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# PERCEPTIONS OF WHITE THERAPISTS' SOCIAL CLASS BY WHITE CLIENTS EXPERIENCING RURAL POVERTY IN MAINE

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# PERCEPTIONS OF WHITE THERAPISTS' SOCIAL CLASS BY WHITE CLIENTS EXPERIENCING RURAL POVERTY IN MAINE

A Dissertation

submitted by

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**This dissertation, titled:**

**PERCEPTIONS OF WHITE THERAPIST'S SOCIAL CLASS BY WHITE CLIENTS EXPERIENING RURAL POVERTY IN MAINE**

**as submitted for final approval by Rebecca Roveto under the direction of the chair of the dissertation committee listed below. It was submitted to the Counseling and Psychology Division and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy Degree at Lesley University.**

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This dissertation is a post-humous love letter to two people who believed in deep study, commitment to learning and the power of using one's voice.

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## ABSTRACT

This dissertation explored the experiences and perceptions of white therapists' social class by white clients facing poverty in rural Maine. Employing an intersectional methodology rooted in Critical White Theory, Critical Theory, and the Critical Theory of Care in Nursing, the study utilized semi-structured interviews, thematic coding, and discourse analysis. The findings revealed that regional cultural values, specifically intergenerational ideals of independence, privacy, and self-sufficiency, significantly impacted clients' encounters with stigma and social exclusion. Notably, participants perceived that Mainecare's, Maine's Medicaid program, reimbursement rates influenced therapist accessibility and questioned if it was associated with a lower social class.

This study made a distinctive contribution by uncovering rural Maine's nuanced perspectives shaped by regional cultural values. Theoretical frameworks from critical white theory and discourse analysis informed the examination of Mainecare's influence on care perceptions. The intersection of racial homogeneity and poverty emerged as vital considerations for therapists. Recognizing the impact of Mainecare bureaucracy on care perceptions and acknowledging the significance of intergenerational values, therapists should be attuned to their own social class positionality. In conclusion, this research emphasized the necessity for mental health practitioners to navigate the unique socio-cultural landscape of rural areas, fostering a deeper understanding of clients' experiences and promoting more effective and culturally sensitive therapeutic practices.

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# CHAPTER I

## INTRODUCTION

In his work describing liberation psychology, Ignacio Martín-Baró (1994) identified that for people experiencing poverty, a need to meet every day basic needs forces people to stay in a "permanent psychological present" (p. 30), a psychological state of limbo, without historical context, making it impossible to both learn from experiences and know the "roots of one's identity" (p. 30). He espoused a need for the "recovery of historical memory" (Martín-Baró (1994, p. 30) which would support a capacity for expanded imagination of liberation from social-political and economic oppression. According to Freire (1970), part of the work of liberation and social/political emancipation is to give precedence to those experiencing poverty.

In contemporary American culture, poverty is often considered a personal failure and serves as foundational benchmark for constructing perceptions of social class hierarchies rooted in power dynamics (Tickamyer et al., 2017). The enduring influence of historical colonial-settler Puritanical beliefs, privileging virtues of piety, independence and hard work as means for social inclusion, are still present in the United States (Dunbar-Ortiz, 2014; Hardesty, 2019; Warren, 2016). Social class, a conduit for power hierarchies, manifests through multiple pathways, including but not limited to education, language and geographics giving rise to classism (Ballinger & Wright, 2007; Bourdieu,1986; Smith, 2010; Tickamyer et al., 2017).

Comprehending classism requires an exploration of how combined roles of poverty, power and social class contribute to subtle, often imperceptible biases, interweaving with

historical, social, political, and economic mechanisms that are frequently taken for granted, thereby placing obstacles in the paths of those experiencing poverty (Smith, 2005). Historically, psychology has been inseparable from bias that centers the socio-political-economic dominant social classes from which it has emerged (Martín-Baró, 1994; Smith, 2010). Although psychotherapy scholarship has explored the experience of therapy for people experiencing poverty for decades and multicultural scholarship and training for therapists regarding biases concerning race, gender, ableism, and sexism have increased in the past 40 years, the role of social class, as a distinct historical-cultural position, has gone largely ignored within therapeutic scholarship and training (Smith, 2005).

The link between rural poverty and mental health disparities has been extensively studied (Campbell et al., 2003; Jensen et al., 2020). In rural areas of the United States where values of independence and self-sufficiency has held significant cultural importance (Thorne & Ebener, 2020; Tickamyer et al., 2017), research has indicated that socio-political-economic structures exacerbate division, exclusion, and limit access to economic, social, and political resources, leading to social exclusion and class disparities (Shucksmith, 2012). This cultural emphasis on self-sufficiency and independence in rural locations has been associated with social exclusion and class disparities, thereby having implications for mental health (Carpenter-Song et al., 2016; Trott & Reeves, 2018). Despite this, psychotherapeutic scholarship appears to have largely overlooked the impact of social class differences between therapists not experiencing poverty and clients facing poverty in rural settings. Further, research appears to be lacking to the potential significance of clients' perceptions of their therapists' social class on experiences of therapy for this population. In rural Maine, social class hierarchies in the therapeutic setting may be obscured by white racial homogeneity.

Maine's enduring racial homogeneity, predominantly characterized by a white demographic (U.S. Census Bureau, 2020), may have contributed to the therapeutic landscape in rural areas. This homogeneity, while often overlooked, may serve to conceal the nuanced dynamics of social class systems, perpetuating oppressive structures and power imbalances between therapists and clients. Maine's racial composition was not always as homogenous as it is currently. Additionally, Maine is not exclusively white and of significant note are the populations who are not white, including four Wabanaki tribes and the five Wabanaki communities including the Mi'kmaq Nation, the Houlton Band of Maliseets, the Passamaquoddy Tribe at Motahkokmikuk, the Passamaquoddy Tribe at Sipayik, and the Penobscot Nation (Abbe Museum, 2024), various global immigrant populations and historical Black populations (U.S. Census, 2020; Hardesty, 2019; Warren, 2016).

Historical factors such as industrial decline and rural isolation have played pivotal roles in shaping its current demographic profile (Hardesty, 2019; Warren, 2016). With this history in mind, this dissertation explored the experiences and perceptions of white therapists' social class by white adults who attended therapy while experiencing poverty in rural Maine. The findings of this study not only contribute to a deeper understanding of the intersectionality of social class, poverty, and white racial homogeneity in therapeutic relationships within the unique socio-cultural context of Maine, but also offer insights to inform cultural and institutional interventions within therapy in Maine. Moreover, this research adds a critical dimension to broader scholarly discussions on the complex interplay between social class, poverty, white racial homogeneity, and mental health, opening avenues for more inclusive and effective therapeutic practices.

## Research Purpose

Research examining the education of counselors' cultural competency training is well documented and has examined how socio-political-economic and racial factors, in the form of western ideology of human development, relationships and hetero-normative family structure, are taught or omitted from counseling training and education (Baima & Sude, 2019; Lee & Bhuyan, 2013). Within this research there does not appear to be scholarship examining how poverty and social class differences in the therapeutic relationship**,** when both client and therapist are white, in rural locations**,** impact client perceptions of therapy. Although racial disparities, in both rural and urban locations, between white therapists and Black, Indigenous, People of Color (BIPOC) clients, have been shown to impact clients experiences of therapy by centering white, middle-class values of independence, western normative descriptions of human development and relationship expectations (Cook & Lawson, 2016; Lee & Bhuyan, 2013), a broad examination of rural poverty and mental health disparities shows a lack of research which centers the cultural distinction of social class in primarily white racially homogenous locations. Additionally, there is research attributing connections among race, social exclusion, social class, and depression/anxiety in rural locations (Jensen et al., 2020; Magnus & Advincula, 2021; Snell-Rood & Carpenter-Song, 2018) however, there does not appear to be research exploring how class disparities and social exclusion (Bourdieu, 1986; Shucksmith, 2012) between therapists and clients in primarily white racially homogenous locations impact clients' experience of mental health care. Specifically, research is lacking in how perceived differences in social class by clients experiencing poverty in rural locations, when both therapist and client are white, impact the experience of therapy for this population.

In rural northern New England, cultural values of independence and self-sufficiency are the norm. Within mental health scholarship, there appears to be a lack of understanding about how mental health needs of residents are in opposition to cultural norms of the region because poverty creates social exclusion and class hierarchies that impact practices of caring (Carpenter-Song & Snell-Rood, 2017; Parr & Philo, 2003). Furthermore, in Northern New England, where shared values of independence and self-sufficiency are normalized (Carpenter-Song & Snell-Rood, 2017) within white racially homogenous therapeutic settings, the impact of social class hierarchies between therapist and client has not been examined empirically.

This dissertation sought to explore the intricate dynamics surrounding social class perceptions among white clients experiencing poverty in rural Maine, within the context of their therapeutic experiences with white therapists. Although Maine is not exclusively white and of significant note are the populations who are not white, including four Wabanaki tribes and five Wabanaki communities , various global immigrant populations and historical Black populations (Abbe Museum, 2024; Hardesty, 2019; U.S. Census, 2020; Warren, 2016), the purpose of this research was to center research within primarily white racially homogenous settings in an effort to explore the perceptions of white therapist's social class by white clients experiencing poverty in rural Maine. With a lens towards social class awareness within white, racially homogenous relationships, this study sought to better understand how client perceptions of therapists' social class impact their experience of therapy in white racially homogenous therapeutic relationships in rural Maine. Additionally, the study sought to explore the influence of racial homogeneity on perceptions of social class between white clients and white therapists in the unique socio-economic landscape of rural Maine.

## Research Questions

This research was guided by the questions:

**(RQ1):** Do clients experiencing rural poverty perceive the social class of their therapist as different from their own and how does that impact their experience and acceptance of therapy? and

**(RQ2):** What role does racial homogeneity play in perceptions of social class between white clients and white therapists in rural Maine?"

Through these inquiries, this study aimed to contribute valuable insights into the intersectionality of social class, racial homogeneity, and poverty within the therapeutic relationship, and expose factors that may impact the effectiveness and reception of therapy in impoverished rural settings.

## Theoretical Framework

The theoretical structure of this research draws on critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005), and critical white theory (Clements & Mason, 2020; Nylund, 2006). A researcher who uses critical theory seeks to examine the intersections of social structures, power, and personal agency to identify social inequities and support ways to create meaningful social change (Carspecken, 1996). Researchers apply critical theory to mental health care practice by examining how social and power structures, as well as personal agency, are enacted within mental health care and utilize such examinations to identify inequities within the practice of mental health care to support change and increase equitable systems of care (Fox et al., 2009). Critical care theory in nursing (Falk-Rafael, 2005) is employed by researchers to examine the multiple ways care is given, taken and shared in medical care and espouses emancipation within medical care. When applied to mental health care, critical care theory in nursing appears to help examine how mental health

practice may be able to shift care away from a theoretical framework based on the individual and towards a practice of relational care. Within mental health research, critical white theory helps researchers examine how notions of white supremacy and white privilege are centered as normative practices and how white identity informs an understanding of social class (Nylund, 2006). This project centered on white people experiencing poverty in Maine, a population with whom little research has been carried out. Through an exploration of their lived experience in therapy, which was theoretically informed by the ways social class, whiteness and rural poverty impact people in this region, this research sought to better articulate what it means to create systems of care that move from a binary understanding of oppressed and oppressor to a relational community of care (Freire, 1970) for this population.

