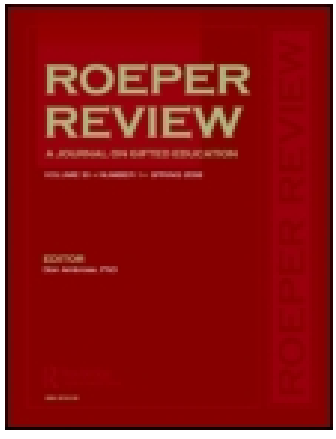

Roeper Review
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uror20

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American Psychological Association
Published online: 20 Jan 2010.

To cite this article: American Psychological Association (2003) Resolution on poverty and socioeconomic status, Roeper Review, 25:3, 103-105, DOI: 10.1080/02783190309554209

To link to this article: http://dx.doi.org/10.1080/02783190309554209

Resolution on Poverty and Socioeconomic Status

Adopted by the American Psychological Association, August 6, 2000.

WHEREAS, the income gap between the poor and the rich has continued to increase, with the average income of the poorest fifth of the population down 6% and the average income of the top fifth up 30% over the past 20 years (Bernstein, McNichol, Mishel, & Zahradnik, 2000);

WHEREAS, the poverty rate in the United States is higher now than in nearly all years of the 1970s, child poverty (at 18.9% in 1998, representing 13.5 million children) continues to be higher here than in most other industrialized nations, and the proportion of the population living below the poverty line in 1998 was 12.7% (representing 34.5 million people) (Center on Budget and Policy Priorities, 1999; U.S. Census Bureau, 1999);

WHEREAS, although Whites represented the largest single group among the poor in 1998, ethnic groups were overrepresented, with 26.1% of African Americans, 25.6% of Hispanics, 12.5% of Asians and Pacific Islanders, and 31% of American Indians on reservations living in poverty (National Congress of American Indians, 2000; U.S. Census Bureau, 1999), compared with the 8.2% of Whites who were poor;

WHEREAS, families* with a female head of household had a poverty rate of 29.9% in 1998 and comprised the majority of poor families (U.S. Census Bureau, 1999);

WHEREAS, the Task Force on Women, Poverty, and Public Assistance of the APA Society of the Psychology of Women (Division 35) has documented from the social sciences research literature the root causes of poverty and its impact for poor women, children, and their families, and called for a more effective public policy founded on this research base (Division 35 Task Force on Women, Poverty, and Public Assistance, 1998);

WHEREAS, poverty is detrimental to psychological well-being, with NIMH data indicating that low-income individuals are 2 to 5 times more likely to suffer from a diagnosable mental disorder than those of the highest SES group (Bourdon, Rae, Narrow, Manderschild, & Regier, 1994; Regier et al., 1993), and poverty poses a significant obstacle to getting help for these mental health problems (McGrath, Keita, Strickland, & Russo, 1990);

WHEREAS, accumulating research evidence indicates that the greater the income gap between the poorest and the wealthiest in a society, the higher the death rates for infants and adults and the lower the life expectancy for all members of that society, regardless of SES (Kawachi & Kennedy, 1997);

WHEREAS, the impact of poverty on young children is significant and long lasting, limiting chances of moving out of poverty (McLoyd, 1998), poverty is associated with substandard housing, homelessness, inadequate child care, unsafe neighborhoods, and underresourced schools (Fairchild, 1984; Lott & Bullock, in press), and poor children are at greater risk than higher income children for a range of problems, including detrimental affects on IQ, poor academic achievement, poor socioemotional functioning, developmental delays, behavioral problems, asthma, poor nutrition, low birth weight, and pneumonia (Geltman, Meyers, Greenberg, & Zuckerman, 1996; McLoyd, 1998; Parker, Greer, & Zuckerman, 1988);

WHEREAS, environmental factors such as environmental contaminants (e.g., lead paint, etc.), crowding, substandard housing, lack of potable water, and so forth have detrimental effects on mental and physical development that perpetuate and contribute to poverty;

WHEREAS, low socioeconomic status is associated in women with higher mortality rates and with osteoarthritis, hypertension, cervical cancer, coronary heart disease, AIDS/HIV infection, and other chronic health conditions (Adler & Coriell, 1997), and poor women are sicker and more likely to have disabilities than their nonpoor counterparts, limiting their employment options and straining their financial resources (Falik & Collins, 1996; Olson & Pavetti, 1997);

WHEREAS, men living in poverty are at high risk of violence (Reiss & Roth, 1993) and women living in poverty are at high risk of all types of violence, including sexual abuse as children, with researchers documenting reports by two thirds of poor mothers of severe violence at the hands of a childhood caretaker and by 42% of child sexual molestation (Browne & Bassuk, 1997), as well as severe and life threatening assaults as adults (Bassuk, Browne, & Buckner, 1996; Brooks & Buckner, 1996; Colten & Allard, 1997; Roper & Weeks, 1993), which presents obstacles to work and self-sufficiency (NOW Legal Defense and Education Fund, 1997; Raphael, 1996);

WHEREAS, lack of affordable health insurance, including mental health and substance abuse coverage, impedes health and well-being, and poor women are over 3 times as likely as higher income women to be uninsured: 36% versus 11%, respectively (National Center for Health Statistics, 1995);

WHEREAS, children of teenage pregnancy and single motherhood are at high risk for a life of poverty, and birth control is not covered by health insurance plans for a significant number of women;

WHEREAS, older adults often live on limited retirement incomes, have limited prospects for future earnings, and frequently face overwhelming health care costs; 13% of older women and 20% of older persons living alone or with nonrelatives in 1998 lived on incomes below the poverty level; and 49% of older African American women living alone lived in poverty in 1998 (U.S. Census Bureau, 1999, cited in U.S. Administration on Aging, 1999);

