and rent. In 2013, the poverty guideline for a family of 2 was $15,730 (U.S. Health and Human Services [HHS], 2013a). In other words, the U.S. Government considers a family of two to not have enough money to meet basic needs if the total family income is less than or equal to $15,730. However, federal minimum wage laws do not reflect that reality: Currently, the federal minimum wage is $7.25. If a woman works a job for the federal minimum wage 40 hours a week with no time off, she would make $15,080 every year, and, according to the Department of Health and Human Services, that is not enough money for a single mother with one child to pay for essentials like food and housing.

Different government aid programs have different income thresholds for program eligibility, all of which are based on the poverty guideline: Head Start, the Supplemental Nutrition Assistance Program (SNAP), Women Infants and Children (WIC), the National School

Lunch Program, and Job Corps, among others. However, to qualify for these programs, if they continue to exist, families do not have to be below the federal poverty guideline; they have to earn below a percentage of the poverty guideline, such as 125%, 150%, and 185%. Each program has a different threshold for eligibility based on a percentage of the poverty guideline (HHS, 2013b).

The term "low-income" in social science literature is used differently in different articles based on the researchers' recruiting method. For example, Cook et al. (2010) recruited women through the WIC program to study the mental health of low-income women. However, the WIC program is only eligible to families who earn between 100 and 185% of the federal poverty guideline. Women who make less than 100% are referred to Medicaid. (U.S. Department of Agriculture, 2013). By recruiting through the WIC program, Cook et al. examined a specific group of low-income people, none of whom were below the federal poverty guideline. Other studies used other recruiting guidelines or tactics which resulted in some research of low-income people being of people who are below the federal poverty guideline, and other research being based on people who earned anywhere between 100 and 200% of the federal guideline. Therefore, academics and policy makers are using different metrics to define low-income. Generally, however, the term "poverty," or "poor," strictly means below the federal poverty guideline.

In addition to these inconsistencies in the literature, the concept of poverty is complicated by people's diverse experiences, based on geography and more nebulous issues generally relegated to social class such as a family safety net and support system and knowledge to navigate complex systems. Creating a more inclusive definition of poverty, Ringen(2009) writes:

> Poverty manifests itself in the lives of persons and families as an enforced lack of basic material power to live as one wants or as reasoned fear that one might fall into that situation. It is to live under the dictatorship of material necessity without choice and control in one's daily life. That's what poverty *is*; it's about freedom and power and lack thereof. (qtd. in Goodman, Smyth, & Banyard, 2010, p. 3)

Whether or not a person has control over her life cannot be reduced to a single number like the poverty guideline; there are countless factors that influence whether a person is living in fear of any unexpected expense that could upset her entire life. To accommodate for diversity of experience and because of lack of an established definition in the literature, the term "low-income" will be used loosely in this paper, meaning to apply to all people who, as Ringen puts it, "live under the dictatorship of material necessity" (qtd. in Goodman, Smyth, & Banyard, 2010, p. 3). In the social science literature, the term "poor" is more consistently defined, meaning anyone who lives below the federal poverty guideline. For the sake of clarity, while the term "low-income" will be used loosely in this piece, the term "poor" will be strictly used to mean below the federal poverty guideline.

The Feminization of Poverty

Women are disproportionately in poverty, or below the federal poverty guideline. This phenomenon was first identified in the 1970s and named the feminization of poverty. The term "feminization of poverty" implies that there is a structural basis to this poverty; it is not simply that women are, by chance, suddenly poorer than men. Rather, there are public policies in place that make it harder for women to economically advance (Gunewardena, 2009).

The most striking, often-cited statistic that demonstrates the feminization of poverty is that 40.9% of single, female-headed houses with children are in poverty compared to 21.9% of

single, male-headed families with children, 8.8% of married couples with children, 18.5% of all families with children, and 11.5% of all families with or without children. Not only is a female-headed household with children almost twice as likely to be in poverty as a male-headed family with children, but it is also over three and half times more likely to be in poverty than all families with or without children (Economic Policy Institute, 2012).

Children are a major expense, and one that cannot be taken lightly for people making close to minimum wage. Therefore, it would make sense that 18.5% of families with children would be in poverty, compared to 11.5% of all families. However, that does not explain how almost twice as many female headed families with children are in poverty than the otherwise identical male-headed families. There are structural barriers to economic mobility that specifically affect women.

