

# MENTAL HEALTH AND ECONOMIC LEVEL

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October 10, 2025

## RECOMMENDED CITATION

mohammad looti (2025). *MENTAL HEALTH AND ECONOMIC LEVEL*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=41067>

## MENTAL HEALTH AND ECONOMIC LEVEL

**Primary Disciplinary Field(s):** Socioeconomic Studies, Clinical Psychology, Community Mental Health, Industrial Relations

### 1. Core Definition

The concept of **Mental Health and Economic Level** addresses the crucial need for specialized therapeutic interventions tailored to the socioeconomic status (SES) of patients. Historically, most established methods of psychotherapy were developed by and for the middle class, failing to resonate or prove effective when applied directly to individuals from low-income or working-class backgrounds. This realization spurred a critical movement in community mental health--championed by institutions like the National Institute of Labor Education and the William Alanson White Institute--to recognize that effective treatment necessitates acknowledging external, physical, and situational factors that dominate the lives of those at the lower end of the economic scale, rather than solely focusing on internal, emotional, and historical dynamics.

This specialized approach is particularly vital given the expansion of **community mental health centers**, which aim to broaden treatment opportunities for underserved populations. Failing to adapt the therapeutic style often leads to high dropout rates among blue-collar workers, who frequently view traditional analytic approaches as "uncongenial." The core definition therefore revolves around shifting the therapeutic frame from internal self-exploration to **immediate symptom relief**, behavioral change, and practical, concrete solutions delivered within a relationship that the patient perceives as more direct and authoritative, often resembling a physician providing tangible advice.

### 2. Historical Context: Recognizing Socioeconomic Disparities in Treatment

Prior to widespread recognition in the mid-20th century, individuals from low-income communities were often neglected by the formal mental health system. **Blue-collar workers** typically received care only after serious disorders or dire emergencies materialized, leading to their relegation to under-resourced city and state institutions. The established psychoanalytic model, dominant in middle-class clinics, proved largely inaccessible and ineffective for this demographic, resulting in quick disengagement and high rates of attrition from therapeutic programs.

The push for differential treatment methodologies gained traction as psychologists and social workers, particularly those associated with union health centers, began documenting the systemic failure of traditional therapies to meet the needs of working-class clients. Key figures, such as Riessman (1964), emphasized that effective intervention required therapists to not only adapt specific techniques but also become deeply familiar with the **goals, hopes, traditions, and**

**general style of life** of low-income populations. This recognition demanded a fundamental shift in institutional procedures, including the simplification and postponement of extensive intake processes to provide immediate, cathartic, and supportive service, satisfying the client's need for a down-to-earth approach and providing valuable diagnostic material to the clinician.

### 3. Differential Therapeutic Models: Middle-Class vs. Low-Income Clients

Significant differences exist in the way middle-class and low-income clients conceptualize the causes, expected processes, and goals of therapeutic treatment. Understanding these divergent perspectives is fundamental to designing effective interventions:

#### Middle-Class Therapeutic Model

**Perceived Cause of Problem:** Internal, emotional, and rooted in relationships that often trace back to childhood experiences.

**Primary Techniques:** Verbal methods such as discussion, **free association**, and other analytic verbal methods.

**Goal of Therapy:** Self-understanding, personality growth, and deep insight into unconscious motivations.

**Therapist Role:** Neutral facilitator guiding self-discovery and interpretation.

#### Low-Income Client Expectations

**Perceived Cause of Problem:** External, physical, and stemming from present situational stressors (e.g., job instability, financial stress), often believing the problem is physically caused.

**Preferred Techniques:** Concrete directions, practical solutions, home visits (over formal office settings), and techniques utilizing **physical activity** or social intercourse.

**Goal of Therapy:** Elimination of immediate symptoms, production of specific changes in behavior, and improvement in perceived physical health.

**Therapist Role:** A physician or authority figure providing expert advice and concrete actions; too much talk or analysis is often confusing and repellent.

### 4. Specialized Techniques for Low-Income Patients

To bridge the gap between traditional treatment and client expectations, specialized techniques were developed focusing on action, group interaction, and the utilization of community resources.

These methods satisfy the low-income client's need for an immediate, down-to-earth approach and maximize engagement:

**Role-Playing and Action Methods:** This approach centers around the patient's specific, present-day problems, allowing them to express themselves openly in an informal setting. Long popular in labor union educational programs, **role-playing** is well-suited to clients who prefer group interaction and tangible behavioral rehearsal over abstract discussion, fostering closer rapport with the therapist.

**Use of Indigenous Nonprofessionals (The Helper Principle):** Utilizing nonprofessional auxiliaries drawn from the client's own background creates a vital connection between the typically middle-class therapist and the client's home life and culture. This "**helper principle**" establishes trust, aids in case coordination, and validates the client's experience within the community, acting as an essential cultural broker.