WHEREAS, lower socioeconomic status among older adults is associated with higher rates of medical and psychological disorders, poor older adults have poorer access to medical care, prescription medications, long-term care, and community-based care (Estes, 1995), and Medicare funds mental health care at a lower rate than medical care, and this further limits the access for older adults in poverty to mental health and substance abuse services;

WHEREAS, migrant families are by the nature of their work and life circumstances poorly served by health and mental health professionals (Portes & Rumbaut, 1996; Wilk, 1986);

WHEREAS, undocumented immigrants are vulnerable to legal actions that inhibit their access to health and mental health services, compounding issues of poverty and limited English language proficiency (Olivera, Effland, & Hamm, 1993);

WHEREAS, research focused on low-income groups including immigrants, ethnic minorities, minimum wage workers, families receiving public assistance, the homeless, migrant workers, and older women is limited;

WHEREAS, low-income groups are the targets of discrimination based on their socioeconomic status as well as other social indicators such as race/ethnicity and gender (Lott, in press);

WHEREAS, perceptions of the poor and of welfare – by those not in those circumstances — tend to reflect attitudes and stereotypes that attribute poverty to personal failings rather than socioeconomic structures and systems and that ignore strengths and competencies in these groups (Ehrenreich, 1987; Katz, 1989; Quadagno, 1994), and public policy and anti-poverty programs continue to reflect these stereotypes (Bullock, 1995; Furnham, 1993; Furnham & Gunter, 1984; Rubin & Peplau, 1975);

WHEREAS, programs that ensure that poor individuals and families have basic needs met are important in addressing the impact of poverty;

WHEREAS, ethnic strife and war disrupt the economic, public health, and social systems comprising the safety net that helps ensure basic needs are met;

WHEREAS, psychologists as researchers, service providers, educators, and policy advocates have a responsibility to better understand the causes of poverty and its impact on health and mental health, to help prevent and reduce the prevalence of poverty and to effectively treat and address the needs of low-income individuals and families by building on the strengths of communities;

WHEREAS, psychologists are ethically guided to "respect the fundamental rights, dignity, and worth of all people" (American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, 1992);

WHEREAS, "psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live" (American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, 1992);

THEREFORE, Be it resolved that the American Psychological Association:

1. Will advocate for more research that examines the causes and impact of poverty, economic disparity, and related issues such as socioeconomic status, classism, ageism, unintended pregnancy, environmental factors, ethnic strife and war, stereotypes, the stigma and feelings of shame associated with poverty, and mental and physical health problems, including depression, substance abuse, intimate violence, child sexual abuse, and elder abuse, as well as advocate for the broader dissemination of these research findings.
2. Will advocate for more research on prejudicial and negative attitudes toward the poor by other persons who may individually or collectively perpetuate policies that tolerate poverty and social inequality.
3. Will advocate for more research on special populations who are poor (women and children, immigrants, undocumented immigrants, migrants, ethnic minorities, older people, people with disabilities and other chronic health conditions such as AIDS/HIV infection, and rural and urban populations).
4. Will advocate for research that identifies and learns from indigenous efforts by low-income people to work together to solve personal and shared problems or create organizations that advocate effectively for social justice.
5. Will recommend that where possible and appropriate socioeconomic status be identified for published reports of social sciences research.
6. Will advocate for incorporating evaluation and assessment tools and for encouraging integrative approaches such as the building of public and private community partnerships in programs addressing the issue of poverty and the poor, which psychological research has identified as effective strategies for addressing community level issues and problems.
7. Will encourage in psychological graduate and postgraduate education and training curricula more attention to the causes and impact of poverty, to the psychological needs of poor individuals and families, and to the importance of developing "cultural competence" and sensitivity to diversity around issues of poverty in order to be able to help prevent and reduce the prevalence of poverty and to treat and address the needs of low-income clients.
8. Will support public policy that encourages access for all children to high-quality early childhood education and a high-quality public school education, better equipping individuals for self-sufficiency.
9. Will support public policy that ensures access to postsecondary education and training that allows working families to earn a self-sufficient wage to meet their family's needs.
10. Will support public policy and programs that ensure adequate income, access to sufficient food and nutrition, and affordable and safe housing for poor people and all working families.
11. Will support public policy that ensures access to family-friendly jobs offering good quality health insurance, including coverage for comprehensive family planning,

mental health and substance abuse services, flexible work schedules, and sufficient family and medical leave.

12. Will support public policy that ensures access to comprehensive family planning in private and public health insurance coverage.
13. Will support public policy that ensures parity with medical coverage for mental health and substance abuse services under Medicare and Medicaid and ensures for all individuals, regardless of ability to pay, access to health care and mental health and substance abuse treatment that is comprehensive and culturally sensitive, that accommodates the needs of the children of parents seeking treatment, and that addresses the special needs of older adults in poverty, including prescriptions and long-term care.
14. Will support public policy that encourages access for all children to high-quality early health care.
15. Will support public policy that ensures for all working families access to affordable, high-quality child care, which is available year round, for the full day, and for all work shifts, as well as before- and after-school care.
16. Will support public policy that provides early intervention and prevention for vulnerable children and families that enhance parenting, education, and community life so that children can develop the necessary competencies to move out of poverty.
17. Will support public policy that provides early interventions and prevention for vulnerable children and families that are strengths-based, community-based, flexible, sensitive to culture and ethnic values of the family, and that have a long-lasting impact.

*The word *family* should be understood to incorporate the functions of family members rather than their biological sex or sexual orientation, for example, lesbian heads of household.

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