## Definition of Topics

This section provides a definition of key topics informing the engagement of the conceptual frameworks for this research. This section discusses accessibility, availability and acceptability, rurality, poverty, social capital, social exclusion, power and social class, and whiteness.

### Accessibility, Availability, Acceptability

The fit between services and consumers is a theme that is shown to be part of the root of barriers to mental health care for rural adults (Penchansky & Thomas, 1981). Penchansky and Thomas (1981) propose a model that focused on the concept of fit between services and consumers of health care. This model focuses on five key components: availability, accessibility, accommodation, affordability, and acceptability. Research shows that accessibility, availability, and acceptability are most prevalent when identifying barriers to mental health services for adults experiencing rural poverty, (Bischoff et al., 2014; Crumb et al., 2019; Jensen &

Mendenhall, 2018; Magnus & Advincula, 2021; Thorne & Ebener, 2020). Embedded within these themes are the issues associated with accommodation and affordability (Penchansky & Thomas, 1981). Accommodation is the extent to which clients' needs are addressed through actions that appropriately meet their needs. Affordability is how the prices of services match with the client's income, ability to pay and insurance (Penchansky & Thomas, 1981). If someone cannot afford services or if their need for childcare is not accommodated, they might not be able to access services. Although there is research about the barriers of availability, accessibility, and acceptability to mental health care, the evidence does not appear to be eliminating those barriers for services for rural poor, and holistic intervention models, based on in depth research in the area of poverty and mental health, is lacking (Jensen & Mendenhall, 2018; Myers & Gill, 2004). In addition, there is a lack of research that identifies how the social, economic, historical, and political features of a rural community create a distinct cultural landscape that impacts how these communities interact with local social service delivery systems (Carson & Mattingly, 2018).

**Rurality**

For the purposes of this study, the definition of rurality is based on definition provided by the U.S. Department of Agricultural, Economic Research Service (n.d). The U.S. Department of Agricultural, Economic Research Service (n.d.) classified *rural* areas as "open countryside, rural towns (places with fewer than 2,500 people and urban areas with populations ranging from 2,500-49,999 that are not part of large market areas)" (p. 1). One area of the United States where there is an understudied rural population is New England. Although New England has dense urban locations, 2.8 million of New England's 14.5 million population (20%) live in rural areas, while 84% of all New England land is rural (Pawlek et al., n.d.).

## Poverty

When examining how poverty creates barriers to care for residents of rural Maine, an intersectional examination of economic, social, and political barriers to meeting one's basic needs offers a comprehensive understanding of poverty. In the United States, poverty is often viewed as a position of deprivation rather than a status held in relationship to social, economic, and political structures (Tickamyer & Wornell, 2017). Within this research, the definition of poverty is not simply an economic status but rather incorporates internal and external identities of social status based on how a person maintains social capital and decreases social exclusion (Bourdieu, 1984; Smith, 2010). Poverty, therefore, is conceptualized as being a positional status which situates poverty with social class hierarchy (Smith, 2010).

To examine poverty requires a comprehensive understanding of what it means to have one's basic needs met, and, how meeting people's basic needs includes the means to liberate people from subjugation and oppression (Freire, 1970; Hong, 2015; Martin-Baro, 1994). While the federal definition of poverty determines access to public assistance, the local community's social and political values can have a strong influence on who receives care (Buck-McFadyen et al., 2018). Poverty, therefore, is experienced as an intersection of lack of income and access to resources including health care and education in conjunction with lack of access to social and political power (Tickamyer & Wornell, 2017).

## Power and Social Class

Power is the ability to want something to be different and having the socio-political-economic means to make it so (Prilleltensky, 2008). The accessibility to power rests on a person's ability to instigate personal and collective change within socio-political-economic structures, which intersect with behavioral, subjective, cognitive, and affective variables

(Prilleltensky, 2008). Access to power impacts experiences and perceptions of personal agency within socio-political-economic structures (Lott & Bullock, 2007; Prilleltensky, 2008; Smith, 2010). Within capitalist socio-economic-political structures, which privileges economic standing, power is conferred through socio-economic status and is identified through social class (Lott & Bullock, 2007). Implicit social control is exercised by social class structures, governing what is deemed normal through socio-political-economic systems like health care, education, housing, and family structure (Lott & Bullock, 2007). Within these systems, terminology associated with social class hierarchies, such as lower class, low class, and poor, serves as political discourses employed to perpetuate institutional power.

**Social Capital**

Pierre Bourdieu (1984) argued that, like economic capital, social capital maintains and reproduces power in society. He defined social capital as "the aggregate or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition--or, in other words, to membership in a group" (Bourdieu, 1984, p. 248). Bourdieu (1984) further espoused, that while multiple people hold high status within social class hierarchies, the assets that have given them status might differ between having more social capital and less economic capital and vice versa. The size of one's social network and the value of those connections determine the amount of social capital one has. Those who have social capital "regulate the conditions of access to the right to declare oneself a member of the group" (Bourdieu, 1984, p. 251). Bourdieu (1984) theorized that social positions occupied by various groups are functions of distribution of capital, namely economic and social capital, creating cultural capital which gives a person or group power and privilege. According to Bourdieu (1984), economic capital is the extent to which a person has financial

resources while social capital is specific cultural knowledge or competence held within society that is an asset. These forms of capital operate within an axis whereby social capital and economic capital meet at various coordinates, based on the volume and composition of held socio-economic assets, to form a person's social class status. Thus, this highlights how multiple people hold high status within social class hierarchies, the assets that have given them status might differ between having more social capital and less economic capital and vice versa.

According to Bourdieu (1984), groups, who share common locations within social hierarchies also share common opportunities, oppressions, values, and social customs, are *habitus*. *Habitus* identifies similarities in beliefs, values, and customs between people within a social location as being the result of being positioned within the same social location (Bourdieu, 1984). The cost of losing social capital is social exclusion (Bischoff et al., 2014; Buck-McFadyen et al., 2018). The loss of social capital in rural Northern New England is expressed through social stigma (Bischoff et al., 2014; Carpenter-Song et al., 2016). The loss of connection through exclusion (Carpenter-Song et al., 2016) can prove devastating for a rural resident in rural New England where social capital impacts how access to hierarchies of power and participation in social life occurs (Buck-McFadyen et al., 2018).

**Social Exclusion**

Although mental health treatment is increasingly normalized in the U.S., it continues to be stigmatized in rural communities (Campbell et al., 2003). Social exclusion is a key component to structures of social class and impacts access to social capital (Bourdieu, 1984). Shucksmith (2012) highlighted how social exclusion keeps oppressed individuals and groups from gaining access to social resources, creating inequality (Parr & Philo, 2003; Tickamyer et al., 2017). Exclusion of access to social resources creates socially constructed hierarchies of class and

inequality (Smith, 2010). Social exclusion appears to be deepening in some rural areas (Snell-Rood & Carpenter-Song, 2018). Social exclusion impacts the acceptability of mental health and public health services in rural locations (Buck-McFadyen et al., 2018; Magnus & Advincula, 2021). In rural locations, loss of social capital means loss of care by the community (Carpenter-Song et al., 2016). In rural northern New England, cultural values of self-sufficiency and independence are strong, and there is a stigma attached to mental health care (Carpenter-Song et al., 2016).

**Critical Whiteness and White Identity**

Whiteness is a social, political, and economic structure of power (Gallagher, 1996). White identity has emerged in the field of Identity politics (Brown, 2017; Nylund, 2006) and is a way of understanding how white people create a sense of identity and see themselves personally and in within the broader scope of society (Nylund, 2006). New England's position as "ground zero" for the colonization (Dunbar-Ortiz, 2014) differentiates it from other areas of white identity formation such as the rural south and western U.S. (Dunbar-Ortiz, 2014).

While skin color is quantifiable, whiteness extends beyond appearance or census information and is exercised through white privilege (Gallagher, 1996; Nylund, 2006). The principles of critical whiteness entail recognizing that white identity is socially constructed and learned, with no singular definition of whiteness (Clements & Mason, 2020). Critical whiteness allows for the examination of the historical formation of white identity, allowing for the dismantling of racialized identities by framing racism as a systemic issue in which individuals are both participants and implicated in complex ways (Clements & Mason, 2020). This perspective is essential for scrutinizing and challenging the norms perpetuated by white racialized identity, including white racial homogeneity, encouraging individuals to acknowledge

their roles in upholding this system. In rural New England, white, racial homogeneity saturates the social, political, economic, and racial landscapes. Maine, a predominantly rural state, is the whitest state in the nation (U.S. Census Bureau, 2020). According to the 2020 U.S. Census, New England is the whitest and oldest part of the country. Thus, exploring white racialized identity facilitates critical examination of whiteness and informs efforts to engage in anti-racist education, activism, and class consciousness (Clements & Mason, 2020).

In counseling, white identity affects how counselors provide services and what they pay attention to when providing counseling services (Nylund, 2006). Many counseling texts and trainings discuss multicultural perspectives and ways to work with particular ethnic groups but have left out any discussion of whiteness, creating a void that normalizes whiteness in opposition to other racial and ethnic groups (Nylund, 2006). Within the practice of social work, Nylund (2006) suggested that social work training must work to create "pedagogical conditions in which students interrogate conditions of otherness, challenge the idea of social work (and other social sciences) as an apolitical, transhistorical practice removed from the power struggles of history and make visible the historical and social construction of whiteness" (p. 30). Nylund (2006) also argued that "critical multiculturalism is more inclusive of white students/social workers and possibly may have the most profound impact on them" (p. 30) by allowing them to critically reflect and deconstruct what being white means to them.

While Nylund (2006) highlighted the impact of white identity within social work, further understanding of the impact of white identity within therapy and the therapeutic relationship in rural Maine is needed. The intersection of white identity and social class formation may be helpful to identifying how therapists enact barriers to receiving care for community members. Exposing whiteness as an identity and not a norm could support shifts in how therapists are

taught to see themselves in relationship to their clients, specifically as it relates to multicultural practice in rural Maine. Through engagement in the act of adopting "critical multiculturalism," which includes a critical analysis of whiteness (Nylund, 2006), mental health therapists may be able to embody a liberatory role (Martín-Baró, 1994) which could destabilize mental health's legacy of racism.