**Personality Adjustment Through Social Action:** As noted by Wittenberg (1948), encouraging involvement in structured, purposeful activities--such as **labor unions**, block committees, hobby groups, or religious organizations--provides low-income individuals with external strength to manage psychological difficulties. This strategy reduces dependence on the therapist by building community support and a sense of efficacy, giving them concrete avenues for handling stress.

**Auxiliary Physical Treatments:** Integrating physical treatments is crucial for acceptability and efficacy because low-income clients frequently believe their problems have physical causes. Treatment plans therefore often include medication (e.g., **tranquilizers**), prescribed diets, or muscle relaxation exercises, aligning the intervention with the client's expectation of receiving medical care for a physical ailment, which provides psychological benefit.

## 5. Union-Based Mental Health Initiatives: Case Studies

Industrial and labor organizations have been at the forefront of implementing these specialized mental health services, recognizing the direct link between worker well-being and job performance. These programs prioritize accessibility, immediate service, and practical outcomes for their members.

### The Hillman Health Center Project (Amalgamated Clothing Workers of America)

This pioneering venture, supported by grants from the National Institute of Mental Health (NIMH) and the Vocational Rehabilitation Administration (Wiener, 1966), focused on **preventive medicine**, aiming to enable disturbed workers to maintain employment while receiving treatment. The project yielded several findings crucial for outreach and retention. Firstly, the union health insurance department proved to be an effective case-finding source, flagging workers who frequently stayed

away from their jobs due to emotional issues. Secondly, the **union business agent**--a respected figure in direct touch with the worker and the job environment--was identified not only as a logical source for referrals but also as a constructive member of the clinical team, ensuring consistency and support in both the workplace and the clinic.

The project found that patient adherence was significantly higher when they were properly prepared for referral and when the referring agent maintained a working relationship with the clinic. Furthermore, successful treatment for the great majority of cases required short-term intervention, often involving less than three months of treatment and fewer than eight face-to-face interviews. Crucially, the program emphasized **immediate scheduling** for the patient, even if the first meeting was brief, fulfilling the client's need for prompt, decisive action.

### The Union Therapy Project (William Alanson White Institute)

Organized in 1963, this New York City project specifically addressed the scarcity of outpatient treatment for **blue-collar workers**. Thirteen graduates of the Institute contracted with United Auto Workers Local 259 (UAW) to provide therapy and social work hours in the evenings at a nominal fee covered by the union welfare fund. The initial phase focused heavily on educating union members to destigmatize mental health treatment, actively combating the prevailing idea that seeking help meant the patient was "psycho" or "nuts." Discussions were held at union meetings and articles were placed in the local's newspaper to normalize the service.

The therapeutic model employed was a **short-term, modified analytic approach** designed to be highly flexible and adapted specifically to blue-collar values and outlooks. It minimized probing into the unconscious and, reflecting the collectivist nature of the client's life, frequently involved family members in group sessions rather than treating the patient alone. Regular seminars were held at the Institute to refine approaches. Similar to the Clothing Workers Project, **shop stewards** emerged as the chief case-finders, leveraged for their trusted position within the workforce to spot trouble in its early stages.

## 6. Outcomes and Limitations of Short-Term, Action-Oriented Therapy

The treatment goals within programs catering to low-income populations are intentionally limited and focused on achieving rapid improvements that stabilize the patient's functional capacity, particularly regarding employment and family life. These goals are distinct from the expansive, long-term self-exploration models traditionally used in middle-class therapy.

The **primary goal** is to effect changes in specific behaviors and attitudes that alleviate immediate suffering and allow the client to maintain social functioning. For example, in the case of Mrs. R., the objective was stabilization through medication and brief, focused counseling, enabling her to return to work parity by addressing her immediate feelings of paranoia and guilt. The effectiveness is

measured by the speed of intervention (seeing the patient immediately), the brevity of treatment (under eight sessions often being sufficient), and the ability of the client to resume or maintain their job responsibilities.

A recognized limitation of this action-oriented model is that it typically does *not* involve the deep **reconstruction of the personality** or extensive exploration of complex, historical trauma. However, given the situational severity and socioeconomic pressures faced by the client population, the immediate objective of functional stability and symptom reduction remains the paramount and most ethical treatment goal, preventing further deterioration and institutionalization.

### Further Reading

[Community Mental Health Service \(Wikipedia\)](#)

Riessman, F. (1964). *New Approaches to Mental Health Treatment for Low-Income People*.

Wiener, L. (1966). *Project on Preventive Medicine in the Amalgamated Clothing Workers*.

Wittenberg, R. M. (1948). *Personality Adjustment Through Social Action*.

[William Alanson White Institute Wikipedia Entry](#)