Women experience vertical and horizontal work discrimination (Charles, 2003) and, due to that, women's wages are usually lower than men's (Coltrane & Adams, 2008).

There is no substantial safety net to help women move out of poverty because American society largely blames them for being poor. If a woman has any children or lives in an expensive part of the country, minimum wage is not enough to meet her basic needs, and, because of the wage gap, there are more women who need to survive on minimum wage than men. Nonetheless, "the meta-narrative of neoliberal economic policies, including those that shape welfare restructuring, appears to be that women are to blame for their concentration among the poor" (Gunawardena, 2009, para. 10). That narrative has led to the ongoing slashing of welfare programs since in the 1990s (Gunawardena, 2009).

It would make sense to an extent that women would be expected to take care of themselves in an individualistic society. However, that does not fully explain why more women

are in poverty than men; public policies have been structured to punish women for being women of color (which low-income and poor women disproportionately are), and for being single, even though socioeconomic status has been linked to placing economic strain on relationships. (Coltrane & Adams, 2008). Building the foundation for blaming poor women for being single and therefore poor, researchers in the mid-20th century focused on the absence of fathers in research on childhood development, rather than poverty, which is often at the base of lack of success for the children. By focusing on the absence of fathers, researchers minimized the much larger effect of poverty on children's development and future class mobility (Coltrane & Adams, 2008).

Women's responsibility for their children is one of the limiting factors that keep them low-income or impoverished. However, low-income women have little control over their own fertility because of inadequate sex education, and, most importantly, unequal access to contraception and abortion services due to cost, geography, and legal barriers (Fried, 2002). Then, when women have children that were not necessarily planned, there is no guaranteed child care or paid maternity leave in the United States to help low-income women complete their education or keep a job (Coltrane & Adams, 2008). The United States does not have substantive policies to support children compared to other industrialized nations (Coltrane & Adams, 2008), which not only hurts children, but also hurts their mothers.

Effects of Poverty

Women disproportionately bear the burden of being low-income and in poverty, and poverty and circumstances that go along with being poor create an enormous amount of stress. As has been the case with the psychological establishment in the past, psychologists often label these women's distress as mental illness, even though the mental health state of low-income

women is often simply a normal reaction to very stressful circumstances. Women's lived experiences in poverty also exacerbate existing predispositions for psychopathology. There has been a large amount of research done that shows that poverty and circumstances related to poverty cause enormous amount of stress, and that, when tested, enormous numbers – between 42 and 60% – are diagnosed with depression or anxiety (Ali, Hawkins, & Chambers, 2010). It's no wonder that they are depressed and anxious because many of these women are constantly fearing for their own safety and the safety of their family, and worrying about how they will feed themselves and their children until they get their next check (Goodman et al., 2010). As a way of dealing with those multiple stressors and symptoms of depression and anxiety, low-income women are also more likely to engage in substance abuse (Rosen, Tolman, & Warner, 2004).

As Hudson (2005) puts it, the negative correlation between socioeconomic status and mental illness is "one of the most consistently replicated findings in the Social Sciences" (p. 3). The relationship between poverty and mental illness is not just correlational; Hudson (2005) found that there is strong support for a causal relationship in which, rather than women losing jobs because of mental illness, or women being poor because they're mentally ill, there is strong evidence that women *become* mentally ill *because* they are economically stressed. Stated differently, women who are under financial strain are more likely to be mentally ill, and that mental illness is probably caused, in part, by the stress associated with economic instability.

Low-income women of color have a unique experience of stress due to cultural differences and the stress that results from the intersection of racism, sexism, and classism, (Chow, Jaffee, & Snowden, 2003; Brooks, 2002; Le, Perry, Zmuda, & Muños, 2010) and women of color are disproportionately low-income and impoverished. Therefore, although race will not be centralized in this summary of mental health effects, it is important to recognize that race and

ethnicity play a crucial part in many women's lived experiences of poverty. Growing up in a poor black community in San Francisco, Brooks (2002) describes the constant fear that she and her neighbors shared in their day to day life. She writes:

> as Black women we often lived in fear of Black men attacking us, of being homeless and of being 'relocated' by the housing authority because of white gentrification. Black women often feared that their sons would be killed by the police, the drug trade or one another; that their daughters would get pregnant, molested in the local preschools or raped (p.105)

Although this is a dated example, taking place in the 1970s, these fears continue, due to continued violence against people of color and the slashing of the welfare programs that began in the 1990s. It is important to recognize the unique experiences of women of color due to the intersection of race, gender, and poverty.