## Summary of Research Design

The purpose of this research was to explore the perceptions of white therapists' social class by white clients experiencing poverty in rural Maine to better understand the way mental health discourse replicates social class structures in racially homogenous therapeutic settings. This study involved 9 adults, ages 18-65, recruited through local community organizations including non-profits, churches, and civic organizations. Participants lived in rural Maine, experienced self-identified rural poverty, and had experiences attempting to access therapy in the previous 5 years by attending at least one counseling appointment in rural Maine. A purposeful sample (Patton, 2015) was used to recruit candidates for participation. Theoretical sampling whereby data were collected iteratively and allowed the researcher to identify gaps during the research process (Levitt, 2021), was utilized.

To support validity, the researcher engaged in critical self-reflection by checking with participants to confirm whether what they had reported was what the researcher had understood. In addition, reflective memoing was utilized to support validity (Marshall & Rossman, 2016). To ensure trustworthiness in this study, credibility, confirmability (Bloomberg & Volpe, 2019) and dependability (Marshall & Rossman, 2016) were addressed in the reflexive process. To provide confirmability and support the goal of acknowledging and exploring researcher biases and unconscious prejudices that may impact interpretations of the data (Bloomberg & Volpe, 2019)

the researcher engaged in critical peer debriefing (Marshall & Rossman, 2016). Within the context of this study, which was exploring perceptions and experiences of social class within therapeutic relationships, which may have enacted power differentials between therapist and client, it was important to account for the possibility that people experienced multiple realities related to power and oppression (Morrow, 2005). Thus, it was necessary to account for emergent themes (Charmaz, 2008) and to address them in the analysis to ensure dependability. The two primary methodological orientations for this research were Discourse Historical Analysis (Reisigl & Wodak, 2016) and Critical-Constructivist Grounded Theory (Levitt, 2021).

**Discourse Historical Analysis**

Discourse Historical Analysis (Reisigl & Wodak, 2016) is used to examine how speech, genres, texts and discourse are interconnected and are situated within historical, socio-political and institutional structures. Through examination of discourse, text and genres (e.g., the language used within a situation, written, spoken and visual body language) aspects of language, and language used within social activities (Reisigl & Wodak, 2016), Discourse Historical Analysis is employed to critically examine the hegemonic production, use and practice of language by those in power to understand how power is gained and maintained (Reisigl & Wodak, 2016). When using Discourse Historical Analysis, multiple inputs, including theory, methods, socio-historical and empirical observations are utilized to provide multiple data sources to increase validity and reliability (Reisigl & Wodak, 2016).

**Critical Constructivist Grounded Theory**

The other methodological approach I used to conduct this study was critical-constructivist grounded theory (Levitt, 2021). Critical-constructivist grounded theory engages examination of socio-political-economic factors to understand and create theory of action

grounded in the experiential knowledge construction of participants (Charmaz, 2017; Creswell & Creswell, 2018). Central to engaging in the examination of socio-political-economic factors to understand and create theory is the development of the methodological self-consciousness of the researcher (Charmaz, 2017). Through the iterative process of asking emergent critical questions throughout the research process, analysis and critical reflection that center social justice aims are possible (Charmaz, 2017). By engaging in the research method of critical-constructivist theory, which centers the lived experience of the research participants through iteratively asking emergent questions based on the information provided by participants, this research method supports liberatory practices of centering participants as experts of their own experience.

## Social Justice Perspectives

The relationship between rural poverty and mental health disparities has been well documented (Jensen et al., 2020). For adults living in rural poverty, these concerns are exacerbated by issues with accessibility, availability, and acceptability of care (Jensen & Mendenhall, 2018; Thorne & Ebener, 2020). In rural New England, the community's social and economic support is contingent on perceptions of a person's ability to maintain independence and self-sufficiency (Carpenter-Song et al., 2016). Social exclusion is expressed through social stigma (Bischoff et al., 2014; Carpenter-Song et al., 2016). Access to power and participation in social life are maintained by demonstrations of self-sufficiency and independence (Carpenter-Song et al., 2016). Capitalist structures lead to the exclusion of people in poverty (Parr & Philo, 2003) and attending to the moral economy of self-sufficiency and independence in rural northern New England is central to understanding mental health care participation impacting practices of care (Carpenter-Song & Snell-Rood, 2017). I was attempting to explore the nuanced relationship between rural poverty, therapy, and the socio-economic and political

structures in rural Maine that contribute to barriers to care. In mental health research, racial homogeneity appears to have been an under studied aspect of rural poverty, and the intersection of rural poverty, racial homogeneity and social class seems to be missing from the literature. Specifically, the role of client perceptions of social class stratifications between therapist and client in rural Maine where racial demographics contain predominantly white racial homogeneity, seems to have been lacking from the research. Highlighting the intersection of cultural/social norms, social class perspectives, racial homogeneity and mental health needs in rural Maine offers an understanding of the lived experience of this population.

## Conclusion and Organization of the Remaining Chapters

When one experiences a prolonged period of economic, psychological or health need in rural Northern New England, there is loss of social capital which manifests as social exclusion and is expressed through social stigma (Bischoff et al., 2014; Snell-Rood & Carpenter-Song, 2018). The loss of connection, through exclusion (Carpenter-Song et al., 2016), can prove devastating for a rural resident in New England where social capital impacts how access to hierarchies of power and participation in social life occurs (Buck-McFadyen et al., 2018). These social stratifications of capital and class are often exacerbated in mental health treatment. Grounded in critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005) and critical white theory (Nylund, 2006), this research sought to explore perceptions and experiences of white therapists' social class by white clients experiencing poverty within racially homogenous rural Maine. Employing an intersectional methodology of and Discourse Historical Analysis (Reisigl & Wodak, 2016) and Critical Constructivist Grounded (Levitt, 2021), this iterative research examined the socio-political-economic themes and discourses that contributed to participant perceptions and experiences.

Recognizing the significance of centering participant voices and experiences, this research engaged the aspirational goal of critical examination to uplift and highlight the lives of people experiencing poverty in rural Maine who have engaged in therapy.

The remainder of this dissertation is organized into four chapters, reference pages, and appendices. Chapter II presents a literature review with a broad overview of systemic barriers to mental health care for people experiencing poverty in rural locations. Chapter III presents researcher epistemological lens, positionality, and identifies the intersectional methodology of critical constructivist grounded theory (Levitt, 2021) and discourse historical analysis (Reisigl & Wodak, 2016) as the methodological framework for this study. This chapter also includes discussion of the study's design and includes discussions of data generation, validity, data analysis and ethical considerations. Chapter IV is a presentation of the major findings of the study and includes narratives from participants. Chapter V presents further inquiry into the findings presented in the previous chapter and examines the implications of the findings within the theoretical contexts of critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical theory of care in nursing (Falk-Rafael, 2005) and critical white theory (Nylund, 2006). The chapter completes with a broad conclusion of the study.

# CHAPTER II

# LITERATURE REVIEW

People in northern New England are predominantly the descendants of the Northeastern colonial-settler project (Tuck et al., 2014) of what is now the United States. The area remains racially homogeneous and predominately white (U.S. Census Bureau, 2020). This research is informed by an epistemology that centers the cosmology of relationship to a specific place. As an act of liberatory solidarity, the word *white* is written in lowercase to decenter white supremacy in written language.

This dissertation explored the nuanced intersection between rural poverty, mental health, and social class structures in racially homogenous northern New England, specifically Maine, and how that intersection may contribute to barriers to mental health therapy. This research asked: "Do clients experiencing rural poverty perceive the social class of their therapist as different from their own and how does that impact their experience and acceptance of therapy?" and "What role does racial homogeneity play in perceptions of social class between white clients and white therapists in rural Maine?" By examining participants' individual, place-based experiences, a better understanding of how to design, implement, and strategize care emerged.

As a researcher, my work seeks to uplift the collective understanding about structural and historical oppression to inform social change. My research identity is situated in an intersectional epistemology of liberation psychology (Martín-Baró, 1994), critical pedagogy (Freire, 1970), and critical psychology (Fox et al., 2009). Through an engagement of critical consciousness (Freire, 1970) , which examines social and political contradictions in society and how these systems

serve to maintain oppression, my epistemological aim is to work against these contradictions by supporting engagement in a relationship of mutual respect and reciprocation. Of particular note, my epistemological lens is turned towards challenging the emphasis on individualism over collectivism to uplift broader societal concerns within mainstream psychology.

With my epistemological orientation central in the review of the literature and to gain a wide-ranging understanding of the social, political, and economic factors that impact metal care for white adults in rural Maine, this literature review engages in a broad review of systemic barriers to mental health care for this population. First, a presentation of the guiding theoretical frameworks is presented. Then this chapter contains a presentation of the empirical review of research. The empirical review begins with a presentation of literature exploring whiteness and white privilege within psychotherapy. Then a presentation of the literature organized around availability, accessibility, and acceptability of mental health care in rural locations, with special emphasis on the existing literature related to New England is presented. Finally, a synopsis of the empirical review is presented.

## Theoretical Framework

This research draws its theoretical framework from critical theory (Carspecken, 1996; Kinchloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005), and critical white theory (Clements & Mason, 2020; Nylund, 2006). By exploring participants lived experiences in therapy through a theoretical lens informed by the intersections of social class, whiteness, and rural poverty, this study aimed to articulate the nuances of creating systems of care that transcend binary oppressor-oppressed paradigms. Instead, it seeks to foster a relational community of care (Freire, 1970; Wilson, 2008) tailored to the needs of this population.

## Critical Theory

Critical theory posits that socio-political-economic systems rooted in capitalist/colonial/settler structures of power always affect people's lived experiences in society, is concerned with social inequities and examines social structures, power, culture, personal agency, and the intersections of these factors (Carspecken, 1996; Kincheloe & McLaren, 1994). The language of the dominant culture informs how people consciously and unconsciously understand themselves, society, and their position within society. According to Kincheloe and McLaren (1994), critical theory holds that certain groups of people are privileged over time. Oppression, a cornerstone of a capitalist/settler/colonial society leads people to believe and accept that their position in society is natural, required, and fixed. Critical theory identifies oppression as a multi-faceted, interconnected set of socio/economic-political systems. Lastly, critical theory highlights that research is not neutral but biased towards those in positions of power and privilege. Many research practices replicate systems of race, gender, class and ableism by privileging the very systems of power they are seeking to research (Kincheloe & McLaren, 1994).

## Critical Care of Nursing Theory

This research also drew from the theory of critical care in nursing (Falk-Rafael, 2005), an emancipatory approach that considers multiple ways care is given, shared, and taken. Critical care of nursing is oriented towards understanding meaning making through the multiple layers of meaningful acts of care. These acts are understood from within the context which they are enacted and are socio-cultural expressions of the people and place from where they come (Falk-Rafael, 2005; Falk-Rafael & Betker, 2012). Critical care in nursing theory informs the exploration of the lived experience of availability, accessibility, and acceptability of mental

health care for study participants. Critical care theory in nursing offers a framework of care that centers emancipation and liberation for providers and those who are receiving care.

### Critical White Theory

Drawing on influences of critical race theory, cultural studies, and post-colonial studies, critical white theory examines and deconstructs notions that whiteness is a place of racial normativity, and posits that whiteness is a social construction (Nylund, 2006). It is primarily concerned with uncovering ways white domination is made and sustains invisible structures of power and oppression (Clements & Mason, 2020; Perry, 2001). Historically, studies of race were oriented towards marginalized racial or ethnic groups. They not only overlooked whiteness but made being white normal and natural (Nylund, 2006), reinforcing notions of "insider/outsider" status (Couture et al., 2012) and the social constructions of power, control, and oppression (Prilleltensky, 2008). This research engages critical white theory to expose and deconstruct hegemonic systems of care rooted in whiteness through the examination of power, oppression, and positionality (Galtung, 1990). Within mental health care in rural Maine, explicit deconstruction and exposure of white normativity is crucial to understanding how social class impacts regional culture and practice of mental health care norms within the region. The following section presents the empirical review of the literature for this study.

## Empirical Review

While research shows that rural locations have distinct cultural identities (Jensen et al., 2020), there is a lack of research demonstrating how social, economic, historical, and political features create distinct cultural landscapes in rural locations, and how these factors shape local social service delivery systems (Carson & Mattingly, 2018), or identify appropriate holistic intervention models (Jensen & Mendenhall, 2018; Myers & Gill, 2004). This empirical review

examines research on barriers to care for people experiencing rural poverty and what might contribute to improved outcomes of their care, including cultural sensitivity, social justice, and holistic approaches. Within this review, research examining whiteness as a socially constructed identity reveals its intricate ties to poverty and its deliberate historical construction as a racialized identity (Clements & Mason, 2020). From this understanding, a review of the empirical research about rural mental health is presented, from a variety of sources, and includes literature about barriers to mental health and public health services for people living in rural poverty in general, and specifically in New England (Carpenter-Song et al., 2016; Carson & Mattingly, 2018; Crumb et al., 2019; Shucksmith, 2012; Storm et al., 2020).

**Critical Whiteness and Psychotherapy**

The study of whiteness and white privilege has traditionally focused on understanding the experiences of white individuals within society, shedding light on power dynamics, and revealing the underlying contexts that perpetuate racial oppression (Clements & Mason, 2020; Matias & Boucher, 2023). However, there appears to remain a notable gap in research regarding the influence of white privilege within social class hierarchies among white individuals, particularly within mental health settings. State sanctioned normative principles of mental health care have been shown to be informed by white middle class hetero-normative values and are reinforced within the practice of mental health (Baima & Sude, 2019; Cottrell-Boyce, 2021). White privilege has been shown to be deeply ingrained in the profession and practice of family therapy, and researchers have emphasized that family therapy has centralized whiteness since its inception (Baima & Sude, 2019; Cottrell-Boyce, 2021). Although therapists may be ethically opposed white privilege, they are participants in, and are benefactors of, a system that perpetuates white privilege (Cottrell-Boyce, 2021). Combs (2019) identified that family

therapists not only need to increase their understanding of the role of white privilege in therapy, but also expand their mental and emotional sense of how racism intersects with the politics of class to better serve clients in fair, equitable and just ways.

Clements and Mason (2020) emphasized that understanding whiteness as a historically and socially constructed racialized identity is crucial for comprehending oneself and others who identify with different socially constructed racialized identities. To understand the experience of mental health care for white adults living in rural poverty, examination the role whiteness plays in the therapeutic relationship may serve to expand critical consciousness among white therapists (Friere, 1970; Ponterotto, 1988). Additionally, researchers have asserted that white therapists needed to learn more about historical and contemporary implications of whiteness as the norm in clinical practice (Baima & Sude, 2019).

In an examination of how whiteness operated as an unmarked feature in therapy, Lee and Bhuyan (2013) identified that although white therapists may be highly experienced and ethically opposed to perpetuating white privilege in theory, in clinical settings white therapists perpetuated marginalization of clients by asserting Western normative values of whiteness for both treatment and assessment. This perpetuation of whiteness caused clients to exert resistance or compliance within the framework of the clinician's dominant paradigm of whiteness, decreasing their autonomy of self. The research showed that the unmarked white bias of the therapist caused dismissal of the client's perception of the root of their suffering and decreased the therapist's ability to be client centered. The resulting outcome were missed opportunities for meaningful engagement between therapist and client. To shift unmarked bias of whiteness by therapists, the research suggests that therapists should be taught using a multi-layered approach, presenting the

historical and social constructs of race in conjunction with self-identity work (Baima & Sude, 2019; Cottrell-Boyce, 2021).

**Availability, Accessibility, Acceptability**

Research shows that availability, accessibility, and acceptability are the most prevalent concerns when identifying barriers to mental health services for adults experiencing rural poverty (Bischoff et al., 2014; Crumb et al., 2019; Jensen & Mendenhall, 2018; Magnus & Advincula, 2021; Thorne & Edener, 2020).[1] Overcoming these barriers to care requires the recognition that rural residents' needs differ from urban residents' (Tickamyer et al., 2017). This section addresses the scholarship that contributes to understandings of the availability, accessibility, and acceptability of mental health services.

**Availability**

Availability refers to the volume of services available in a specific geographic location (Penchansky & Thomas, 1981). Decentralized systems of care, lack of providers, lack of amenities, lack of infrastructure, and difficulty retaining providers all impact availability (Carson & Mattingly, 2018; Wilson et al., 2018). According to Carson and Mattingly (2018), the most problematic barrier for providers was a lack of funds. The most significant accessibility issue for clients was eligibility for insurance. The lack of providers, services, and resources indicates larger social and culture disparities in health services that rural residents experience throughout the United States (Tickamyer et al., 2017).

[1] Issues of accommodation and affordability are embedded within these themes (Penchansky & Thomas, 1981). Accommodation is the extent to which client's needs are addressed through actions that appropriately meet their needs. Affordability is how the price of services matches with the client's income, ability to pay, and insurance (Penchansky & Thomas, 1981). If someone cannot afford services or if their need for childcare is not accommodated, they might not be able to access services.

### *Lack of Providers and Services*

Lack of providers and services for rural residents experiencing poverty is a considerable barrier to care (Carpenter-Song & Snell-Rood, 2017; Jensen & Mendenhall, 2018). Rural locations tend to have few social service agencies or medical specialists due to their low population density (Buck-McFadyen et al., 2018; Carson & Mattingly, 2018). Jensen et al. (2020) found that rural residents receive less comprehensive care such as psychiatry, psychotherapy, and case management and the few providers who do exist, have heavy caseloads, leading to delayed care.

### *Coverage for Services*

How and when people can qualify for health insurance affects the availability of care. If a client begins to make more income, but not enough to move from poverty to the middle class, they may suffer a gap in availability of services: they do not generate enough income to cover the cost of health care yet are no longer eligible for supplemental funding such as state-funded health care (Carson & Mattingly, 2018). While social service agencies often have some supplemental funding, rigid policies about how funds can be spent are also a barrier to availability (Carson & Mattingly, 2018). Provider organizations' funding streams are not often structured to allow flexibility of disbursement. In addition, funding for staffing services and outreach programing has been shown to be lower in rural than urban areas for similar services, which adversely impacts the recruitment and retention of staff (Carson & Mattingly, 2018). Buck-McFadyen et al. (2018) demonstrated the need for increased funding for non-profits, culturally informed training for providers, and student loan forgiveness for new providers. The dearth of publicly funded health insurance, combined with restrictions on how social service

agencies can spend funds (Carson & Mattingly, 2018), creates a gap in service availability for low-income populations in rural locations.

### *Retention of Providers*

Three issues emerged from a review of research on retention, namely new providers' student loan debt, the low reimbursement rates for their services, and the social isolation they experience after moving to a rural community. Wilson et al. (2018) highlighted the need for low-cost housing and, like Buck-McFadyen (2018), recognized the need for student loan forgiveness for new therapists. Storm et al. (2020) found that low Medicaid reimbursement rates for mental health services had a direct and adverse result on staff retention in rural northern New England. Agencies were less able to provide consistent services because they lacked funds and staff (Storm et al., 2020).

According to Magnus and Advincula (2021), when providers moved from urban to rural locations, they experienced isolation, lack of activity and social connection. These factors frequently led the new providers to leave the area, making provider availability inconsistent as a result. This lack of consistency, in turn, caused residents to distrust mental health providers and agencies (Magnus & Advincula, 2021). Thus, difficulty retaining providers in rural locations becomes both a financial and social barrier for people seeking services. Wilson et al. (2018) showed that retention was higher when providers exhibited any of the following, or a combination: were willing to travel long distances to work with clients; had historical ties to the community; wanted to live a rural lifestyle; or understood the complications of navigating boundaries and culture in rural communities.

### *Geography and Travel Time*

In addition to lack of public transportation infrastructure, distance between locations in rural areas is a barrier to access (Storm et al., 2020). Even when clients have transportation, the distance and time it takes to attend appointments present problems (Carson & Mattingly, 2018). In rural New England, Carson and Mattingly (2018) found that when non-profit agencies increased the availability of mental health services through satellite offices, the shorter distance required to attend services helped clients to access services.

## Accessibility

Accessibility to services describes the relationship between the location of service and the location of clients. Accessibility considers the client's transportation resources and travel time, distance, and cost (Penchansky & Thomas, 1981). For rural residents experiencing poverty, access to health services, from primary care to mental health, relies on the extent to which they can *reasonably* access care resources (Bischoff et al., 2014).

### *Transportation*

Reliable transportation has a significant effect on access to mental health services for the rural poor (Buck-McFadyen et al., 2018; Magnus & Advincula, 2021). Heavy reliance on cars was associated with isolation and difficulty attending appointments, with some rural residents reporting that they could not afford car maintenance and gas (Buck-McFadyen et al., 2018). When patients relied on other people to provide transportation to appointments, interpersonal relationships, self-perception, and social capital all suffered. Magnus and Advincula (2021) found when residents were not able to access treatment, they continued to experience emotional instability. Both studies highlight how lack of transportation to access mental health services is associated with isolation, social exclusion, and stigma.

### *Mental Health Literacy*

Research has demonstrated that mental health literacy, the extent to which a person understands how to access mental health care, can improve people's access to mental health care. For example, Thorne and Ebener (2020) found that, when promoted across primary care, community outreach and partnerships, and in the context of psychotherapy, mental health literacy had more impact on rural adults' willingness to access services than concerns about confidentiality, religion, or self-sufficiency. Magnus and Advincula (2021) had similar findings, showing that mental health literacy efforts helped establish trust for providers and increased accessibility to mental health services (Magnus & Advincula, 2021; Wilson et al., 2018).