While all low-income women are under stress simply from worrying about their money and women of color have to worry about the added factor of individual and structural racism, there are additional factors in women's lives that are linked to poverty that add stress of their own. For instance, many low-income women live in predominantly low-income communities. Evidence has shown that simply living in low-income communities has been found to be linked to psychology stress (Gapen et al., 2011). Specifically, there is a well-established research link between neighborhood disadvantage, perceived neighborhood disorder, and depression, anxiety, and, to a lesser extent, schizophrenia (Gapen et al., 2011). Due in part to the disorder of their communities, low-income women tend to be socially isolated, meaning that they lack substantive social support to help them cope with stress and navigate difficult situations (Gapen et al., 2011). In addition to perceived neighborhood disorder being linked to depression and anxiety, feelings

of social isolation have been shown to be a risk factor for depression and other mental health disorders, particularly for women (Goodman et al., 2010).

Another stressor that is related to economic status but is not directly tied to money is exposure to trauma; people with low socioeconomic status are simply more likely to experience traumatic events (Gapen et al., 2011). Fifty to sixty percent of all Americans will be exposed to a traumatic event in their lifetimes, while one study of a low-income, predominantly African-American community in a major city found that 83% of the residents of that community had experienced a traumatic event (Gapen et al., 2011). Unfortunately that study did not break down those numbers by gender, but it is well known that women disproportionately experience domestic and sexual violence and that stress from poverty is known to be linked to higher incidence of those types of violence ("Poverty and Sexual Violence," 2013; Bell, 2003).

Women must take on their disproportionate experiences of sexual and domestic violence in addition to violence that all members of an impoverished community experience. Sexual assault, in addition to being extremely traumatic, can result in pregnancy which is nearly impossible for low-income women to terminate. Therefore, women are often forced to take on the financial burden of a child that resulted from rape. Both intimate partner violence and sexual violence often lead to post-traumatic stress disorder (PTSD), which is already disproportionately prevalent in low-income communities: while the lifetime prevalence of PTSD in the U.S. population is 7.8%, the rate of PTSD for people living in low-income communities is 43% (Gapen et al., 2011). Low-income women are actually "much more likely than their higher income counterparts to have experienced interpersonal violence in childhood and in adulthood" (Goodman et al., 2010). Therefore, low-income women are not only at higher risk for experiencing interpersonal violence, but they are also more likely than their non-low-income

peers to experience domestic violence and sexual violence, which A. Smith(2007) claims can destroy a person's sense of her own humanity.

A huge stressor on low-income women is that they have practically no power to change their circumstances, yet they are blamed by mainstream society for their concentration among the poor (Gunawardena, 2009). The American narrative is that we can work hard and get ahead, but with wages not keeping up with cost of living and the social safety net deteriorating, this is not the case for low-income women (Ehrenreich, 2001). Women having no opportunity to change their circumstances and not having power over the direction of their lives leads to extreme feelings of powerlessness (Goodman et al., 2010). This feeling of powerlessness is a precursor to depression and substance abuse (Goodman et al., 2010).

There are myriad stressors in low-income women's lives and they have practically no opportunities to better their circumstances. Therefore, it is little wonder that they disproportionately report symptoms of depression and anxiety, and often abuse substances as a way of coping.

The Inadequacies of the Existing Mental Health Care System for Low-Income Women

Structural Inadequacies

Even though low-income women have depression and anxiety at a far higher rate than the general population, most of them do not receive mental health care treatment. There are several ways in which the existing mental health care system is structured that inhibit low-income women's access to care.

If a woman decides that she wants to get treatment, many of the same stressors that contribute to her mental illness in the first place also keep her from accessing treatment: cost, lack of child care, and lack of transportation (Anderson et al., 2006). Many women do not have

health insurance or, if they do, they have to navigate the complicated health insurance system in order to get eligibility for care; and, because knowledge of how to navigate these systems is often class-based, low-income women tend to be the least able to advocate for themselves in that area. On top of all of the day-to-day difficulties of being low-income, "seeking treatment might seem like just one more burden" for women (Anderson et al., 2006, p. 972).