Improving primary physicians' education on mental health literacy topics is helpful because if rural residents ask how to access mental health services, it often is through their primary provider (Thorne & Ebener, 2020). Physician education was shown to increase patients' mental health literacy and increased access to services (Thorne & Ebener, 2020). Similarly, Magnus and Advincula (2021) found that when social workers created community outreach programs that addressed issues of stigma and mental health, residents in rural locations were more willing to access mental health services. Wilson et al. (2018) suggested that collaboration across medical practitioners, schools, and churches, could further mental health education, and discussed the potential of telehealth as a solution in rural areas. When mental health providers collaborated with medical professionals to increase mental health literacy, clients were better able to understand how to access care and support (Bischoff et al., 2014). Providing specific information about a provider's location, services, and transportation options increased clients' abilities to access services (Magnus & Advincula, 2021).

**Acceptability**

Changing how rural residents view mental health care requires examining how this population accepts mental health support and care. Acceptability is less easily identified and measured than availability or accessibility. Acceptability of care is psychological, interpersonal and cultural (Jensen & Mendenhall, 2018; Penchansky & Thomas, 1981). It is impacted by clients' perceptions of care and their subjective sense of care, making it difficult to clearly operationalize. Such perceptions include a) adequacy and appropriateness of care, b) access to care, c) providers' cultural competence, and d) friends' and family members' attitudes toward mental health treatment (Bischoff et al., 2014; Parr & Philo, 2003). Acceptability is a multi-layered, intersectional relationship that also implicates providers' perceptions. The provider's and client's respective ages, sex, and ethnicity impact acceptability of services, as does the context, type, religious affiliation, and neighborhood of the facility. Finances, including income and ability to pay, and the form of insurance (if present), all influence client and provider perceptions (Penchansky & Thomas, 1981). The stigmatization of mental health needs presents a barrier for rural residents (Magnus & Advincula, 2021). Community and larger socio-political attitudes towards mental illness and treatment have led to the internalization of stigma and subsequent lack of engagement with treatment related to mental health. This dynamic leaves communities divided, and residents who need the most help are often ostracized (Magnus & Advincula, 2021). Families experiencing extreme poverty hide their needs to save face and social capital, prioritizing reputation over their care (Carpenter-Song et al., 2016).

With regard to acceptability, cultural values of self-sufficiency and independence (Carpenter-Song et al., 2016; Carson & Mattingly, 2018; Jensen et al., 2020), the racial identity of both provider and client (Baima & Sude, 2019; Cottrell-Boyce 2021), and class stratification

(Balforth, 2009; Ballinger & Wright, 2007; Cook & Lawson, 2016; Smith et al., 2011; Trott & Reeves, 2018) can present additional barriers. Cultural sensitivity (Bischoff et al., 2014; Jensen et al., 2020), social justice approaches that center the experience of the client (Crumb et al., 2019), and holistic practices (Watson, 2019) have been identified as ways to approach and shift levels of acceptability.

### *Social Class Stratification*

The role of social class hierarchies of both therapists and clients has been shown to be a significant factor in contributing to therapeutic dynamics, with research primarily focusing on the role of therapists. Smith et al. (2011) and Ballinger and Wright (2007) both delved into the intricate interplay between social class and therapeutic dynamics, shedding light on the significant role of social class in counseling contexts. Smith et al. (2011) focused on the influence of just-world beliefs on therapists' perceptions of clients from different social classes. Their study highlighted how therapists who held beliefs in a just world tended to perceive clients from poor or working-class backgrounds as less pleasant to work with and more dysfunctional. They identified that this bias could potentially impact treatment outcomes, as these negative attitudes might already be present during the initial stages of therapy. Additionally, the researchers noted that therapists' lack of awareness of class differences beyond their own middle-class experiences could further contribute to biases against clients facing poverty (Smith et al., 2011).

In contrast, Ballinger and Wright (2007) explored perceptions of social class within counseling by counselors, emphasizing the significance of social class identity in shaping interpersonal dynamics between clients and counselors. They found that discussions about class were often overlooked or understudied in counseling training programs, leaving counseling

trainees ill-prepared to address these issues with clients. However, when counselors were able to openly discuss class, therapists reported gaining a deeper understanding of their clients' experiences. Furthermore, the study highlighted the impact of counselors' own class identity on their interactions with clients, as well as the role of language and regional accents in shaping counselors' perceptions.

In researching counselors' understanding and awareness of socioeconomic status, Cook and Lawson (2016) identified that despite some awareness of social class dynamics, counselors' understanding predominantly centered on economic factors. Highlighting challenges in terminology usage, echoing broader issues in counseling literature concerning social class, the research suggested potential influences of social desirability or early stages of social class consciousness development, characterized by a limited comprehension of social class dynamics and privilege. In addition, the research indicated that counselors' assumptions about social class underscored a lack of awareness regarding how social class membership impacts individuals' access to resources and communal values and counselors tended to overlook the broader cultural implications of social class, such as its influence on individuals' worldviews, values, and behaviors (Cook and Lawson, 2016). The limited perspective identified by Cook and Lawson (2016) could potentially hinder counselors' ability to effectively meet clients' needs, leading to disparities in the therapeutic relationship. Like other research (Balforth, 2009; Smith et al., 2011), Cook and Lawson (2016) emphasized the importance of counselors continuously examining their biases and explicitly addressing clients' social class experiences. The researchers highlighted that ongoing reflection and education on social class dynamics are crucial for fostering culturally competent counseling practices.

In their research exploring social class and therapy, Balforth (2009) provided additional insights from the perspective of clients. Their research explored how clients identifying as working class perceived differences in social class identity within the therapeutic relationship. The study highlighted how clients' experiences of marginalization and feelings of disempowerment within therapy sessions were often rooted in therapists' lack of understanding of their unique life experiences and socioeconomic constraints. Moreover, Balforth (2009) identified instances where clients engaged in power struggles with their therapists, viewing these interactions as opportunities to educate therapists about class identity. However, therapists' unconscious assumptions about their own social class as the norm often led to ruptures in the therapeutic relationship, as they failed to acknowledge and address the clients' class identity.

Overall, these studies underscore the complexity of social class dynamics within therapy settings and the importance of acknowledging and addressing these issues to ensure culturally competent and effective therapeutic practice. The research underscores the need for counselors to critically engage with social class dynamics by considering the complexities of both their own and their clients' socioeconomic backgrounds to ensure effective therapeutic outcomes.

### *Culture of Self-Sufficiency*

In studying how shared economic distress impacted local moral economies about deservingness of mental health services and treatment in a rural community, Snell-Rood and Carpenter-Song (2018) identified that “attending to local moral economies that shape mental health deservingness is critical to understanding the complex overlaps and intersections between state, communities and family discourses” (p. 76). Conforming to a community’s “values of care” (Antrop-González & De Jesús, 2006, p. 413), in other words, how the expression of care

within a community is accepted, given, and received, is a significant determinant of the expression of that care.

In rural northern New England, communities share a distinct culture and values rooted in racial homogeny (Carpenter-Song et al., 2016). The morals that shape mental health deservingness are self-sufficiency and independence (Carpenter-Song et al., 2016; Carson & Mattingly, 2018; Jensen et al., 2020), and chronic economic need can result in social exclusion (Bischoff et al., 2014; Carpenter-Song et al., 2016). Therefore, engaging in acts of care that resist self-sufficiency and independence may threaten an individual's social standing within the community (Carpenter-Song et al., 2016). Although community support in the wake of tragedy such as a house fire or death is strong in rural New England, being in a position of chronic need, whether economic, psychological, or health, leads to social exclusion (Carpenter-Song et al., 2016). This exclusion can lead to increased levels of isolation and loneliness. Because social connection, which decreases isolation and loneliness and increases access to care, is contingent on community perceptions of self-sufficiency and independence, maintaining perceptions of self-sufficiency is often prioritized over getting care for this population (Carpenter-Song et al., 2016). By exploring the perceptions of the moral concept of deservingness of mental health care in rural New England, greater understanding of barriers to acceptability of mental health care for this population may emerge.

### *Cultural Competency*

When rural residents attempt to access mental health support, the fragile infrastructure for mental health care in rural locations can exacerbate the experience of stigmatization, ostracism, and mental health struggles (Carpenter-Song & Snell-Rood, 2017). The internalized experience of stigma and shame combine to create a reluctance to seek help (Bischoff et al., 2014; Magnus

& Advincula, 2021). Thus, practices of cultural competency are paramount to increasing the acceptability of mental health services in northern New England.

Culturally competent counselors use their social and cultural power to work on behalf of their rural clients' wellbeing. Bischoff et al. (2014) indicated that mental health clinicians needed to achieve cultural competency through an intentional practice of cultural sensitivity when working in a rural location. To do so, mental health counselors must acknowledge that rural culture is unique and different from urban culture (Bischoff et al., 2014). The cultural value rural residents attach to independence and self-sufficiency causes mental health stigma to manifest differently (Jensen et al., 2020), demanding extra sensitivity from providers.

**Social Justice Approaches**. Social justice in action increases the acceptability of mental health support for rural populations. Considerations of whiteness and social class are pivotal to this approach. When providers center their clients' economic, social, and political experiences, clients' acceptance of services increases (Crumb et al., 2019; Wilson et al., 2018). In their study of counselors' integration of social justice advocacy with rural populations, Crumb et al. (2019) identified three areas of practice for counselors to increase social justice advocacy. First, when counselors had a better understanding of how class and race impacted clients' worldview, they improved their empathy and connection with clients. Recognizing when clients had limited access to resources and appreciating their existing support systems, helped counselors more accurately reflect their clients' resourcefulness. The clients' engagement with mental health services also improved. Second, counselors found it difficult to engage in therapy when clients' basic needs were not met. Third, counselors committed to social justice promoted a multi-stakeholder continuation of care for clients, advocating for them across interpersonal, intrapersonal, and institutional domains. Thus, Crumb et al. (2019) demonstrated that when

counselors leveraged their social and cultural power on behalf of their clients, counselors uplifted their client's experiences and provided services in solidarity.

**Women and Holistic Models of Care**. Scholarship in the field of family therapy shows the need to examine the experience of women living in rural poverty (Jensen & Mendenhall, 2018; Myers & Gill, 2004; Watson, 2019), making it an important subtopic in social justice in mental health care. Watson (2019) conducted a qualitative study that explored how female mental health clients living in rural poverty experienced counseling. The study found that clients' perceptions of counseling influenced their experience of counseling. If they believed they could be helped, and their counselor was caring and supportive, they were more able to enact changes formed through the therapeutic process. Two additional key factors were the clients' participation and commitment. These findings support Prilleltensky's (2009) conceptualization of the influence of "value added/value taken" on the experience of wellbeing. Clients reported that counseling was more helpful when they perceived it not only as something that was being done *for them* (passive), but as something they had *responsibility to do* (active). These findings align with broader, non-gender-based assertions that perception affects acceptability for rural clients experiencing poverty (Bischoff et al., 2014; Parr & Philo, 2003). Nevertheless, the perceptions held by rural, working-class women about mental health services may not yet be well understood.

In their review of factors that contribute to the experience of rural white women experiencing poverty, Myers and Gill (2004) discussed the cycle of poverty as a condition of structural violence that decreases access to health care, education, housing, and public assistance. The authors presented an alternative model to address the disproportionate number of women who experience rural poverty--as they put it, "the cycle of poverty and compromised wellness"

(Myers & Gill, 2004, p. 232). The model emphasizes understanding and intervention in three areas: the experience of poverty, the impact of poverty, and implications for mental health. Counselors who address the cycle of poverty and compromised wellness could shift how clients view their own strengths, creating more opportunities for change. However, no studies showing the results of implementing this model were available for this review.

## Synopsis of the Literature Review

The review of the literature on mental health care in rural locations focused on critical whiteness, availability, accessibility, and acceptability. Previous research found issues of accessibility, availability, and acceptability were likely prevalent when identifying barriers to mental health services for adults experiencing rural poverty, (Bischoff et al., 2014; Crumb et al., 2019; Jensen & Mendenhall, 2018; Magnus & Advincula, 2021; Thorne & Edener, 2020). Moral concepts of deservingness influenced participation in mental health services in rural communities experiencing poverty and was impacted by social capital and social exclusion (Buck-McFadyen et al., 2018; Shucksmith, 2012; Snell-Rood & Carpenter-Song, 2018). The role of racial identity has been shown to impact the therapeutic relationship and providers would benefit from better understanding how their racial identity impacts the therapeutic relationship (Baima & Sude, 2019). The use of psychological language, regional accents of providers and centering western psychological development as ideal, can indicate variations in educational levels between provider and client and highlight unmarked social constructs of white privilege within the counseling room, leaving client's perceptions of their own experiences unexamined, thusly impacting perceptions and the acceptability of services by clients (Ballinger & Wright, 2007; Lee & Bhuyan, 2013).

Emergent issues include lack of providers, availability of transportation, difficulty with insurance, and mental health literacy (Bischoff et al., 2014; Buck-McFadyen et al., 2018; Magnus & Advincula, 2021; Thorne & Ebener, 2020; Wilson et al., 2018). Socio-political factors, including social class, whiteness, self-sufficiency, and independence strongly influenced the acceptability of care (Baima & Sude, 2019; Carpenter-Song, 2018; Cottrell-Boyce, 2021; Trott & Reeves, 2018). The literature shows that education, community engagement, socially-just approaches to counseling, and meeting the needs of women are vital when providing mental health services in rural locations (Crumb et al., 2019; Jensen & Mendenhall, 2018; Myers & Gill, 2004; Watson, 2019). Understanding the local community's perception of care and individuals lived experience of care within the local community (Jensen et al., 2020) is vital. Engaging in an intersectional research methodology of critical constructivist grounded theory (Levitt, 2021) and discourse historical analysis (Reisigl & Wodak, 2016) provides tools to examine the complexity of experiences and perceptions of people experiencing rural poverty in Maine who are seeking therapy. The following chapter provides a presentation of the methodological process engaged in this research.

# CHAPTER III

# METHODOLOGY

This chapter introduces the assumptions, research design, and methodology of the present study. It explains how the design serves to address the following research questions:

**(RQ1):** Do clients experiencing rural poverty perceive the social class of their therapist as different from their own and how does that impact their experience and acceptance of therapy? and

**(RQ2):** What role does racial homogeneity play in perceptions of social class between white clients and white therapists in rural Maine?

This chapter begins with a summary of the epistemological foundations of this work. Then, an overview of the design rationale of the study is presented. Then, researcher positionality is addressed. This is followed by presentation of the research design and includes procedures for data collection and analysis, with a discussion of validity, and ethical considerations.

## Epistemology

This section identifies the epistemological framework for this research. Operating from a lens centered on critical theory (Carspecken, 1996; Kinchloe & McLaren, 1994), critical care in nursing (Falk-Rafael, 2005) and critical white theory (Clements & Mason, 2020; Nylund, 2006). I aim to advance comprehension of structural and historical oppression, with a lens towards societal transformation. My research approach aligns with an intersectional perspective by fostering critical consciousness. I explore societal contradictions that perpetuate oppression,

striving to counter them through fostering respectful and reciprocal relationships. Notably, my focus challenges the prevailing individualistic narrative in mainstream psychology, prioritizing collective well-being and broader societal issues with particular focus on the ways poverty dehumanizes people and what it means to create systems of care that move from a binary understanding of oppressed and oppressor to a relational community of care (Freire, 1970). With a commitment to emancipation, this study focused on ways that poverty dehumanized people and perpetuated oppression but was predicated on the belief that emancipation does not rest solely on the elimination of poverty (Martín-Baró, 1994). Rather, such emancipation is possible only when poverty is no longer a socio-political determinant of human worth. An intersectional epistemology of liberation psychology (Martín-Baró, 1994), critical pedagogy (Freire, 1970) and critical psychology (Fox et al., 2009), provided a philosophical understanding of how to consider therapist, client, and psychology in rural Maine. Within this study, I apply a critical framework to deconstruct hegemonic systems of care that maintain and enact direct, structural, and cultural violence (Galtung, 1990).

**Liberation Psychology**

Liberation psychology seeks to uplift the collective understanding of structural and historical oppression to enact social change (Martín-Baró, 1994). Martín-Baró (1994) asserted that individualism is used to deny the socio-economic structures and conditions that shape the practice of psychology and is often applied in psychology, denying differing subjective and objective realities. The result of this denial reinforces socio-political-economic systems of oppression while placing the blame for failure on the individual (Martín-Baró, 1994). According to Martín-Baró (1994), such denial and blame are also pervasive for people experiencing poverty.

Liberation psychology ask questions with regards to social and economic justice and representation within social and class structures (Martín-Baró, 1994). Therefore, liberation psychology seeks to uplift the collective understanding about structural and historical oppression to inform social change (Martín-Baró, 1994). Within this research, an understanding that individualism within psychology may often serve to reinforce perceptions of individual pathology, liberation psychology provided an epistemological stance whereby it was possible to consider socio-political-economic structures and conditions as central to shaping experiences and perceptions of participants lives.

**Critical Pedagogy**

This project centered the philosophical framework of Freire's (1970) critical pedagogy. Freire's critical pedagogy engages a democratic approach within education by critically examining the hierarchical power difference between teacher and student which centers the student as a receptacle of information transferred by a teacher. Freire identified that a democratic learning environment centered both teacher and student as learners engaged in a relationship of mutual respect and reciprocation (Freire, 1970). Freire asserted that power is not simply external, but rather is a state of internalized oppression which serves to assert social control and marginalization of populations to maintain power hierarchies. The result is that even when oppressors are not present, marginalized people behave in accordance with how oppressors would have them behave (Freire,1970). To contend with and liberate people from oppression Freire (1970) advocated the practice of conscientização or critical consciousness. According to Freire (1970), conscientização/critical consciousness is the process of examining the social and political contradictions in society which serve to maintain oppression with the objective being to act against such contradictions. This process requires developing a critical viewpoint to analyze

and understand both oneself and broader human relationships. This process often starts with one's own reflexive examination of their socio-political-economic experiences and how these experiences shape their perception of reality (Freire, 1970). In so doing, the practice of conscientização can extend to an understanding one's own ability to create and shape their reality, creating the conditions whereby people are empowered to act on their own agency (Freire, 1970).

**Critical Psychology**

Critical psychology (Fox et al., 2009) attends to interrelated central concerns and core concepts focusing on social justice by promoting welfare of communities' writ-large with a particular focus on oppressed groups. In addition, critical psychology seeks pathways to transform intrenched ideologies and practices within both society and psychology. This is achieved by challenging the prevailing emphasis on individualism over group dynamics and broader societal concerns within mainstream psychology. This focus on individualism tends to prioritize certain values and erects barriers to community and mutual support, thereby empowering unjust institutions. At its core, critical psychology contends that the dominant practices and institutional affiliations of mainstream psychology disproportionately harm members of marginalized groups, thereby facilitating the perpetuation of inequality and oppression (Fox et al., 2009). Despite individual or collective intentions to the contrary, this still takes place (Fox et al., 2009).

Drawing from liberation psychology (Martín-Baró, 1994), critical pedagogy (Freire, 1970) and critical psychology (Fox et al., 2009), the researcher engages in a critical deconstruction of hegemonic systems of care through the examination of power, oppression, and positionality (Galtung, 1990). To gain a greater understanding of the consequence of

individualist values within psychology, this research centered institutional and cultural contexts which contribute to the marginalization and oppression of people experiencing poverty in rural Maine who were seeking therapy. This research is informed by the practice of uplifting the collective understanding of systemic oppression within local communities to further enact change and seeks to transform entrenched ideologies and practices within both society and psychology. Centering the lives of people experiencing rural poverty in Maine, this research was informed by the recognition that people live in a state-sanctioned system that perpetuates neoliberal oppression (Hong, 2015) and hegemonic systems of care to enact direct, structural, and cultural violence (Galtung,1990). This research is informed by the recognition that challenging mainstream psychology's dominant practices and institutional affiliations, which disproportionately harm members of marginalized groups, has the potential to bring about change in oppression and marginalization.

## Design Rationale

This section introduces the two primary methodological orientations for this research embedded in critical research that promotes liberation, emancipation, transformation, social change, and consciousness raising (Levitt, 2021). Functioning from a critical epistemology, this research sought to engage emancipatory research practices through Discourse Historical Analysis (Reisigl & Wodak, 2016) which sits within the broader method of Critical Discourse Analysis (Fairclough, 2015; van Dijk, 1993) and Critical-Constructivist Grounded Theory (Charmaz, 2017; Levitt, 2021). The purpose of this research was to explore the perceptions of white therapist's social class by white clients experiencing poverty in rural Maine to better understand the way mental health discourse replicates social class structures in racially homogenous therapeutic settings. Through analysis of client's perceptions of mental health discourse within

the therapeutic setting, this research had the aspirational goal of contributing to the theoretical understanding of therapy discourse within this location.

**Discourse Historical Analysis**

Critical Discourse Analysis (Fairclough, 2015; van Dijk, 1993) is utilized to analyze language in relationship to social inequity and social power. This is done by focusing on the role of discourse in the production, reproduction and creation of power and dominance (van Dijk, 1993). Critical Discourse Analysis (Fairclough, 2015; van Dijk, 1993) and Historical Discourse Analysis (Reisigl & Wodak, 2016) stress the relationship between discourse and social structures.