Living in a low-income community also contributes to the difficulty for a woman to access care because there is a lack of providers in those areas (Chow et al., 2003). Lack of providers in the immediate area makes lack of transportation a larger problem and means more time to leave children alone or in someone else's care. In part due to the lack of local providers, the vast majority of low-income women seeking mental health care only do so when they are in crisis, at which point they go to public hospitals or mental health crisis centers (Chow et al., 2003). Low-income women living in rural communities have a particularly hard time accessing care because there are simply not providers in rural areas (Rosen et al., 2004; Kazdin & Blase, 2011).

Functional Inadequacies

Logistical barriers alone cannot entirely account for how few women seek out care. According to Anderson et al. (2006), various perceptions about mental illness and mental health care workers probably accounts for that difference. One type of perception is women not seeing themselves as mentally ill. Therefore, they do not see the need to seek mental health care treatment. In one study by Rosen et al. (2004)of both white and black women receiving welfare in an urban Michigan county, of the women who had a mental health disorder (24.7% of 2379 women), 60% of those women did not see themselves as having a mental illness or substance abuse problem.

According to Brooks (2002), people in poor communities often think that mental health problems are something that rich people have; it is not part of the culture of low-income communities to seek out mental health care. This culture of not seeking out mental health care may stem from several factors.

First, while most low-income women see their distress as a result of their difficult life circumstances, the mental health system uses a framework in which extreme experiences of distress are evidence of an illness (Anderson et al., 2006). Therefore, it is no surprise that low-income women think that a system that would diagnose them with an illness and be given therapy and medication would be relevant to them (Anderson et al., 2006). To an extent, the perception that the mental health system's approach to treatment is not relevant to low-income women's lives is accurate. Psychologists have been generally focused on sick care rather than addressing the underlying equalities that affect these women's lives. Also, those sick care treatments have been designed to serve middle-class people, whose lives are significantly different from the lives of people living in poverty (Ali, Hawkins, & Chambers, 2010).

This is not to say that low-income women do not need individual therapy to talk through issues just as much as everyone else. According to L. Smith (2010), it would be classist to assume that low-income people don't need talk therapy just as much as everyone else; in addition to the poverty-related stress, they are people with feelings they need to process and issues they need to work through.

In addition to mental health workers not understanding or incorporating the realities of being low-income, they similarly often do not understand or incorporate the specific needs of people of color, and low-income women are disproportionately women of color (Gunewardena, 2009). Multiple studies have shown that cultural barriers influence the effectiveness of care

(Kazdin & Blase, 2011), yet current providers do not match the ethnic and cultural characteristics of the populations who need care, including low-income women of color. Even though some interventions are just as effective when clients and providers do not have the same cultural or ethnic background, research has shown that a cultural or racial match can potentially affect the outcome of the therapy. Additionally, the lack of people who understand their cultural values may keep distressed people from seeking or continuing to receive care because of a perception that therapists from a different cultural or ethnic background will not understand the woman's experiences and feelings (Kazdin & Blase, 2011). hooks (2005) supports this claim when she says that members of black communities often do not go to psychologists because psychologists do not understand or incorporate issues related to the black experience. The perception that mental health care is for white people goes so far that African-Americans pridefully claim that African-Americans do not have mental illness at all; mental illness is one of white people's weaknesses (hooks, 2005).

As has been true throughout the history of clinical psychology and mental health workers interacting with low-income people, mental health workers continue to interface most with low-income women in a punitive context or in a way that associates it with other systems of structural violence. This association could potentially make women less likely to seek out mental health care. For instance, as mentioned earlier, many low-income women come in contact with social workers who, as low-income women often see it, threaten to take away their children (Brooks, 2002). Also, low-income women's mental illness is often only recognized when it is connected to committing a crime. For instance, substance abuse is often related to dealing with multiple stressors and ways of coping with depression/anxiety, and is common among poor people (Rosen et al., 2004), yet low-income women with substance abuse problems are most likely going to be

identified through the criminal justice system when they are convicted of drug-related crimes. However, the purpose of that system, although often stated to be rehabilitation, rarely does substantive substance abuse treatment (Scully, 2002). Even when women have been convicted of drug-related crimes, few of them receive treatment for their addiction (King & Mauer, 2002, p. 9). Only a fraction of mental health care workers are part of the criminal justice system, yet, because prisons are marketed as places for rehabilitation – they are even called "correctional facilities" – low-income women could easily associate them with mental health caregivers in general. As either being perceived as part of often harmful structures or actually participating in them, psychologists have not shown themselves to be committed to the wellbeing of marginalized groups, including low-income women. Both structural barriers – not being able to afford or access care – and functional barriers – not trusting mental health care workers or not thinking that mental illness is relevant to their lives – keep women from receiving adequate mental health support.