Discourse Historical Analysis (Reisigl & Wodak, 2016) is used to examine how the interaction between speech, genres, texts, and discourse is situated within historical, socio-political, and institutional structures. This analysis is oriented to critically examine the hegemonic production, use and practice of language by those in power to understand how power is gained and maintained (Reisigl & Wodak, 2016). Discourse Historical Analysis engages multiple inputs, including theory, methods, socio-historical and empirical observations to follow the principle of triangulation (Reisigl & Wodak, 2016), in other words the use of multiple data sources to increase validity and reliability. The principle of triangulation is practiced through examination of discourse, text, and genres. Discourse is the language used within a situation. Texts are the written, spoken, and visual (body language) aspects of language and genres are the use of language within social activities (Reisigl & Wodak, 2016).

Context is the practice of examining the elements of the principle of triangulation within the historical, socio-political, and situational location where they have and do occur (Reisigl & Wodak, 2016). When analyzing context, considerations encompass the linguistic elements,

textual relationships, social and institutional language shaped by the situation, and the embedded socio-political and historical dimensions within the discourse. Critically, this process seeks to decrease taking discourse out of context without re-contextualizing it within the socio-political, historical location where it is occurring causing a replication of systems of oppression and socio-political power (Reisigl & Wodak, 2016).

**Critical Constructivist Grounded Theory**

Grounded Theory seeks to create an abstract theory of action rooted in the experiential knowledge construction of the research participants (Creswell & Creswell, 2018). Constructivist Grounded Theory identifies and theorizes how meaning and actions influence each other in knowledge construction (Charmaz, 2017). Critical-Constructivist Grounded Theory motivates an examination of how socio-political-economic factors, including race, poverty, social class, and mental health, intersect to create perceptions and experiences (Charmaz, 2017). Within Critical-Constructivist Grounded Theory the researcher asks emergent critical questions iteratively, throughout the research process (Charmaz, 2017; Levitt, 2021), in a cyclical process of induction (Levitt, 2021). Iteration allows for critical reflection and analysis that center social justice aims (Levitt, 2021). This theoretical approach requires the researcher to consider their research in relationship to three key questions:

1. How and why meanings are formed interpersonally?
2. How privilege, oppression, and systemic differences influence experiences; and
3. How the research context and power dynamics shape the findings. (Levitt, 2021, p. 14)

This process supports the development of methodological self-consciousness (Charmaz, 2017), supporting researchers' capacity to critically analyze the emerging data, their positionality, and actions throughout the research process.

Both Discourse Historical Analysis (Reisigl & Wodak, 2016) and Critical-Constructivist Grounded Theory (Charmaz, 2017; Levitt, 2021) are rooted in critical epistemology. Discourse Historical Analysis supports examination of discourse through context by examining the elements of the principle of triangulation within historical, socio-political, and situational locations (Reisigl & Wodak, 2016). Critical-Constructivist Grounded theory is a method that helps researchers craft emergent critical questions iteratively, throughout the research process to examine how socio-political-economic factors, including race, poverty, social class, and mental health, intersect to create perceptions and experiences (Charmaz, 2017; Levitt, 2021).

## Researcher Positionality

My interest in this research was rooted in my experience of working as a mental health therapist in rural Maine. Understanding how social class formation may privilege who is seen and valued as the constructor of knowledge led me to examine how language, spoken, written and body language, enacted within therapeutic settings, may replicate, and perpetuate broader socio-political systems of power which disappear people experiencing rural poverty. Euro-American knowledge construction informs counseling training, practice, and policies and is further reinforced within counseling by white clinicians who are the beneficiaries of that knowledge construction (Nylund, 2006). Suzuki et al. (2007) claimed that the researcher's perspective is connected to their level of experience with the community. Reflecting on how my positionality as a white, middle-class, cisgender woman who practices as a mental health clinician in rural Maine might impact how *I* practice as a mental health clinician, led me to

consider the implications in my own mental health counseling practice serving white clients in rural Maine who experience poverty.

Dutta (2016) argued that "a number of community psychologists have critiqued the ways in which Euro-American standpoints are privileged in knowledge construction" (p. 331). Because of Dutta's (2016) argument, by examining my mental health education, I questioned that the construction of mental health knowledge, theory and practice was reproducing Euro-American structures and practices of white supremacy in mental health counseling. This questioning led me to examine how, as a white therapist practicing in racially homogenous rural Maine, I was potentially reproducing systems of oppression with my clients through the unmarked class privilege within the therapy setting. Further, this reflection led me to wonder about the role of social class and socio-economic racial identity as factors that would influence how white clients' experiencing poverty perceive the social class of their white therapists and how that would impact their experience of mental health services.

Critical research is dependent on the researcher's capacity to engage in self-reflection (Fine, 2018). This practice includes positioning the research within broad socio-political context and centering the socio-political positionality of the research participants as central to data interpretation (Reisigl & Wodak, 2016). Discourse Historical Analysis requires that the researcher engage in transparency about their positionality and utilize theoretical understanding to justify why particular interpretations of participants discourse are more valid than others (Reisigl & Wodak, 2016). Critical-Constructivist Grounded Theory depends on reflexivity, or methodological-self-consciousness (Charmaz, 2017). As a critical researcher rooted in a critical-ideological framework, my work reflects my own subjective experience as well as that of the participants. Morrow (2005) observed that subjectivity and objectivity engage together in the

qualitative researcher through intersubjectivity. This concept theorizes that gender, race, ethnicity, class, religion or spiritual beliefs, as well as myriad intersectional identities, which are often inseparable, shape researchers' lives and inform how the researcher understands and interprets the data (Couture et al., 2012). To address potential differentials related to power and make them explicit to the research participants, my reflexive process led me to examine how my positionality as an outsider (Ross, 2017) who holds an intersection of power and privilege might affect my communications with participants. This reflexive understanding provided structure throughout the research process not to assume that the participants and I shared understandings about therapy, mental health, race, class, gender, sexual orientation, religion, spiritual beliefs, or socio-economic positions in rural Maine.

As a mental health clinician who was a graduate researcher with economic power and class privilege, I recognized that assumptions I held about therapy, poverty and social class could restrict, cause avoidance, or cause misunderstanding of those concepts between myself and participants, decreasing opportunities for insight into participants' socio-political identity formation. I attempted to consider implicit power differentials between myself and the participants (Patton, 2015) by attending to my outsider positionality (Ross, 2017).

To attend to outsider positionality (Ross, 2017) and the economic, professional, and educational power I may have carried, throughout the research process I explicitly identified my positionality with participants by telling them that I was a therapist working in rural Maine who was a doctoral student. Further, I explained the purpose of the research was to better understand experiences and perceptions of people experiencing poverty in rural Maine when attending therapy, to make more visible what is often invisible, rural white poverty. On the one hand, I was exhibiting power and privilege by going in and talking to people who possibly experienced

marginalization in ways I did not. On the other hand, I was engaging my power to uplift and make visible and bring voice to a population who may often go unseen. Although I could have centered the work on therapists, and as this research shows, further research exploring perceptions and experiences of therapists' social class by therapists may be needed, as a critical, liberatory researcher, it was important to use my possible power to expose what might not otherwise be exposed and center participants' voices.

## Research Design

This section offers a presentation of the design structure. First, explanation of the recruitment process is presented, followed by an overview of participants and then an explanation of sampling. This is followed by a presentation of data generation, data analysis and validity. Lastly, ethical considerations within the study are presented.

### Recruitment

Participants were recruited through local community organizations including non-profits, for-profit, churches, civic organizations, health clinics and mental health list-servs. Recruitment of participants was made through phone calls, emails, and word of mouth. Phone calls were made to counseling organizations, churches, community civic organizations and health clinics by the researcher to ask if recruitment flyers could be circulated within the organization. Emails were sent with a recruitment flyer to mental health community list servs and included researcher contact information for individuals interested in participating. Interested participants contacted the researcher via email and/or phone. During the initial interview process, the researcher provided additional information about the study that was applicable, including identifying researcher positionality, conducting a demographic survey to ensure potential volunteers were eligible for participation, and provided consent documents.

## Participants

The study involved 9 adults, ages 18-65, who live in rural Maine (in counties with less than 50,000 people). Participants self-identified as white and had attempted to access mental health therapy in the previous 5 years by attending at least one counseling appointment in rural Maine. To qualify for participation, participants were required to make less than $23,000 per year and/or be eligible for Mainecare. The financial criteria for participants were determined by eligibility criteria for Mainecare (Maine Department of Health and Human Services, n.d,) and the definition of poverty within this study which extended beyond economic and included an intersectional examination of economic, social, and political barriers to meeting one's basic needs, offering a comprehensive understanding of poverty. Each participant self-identified as meeting the income and/or Mainecare requirement for participation. Participants identified as men or women, lesbian, gay, bi-sexual, queer, or heterosexual, partnered or single. Some participants had children, and some did not. Due to the research purpose of exploring perceptions and experiences of white therapy clients of white therapists' social class, members of the BIPOC community were be excluded from this study. Additionally, all eligible participants who completed the interview were provided with a $25 gift card to either a grocery store or retail establishment of their choice.

## Sampling

This study sought to draw from the contextual, demographic, and perceptual experiences (Bloomberg & Volpe, 2019) of the participants. A purposeful sample (Patton, 2015) was used to recruit participants throughout various rural counties in Maine and met the following criteria to recruit candidates for participation: Participants were recruited through local mental health list-servs, community organizations including non-profits, free medical clinics, churches, and civic

organizations. Candidates self-identified as white adults ages 18-65, who lived in rural Maine and either made less that $23,000 per year and/or qualified for Mainecare. Additionally, all participants had experience accessing therapy in rural Maine. The study excluded members of the BIPOC community, children under 18 and adults over 65 as those populations experience intersections of socio-political consideration beyond the reach of this study.

## Data Generation

Data were collected via individual, semi-structured interviews via online technology or in person, and were recorded using a recording device and then transcribed by the researcher using transcription software. Research memos, following the interviews, were an additional source of data. Discourse Historical Analysis (Reisigl & Wodak, 2009) was used to gain a nuanced understanding of the historical socio-economic-racial discourses impacting participants experiences and perceptions of therapy and therapists in rural Maine. Critical Constructivist Grounded Theory was used to analyze individual narratives, leading to categories, themes and sub-themes as described in Charmaz (2014) and Levitt (2021).

### Semi-Structured Interviews

Data in this research was generated through semi-structured, one-on-one interviews with participants (Levitt, 2021). Each interview lasted between 60 and 90 minutes. One-on-one interviews offer flexibility about where and when interviews will occur, thereby centering the needs of the participants in solidarity with their daily lives (Denscombe, 2007). Semi-structured interviews also allow the interviewee to address topics and develop ideas in a way that removes the adherence on a structure developed by the interviewer (Denscombe, 2007) which is consistent with the practice of centering participants' experiences in this study. Data were

collected via individual, semi-structured interviews with participants that were recorded using a recording device or via online technology and then transcribed and coded by the researcher.