There have been many public policy approaches to try to overcome barriers to access; everything from encouraging providers to move to rural areas, to having mental health care services covered under insurance policy on par with other health care, to trainings for psychologists on working with multicultural populations. Even if all of the perceptions were addressed, the psychological establishment still doesn't address huge portions of women's lives – instead, it is set up in such a way as to see a woman's problems as being strictly her own, and treating her accordingly by having her address her own ways of thinking or behaving.

Individual Therapy Cannot Eliminate Mental Illness in Society

Even for people for whom the system has been set up – people who experience less structural violence than low-income women – the system will not ever work; there will never be

enough mental health care workers to meet the needs of all the people experiencing mental illness. Leading psychological scientists are just starting to realize and speak up about how the field needs to be restructured in order to better reach more people with fewer providers, which will mean breaking away from conventional practices and using many more types of preventative care that promote mental wellness rather than only sick care.

According to Kazdin and Blase (2011), Kazdin being one of the leading thinkers in Psychological Science (R. Hancock, personal communication, September, 2013), if psychologists continue to hold so strongly to the sick-care, individual-therapy model, there will never be enough providers for all of the people who are experiencing mental distress. Therefore, it would be advantageous not only for low-income women, but for all people, for mental health care providers who are committed to creating a more mentally healthy society to broaden their definition of care.

According to Kazdin and Blase (2011), approximately one quarter of the U.S. population has a psychiatric disorder in a given year, and that is only counting people who meet all the criteria for a mental disorder; there are many people who experience dysfunction or distress who are below the threshold for diagnosis. Therefore, more than one quarter of the U.S. population is suffering from mental distress every year. However, currently there are only 700,000 total mental health care professionals in the United States, and they are near capacity while treating the 32.9% of people with a diagnosable disorder who are currently in treatment. Even if the mental health professional workforce doubled, Kazdin and Blase (2011) point out, that would not meet the need of all of the people with diagnosable mental health issues, and that solution completely ignores people with subthreshold illnesses. It would also be exceedingly difficult to double the workforce. It is unclear whether the economy could support that many mental health care

workers.

Even if the economy could support them, mental health care workers are not evenly distributed in different communities; they are focused in affluent, urban areas. Therefore, having more providers would not be enough. There would need to be incentives for mental health professionals to work in underserved areas (Kazdin & Blase, 2011). Finally, Kazdin & Blase argue that the demographics of providers would have to drastically change in order to provide adequate care to an increasingly diverse population.

Individually, these problems are extremely difficult if not impossible to overcome. Collectively, however, Kazdin and Blase (2011) claim, these barriers are insurmountable. Therefore, they argue that psychologists and other mental health care providers must broaden their approach to mental health care, breaking from the sick-care model and branching into preventative care. They also claim that many interventions need to be developed that do not require that people be in one-on-one interactions with providers. Instead, they call for more research for treatments that can better reach larger numbers of people. By doing this, Kazdin wields his position in the field to challenge the conventional model of mental health care.

Potential Alterative Models of Care

As Kazdin and Blase (2011b) point out, there can be no single solution to make everyone mentally healthy, either at the prevention or treatment levels. Therefore, mental health care professionals need to start employing a much wider variety of tools than individual talk therapy. An ideological shift in the delivery of mental health care to "reduce the burden of mental illness," (p. 21), as Kazdin and Blase (2011a) put it, could mean more institutionally legitimized pathways to improving the mental health of low-income women.

Both mental health care workers and low-income women themselves are already taking

action to try to improve the mental health care of low-income women. What follows is a brief summary of some of the models of care that have been developed for low-income women, and how those models do or do not fit in with Kazdin and Blase's vision of a new mental health care system. How Kazdin and Blase's theory can be expanded to support low-income women will also be explored. The hope is that if psychologists can break out of their narrow approach to mental health care, as Kazdin and Blase suggest, they can do so in such a way that does not leave out the specific needs of low-income women.

One of the largest potential points of disagreement between psychological scientists and people who are already working to meet the needs of low-income women is an ideological difference: there is a huge push within psychological science for evidence-based treatments, meaning treatments that have been empirically studied and shown to be effective (Kazdin & Blase, 2011). What is considered legitimate research varies on a spectrum between people who think that only randomized controlled trials can erase confounding variables and show that the treatment actually works, to people who believe that qualitative accounts are just as valuable (Schneider 1998). In terms of how this philosophical divergence affects low-income women, proponents of quantitative evidence-based practices claim that non-empirically tested treatments could just as likely be doing harm instead of good. Therefore, they argue, if low-income women have less access to empirically tested treatment that wealthier people, that is a form of classism and malpractice (Kazdin & Blase, 2011a). However, others would argue that this narrow definition of scholarship leaves out many potential solutions and is often linked to the qualifications of the people doing the research, thus maintaining a system in which marginalized people will never be able to speak up for themselves. Additionally, empirical studies have the potential to erase individual differences and the specific needs of marginalized people. Settling

this conflict is far beyond the scope of this investigation, but will have to be resolved in some way so that all effective interventions to improve low-income women's health can be connected together to create a large toolbox of interventions in order to reach all low-income women. What defines "effective" will have to be determined elsewhere. However, the bottom line is that low-income women's experiences cannot be marginalized – treatments have to be effective for them. When psychologists tell marginalized people that what those people are doing is "wrong," they risk going down the same path of maintaining structural violence against those people.

Because no single approach can reach all people and effectively deal with all types of mental illness, Kazdin and Blase's (2011b) plan recommends that psychologists develop a "portfolio of models" of mental health care delivery that would increase both "the proportion and diversity of individuals reached with effective interventions" (p. 507). First, they address how conventional therapies can be adapted to be wider-reaching and then they propose new approaches to care that can reach a larger swath of people. Kazdin and Blase focus the most on treatment options rather than prevention strategies because most existing research is in that area.

For decades, the guiding questions for therapists when developing treatment for an individual has been: "What treatment, by whom, is most effective for this individual with that specific problem and under which set of circumstances (Paul, 1967, p. 111)" (Qtd.in Kazdin and Blase 2011b).

However, for the sake of reaching the most people, Kazdin and Blase (2011b) say that although the cultural background of both the therapist and the client moderates the effectiveness of treatment, they intend to focus on developing treatments with robust main effects that can reach the largest number of people. Although it makes sense from a numbers perspective, this approach has the potential to erase the needs of marginalized people such as low-income women

because, when solutions for all people are developed, the specific needs of marginalized groups are often left out (Smith, 2005; Lorde, 1984; Baca Zinn & Thornton Dill, 1996). In order to make sure that interventions help low-income women, they and other marginalized people must be centralized in the testing of the effectiveness of treatments; historically, therapy trials have been done on more privileged people.

Instead of creating more general approaches that work for everyone like Kazdin and Blase suggest, some therapists and laypeople are developing interventions for low-income women that specifically meet the needs of low-income women. One way of doing this is to tailor a program to low-income women by adapting evidence-based treatments for specific populations by working with the women to find how out how to make the treatment most compatible with their culture and class status (Le et al., 2010).

Beyond simply tailoring otherwise-conventional treatments, some therapists have begun incorporating confronting structures of oppression, such as gender, race, and class in American culture, in their treatment. For instance, Weintraub and Goodman (2010) have worked on a technique called Relationship Centered Advocacy (RCA). RCA is based on the principal that emotional and economic difficulties are inextricably linked, and therefore must be addressed together. In RCA, the therapist centralizes the relationship between herself and the low-income woman she is working with. Then, the therapist gives emotional and instrumental support. For instance, in addition to talking to a woman about her feelings, a therapist doing RCA might also help a woman fill out an application for a government-subsidized cell phone so the woman can receive calls from potential employers, or help a woman know her rights regarding her lease.

All of these are variations on the traditional therapy model. However, Kazdin and Blase(2011a) offer suggestions for other treatments that entirely break from the traditional

therapy model. Some of these treatments could be useful to low-income women. First, Kazdin and Blase talk about promoting mental wellness through entertainment like television, which has been successful in reducing the rate of HIV transmission in some communities. Another approach that they suggest is to train non-therapists such as teachers and community-members to administer interventions; that would in part deal with the provider shortage. Kazdin and Blase do not suggest that non-therapists would replace professional therapists, but rather that the work of those people would be another tool in the multi-tiered approach to reducing mental illness for everyone. This approach could be particularly helpful for low-income women because therapists often do not understand the main stressors in low-income women's lives, and would reach many women who would not be able to access care otherwise. Kazdin and Blase (2011a) emphasize that one of the main benefits of this approach is that it allows for varying amounts of contact between the non-therapist who is administering the intervention and a therapist.

There is a history of low-income women and women of color gathering together to care for each other's mental health through sharing of strategies and lending emotional support (hooks, 2005). Because of distrust of the mental health care system, many black women also look to literature such as Alice Walker's *The Color Purple* for support. *The Color Purple* tells the story of a poor black woman who faces incredible obstacles in her early life, but eventually builds a good life for herself (hooks, 2005). Incorporation of literature which speaks to the experiences of low-income women could be another powerful therapeutic tool to incorporate in the multi-tiered approach to wellness.

Another approach to improving low-income women's mental health is to build better communities. Community stress has been found to detrimentally affect low-income women's mental health (Gapen et al. 2011) However, community cohesion has a moderating effect on

neighborhood disadvantage and psychopathology (Gapen et al., 2011). That is to say, when a woman believes in the strength of her community more, she is less likely to exhibit signs of psychopathology. Similarly, social ties seem to work against PTSD symptoms and similar effects of neighborhood disorder. This suggests the possibility for interventions that build community cohesion and social ties within communities.

As approaches to treatment move further away from being conventional psychotherapeutic practices, they more closely resemble changes to public policy. Kazdin (2011b) acknowledges that multiple fields will need to work together to reduce the burden of mental illness. However, he does not go so far as to call on psychologists to advocate for public policy that supports mental wellbeing, even though many of the stressors that lead to mental illness directly stem from poor public policy. Addressing public policies such as supporting women's right to terminate pregnancies, supporting a higher minimum wage, and ending the dismantling of the welfare system would all do good for the mental health of low-income women. Of course, those claims need to be tested empirically, but that is the job of psychologists, so they should test it.

It could be argued that this kind of social justice related work to address structural inequalities is not the job of clinical psychologists and other mental health care workers. However, if psychologists are going to take preventative actions to reduce the burden of mental illness, it would make sense for them to go to the source of many of those illnesses: structural violence against marginalized people. Psychologists have the skills to do effective research to determine what societal changes improve people's emotional well-being. To do that kind of research, clinical psychologists and social psychologists will have to work closely together.

As psychologists work to develop new interventions to reduce the burden of mental

illness, they will hopefully, in addition to recognizing public policy as within their domain, also listen to the needs of the people who are currently not receiving adequate care such as low-income women. Whether psychologists talk to women and use what the women say as the direct basis for developing treatment or the psychologists use those conversations to better develop empirical research questions, the women whose lives will be affected need to have a voice. Many low-income women have known that their distress was a result of their circumstances for a long time, while psychologists are only starting to incorporate that reality into treatments. A lot of the time, women know what they need.

Mental Wellness as Political Resistance

Audre Lorde (1988), a black, lesbian feminist valued her mental health because she saw it as a form of resistance. She said "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare."

In this society, structural violence creates extreme stressors for low-income women and women of color. The mental illness that results from that stress can be seen as an extension of that structural violence. After all, women who are struggling with mental illness will be less capable of advocating for themselves and their rights in society. Therefore, low-income women need to support each other and develop practices to try to keep themselves mentally healthy. By keeping themselves sane, they resist oppressive structures.

It is possible that psychologists will institute more preventative mental health care, and some of that mental health care may be about addressing structural violence. However, communities cannot, and have not, waited for psychologists to come and get them out (hooks, 2005). Communities continue to organize to keep themselves safe and sane, and to look out for themselves when no one else has. If mental health care workers come to work side by side with

low-income women to change public policy in such a way as to dismantle oppressive structures, hopefully those mental health care workers can work with low-income women as allies, rather than as caregivers or protectors.

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