## Data Analysis

Data analysis employed both Discourse Historical Analysis and Critical-Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021; Reisigl & Wodak, 2016). Data analysis generated via Discourse Historical Analysis (Reisigl & Wodak, 2016) examined discourse context. Examination of discourse context was practiced through examination of discourse, text and genres (Reisigl & Wodak, 2016). These elements were then examined within the historical, socio-political, and situational location of rural Maine. Data analysis generated via Critical-Constructivist Grounded Theory (Charmaz, 2008, 2014; Levitt, 2021) was done using MAXQDA, a qualitative analysis software, and utilized four levels of Constructivist Grounded Theory: initial coding, focused coding, axial coding, and theoretical coding (Charmaz, 2014). Initial codes were identified from raw data and over 500 initial codes were identified. Next, focused coding was used to synthesize and sort the data into broad thematic codes. Next, axial coding was used to organize the thematic codes systematically into categories, leading to the exposure of emerging themes at a conceptual level. Analysis of the interviews involved constant, multi-layered comparison of data units to identify patterns which in turn became categories (Charmaz, 2014; Levitt, 2021). Using a line-by-line method, each interview was coded using a constant comparative method to identify differences and similarities between participant perceptions and experiences (Charmaz, 2008, 2014; Levitt, 2021). The final stage of the analysis was theoretical coding, involving relating themes to one another and pointing toward a theory. Throughout the analysis process, questions centered in Discourse Historical Analysis, were utilized in the process of multi-layered comparison. These questions included:

1. How are persons, objects, phenomena/events, processes and actions named and referred to linguistically?
2. What characteristics, qualities and features are attributed to social actors, objects, phenomena/events and process?
3. What arguments are employed in the discourse in question?
4. From what perspective are these nominations, attributions and arguments expressed?
5. Are the respective utterances articulated overtly, intensified or mitigated? (Reisigl & Wodak, 2016, p. 32)

The analysis involved critical examination of historical and contemporary discourses surrounding mental health, poverty, social class, and racial homogeneity within the research participants' responses. The intersection of individual experiences identified through Critical Constructivist Grounded Theory (Charmaz, 2008, 2014; Levitt, 2021) analysis and the broader discursive contexts of both discursive narratives and strategies, identified using Discourse Historical Analysis (Reisigl & Wodak, 2016), provided findings which were examined within the historical and contemporary contexts within which perceptions were formed by participants. Additionally, Discourse Historical Analysis (Reisigl & Wodak, 2016) was utilized to examine how language was used in historical, social and political contexts over time. This was done with a critical theoretical understanding of power relations, ideologies and social structures embedded within discourse.

## Validity

Validity requires criteria for evaluating the trustworthiness of the research (Bloomberg & Volpe, 2019). Suzuki et al. (2007) asserted that data gathering can be reflexive and is a process

that can encourage the researcher's practice of critical self-reflection. Critical self-reflection is achieved in qualitative research through multiple practices, including member checking, memoing, journaling, and prolonged engagement (Marshall & Rossman, 2016). To ensure trustworthiness in this study, credibility, confirmability (Bloomberg & Volpe, 2019) and dependability (Marshall & Rossman, 2016) were addressed.

**Credibility**

Credibility is the degree to which participants' perceptions of themselves align with the researcher's portrayal of who they are (Bloomberg & Volpe, 2019). To address concerns and create credibility (Patton, 2015), the researcher engaged in member checking, peer debriefing, and prolonged engagement (Marshall & Rossman, 2016). Member checking occurred through a process of sharing the data and interpretations with participants during the interview process (Marshall & Rossman, 2016). The researcher engaged in the practice of peer debriefing with critical peers group after listening and transcribing the interviews. This process included discussion of emergent findings and critical peer feedback that checked that the analysis was grounded in the data (Marshall & Rossman, 2016).

In addition, the researcher wrote post-interview memos (Charmaz, 2014; Denscombe, 2007; Levitt, 2021). The memo process supported data generation by allowing the researcher to capture observations and immediate interpretations, practice theoretical reflection and development, track reasons for shift in the interview process, and help to generate reflection during the coding process (Levitt, 2021).

**Confirmability**

Like credibility, confirmability is achieved through reflexive practices. While credibility seeks to ensure that participants' perceptions of themselves align with the researcher's portrayal

of who they are (Bloomberg & Volpe, 2019) and is achieved through the researcher's reflexive engagement of member checking and peer debriefing, confirmability explores researcher biases and unconscious prejudices that may impact interpretations of the data (Bloomberg & Volpe, 2019). Through critical peer debriefing, a practice which seeks to acknowledge and explore biases and unconscious prejudices of the researcher (Marshall & Rossman, 2016), the researcher engaged with critical peers to ensure that the analysis was rooted in the data and not informed by the unconscious biases of the researcher.

**Dependability**

Marshall and Rossman (2016) defined dependability as how the researcher accounts for changes in the design and conditions that occur through an increased understanding of the study setting and phenomenon of interest. As more data were gathered and multiple realities began to emerge, it was necessary to account for emergent themes and to address them in the analysis to ensure dependability. To account for emergent themes and ensure dependability of the findings within the intersectional data analysis process of using Critical Constructivist Grounded Theory (Charmaz, 2008, 2014; Levitt, 2021) and Discourse Historical Analysis (Reisigl & Wodak, 2016), this research employed constant comparison of the data (Marshall & Rossman, 2016). This occurred with the raw data gathered within the initial stages of coding and continued throughout the coding and analysis process. Data gathered from both methodologies was compared and analyzed to support dependability. This process served as an important pathway to centering the voices and experiences of participants, ensuring greater levels of dependability of the findings.

## Ethical Considerations

The anticipation of ethical issues that may arise during the research process is an important consideration. To engage in ethical practice, identifying ethical considerations, which may arise prior, during and after the study, must be assessed (Creswell & Creswell, 2018).

### Considerations Prior to Conducting Study

To address concerns about possible selection of research sites that may have had a vested interest in the outcome of this research (Creswell & Creswell, 2018), the researcher identified locations for recruitment where she did not have personal affiliation. The purpose of this was to reduce the possibility of potential power differentials between myself and the participants, wherein I hold "insider status" (Ross, 2017) and may have had bias towards the outcome of the study on behalf of the organization.

### Considerations During the Study

Throughout the research process, the researcher engaged in reflexive practices to support the validity of the findings. These processes included protection of the participants and guarding against misconduct.

#### *Protection of Participants*

Protection of the participants requires consideration of multiple variables including protecting the participants from undo harm (Creswell & Creswell, 2018). To do this, the researcher gained permission from the participants via informed consent, which included an explanation that the participants did not have to sign the form, could withdraw at any time and provided written explanation of the research. The researcher provided disclosure of her positionality as a researcher who is also a therapist in rural Maine. To develop trust with the participants, the researcher discussed the purpose of the study and how the data would be used

with each interviewee. To the extent possible, discomfort and/or emotional dysregulation which might have occurred for the participants was discussed, and all interviews occurred in a private location that was, to the extent possible, able to decrease power differentials between the participant and researcher (Creswell & Creswell, 2018). In addition, involving the participants as co-collaborators supported the act of trust-building (Creswell & Creswell, 2018).

To further support the protection of the participants, the practice of reflexivity, through memoing and critical peer review was enacted. The researcher engaged in reflexive memoing throughout the research process and findings from that memoing were used to complete the reflexive statements in this chapter. In addition, the researcher conferred with peers to receive feedback about her ethical practices by sharing with peers how she conducted the informed consent process. This reflexive process required a constant reflection regarding the relationship between the researcher and the participants. Examining the role of power differential by asking questions such as, “Is the relationship non manipulative? Is there potential for reciprocity? Is there the potential for pain and anguish when the person interviewed shares painful experiences? Am I protecting the identity of the interviewee?” (Marshall & Rossman, 2016, p. 164) guided the reflexivity process.

### *Guarding Against Misconduct*

Guarding against misconduct informed all stages of the research process. To guard against misconduct, the researcher obtained approval from the Institutional Review Board (IRB) of Lesley University. Transcribed data and recordings were kept in a locked file in a locked office. All recorded interviews were deleted at the completion of the data analysis. Consent forms will continue to be kept locked, and all identifying information will remain confidential. All informed consents and demographic information will be destroyed after 5 years.

## Conclusion

This research explored the perceptions of white therapists' social class by white clients experiencing poverty in rural Maine to better understand the way mental health discourse replicates social class structures in racially homogenous therapeutic settings. Functioning from a critical framework which centers the lived experience of this population, this research sought to enact practices of solidarity, liberation, and emancipation by conducting research in a way that is centered in the experience of the participants. This research asked the questions:

**(RQ1):** Do clients experiencing rural poverty perceive the social class of their therapist as different from their own and how does that impact their experience and acceptance of therapy? and

**(RQ2):** What role does racial homogeneity play in perceptions of social class between white clients and white therapists in rural Maine?"

Exploring client perceptions and experiences of their therapists' social class in racially homogenous white rural Maine, this research sought to better understand how social class perceptions affect therapeutic relationships in this location. To support the critical framework of this research, the methodology of Discourse Historical Analysis (Reisigl & Wodak, 2016) and Critical-Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021) were utilized to examine the findings and uplift the voices of participants as the primary experts of their lived experiences.

# CHAPTER IV

# FINDINGS

The purpose of this research study was to explore the perceptions and experiences of white therapists' social class by white clients experiencing poverty in rural Maine. This chapter presents the key findings obtained using an intersectional method of combining Discourse Historical Analysis (Reisigl & Wodak, 2016) and Critical Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021). This chapter begins with a review of the participant demographics. This is followed by the presentation of the findings. The presentation of the findings is organized into three broad categories: Context of Maine Culture, Institutional Context of Mainecare, and Perceptions of Therapists. Within each of these categories, themes and sub-themes are presented. Lastly, a conclusion which summarizes the findings is presented.

## Participant Demographics

This research explored how white clients, living in poverty in rural Maine, perceived and experienced the social class of their white therapists. Demographic qualifications of participants required that they make less than $23,000 per year and/or qualify for Mainecare, be age 18-65, identify as white, live in rural Maine, and experience poverty. Within this research, poverty is defined as the intersectional experience of lack of income combined with lack of access to social and political power, impacting access to resources including health care and education (Tickamyer & Wornell, 2017). Poverty, therefore, is more than just about money and instead can be conceptualized as being a positional status which situates being poor within social class hierarchy (Smith, 2010).

Participants self-identified as attending or having attended therapy while having incomes below $23,000 per year and/or qualifying for Mainecare. They identified as living in rural Maine and being white. Participants were not specifically screened for gender, but 8 of the 9 participants were female. Education level and occupation level were identified to provide demographic information and socio-educational context about participants. There was not a specific education or occupation criterion requirement for eligibility to participate in the research. See Table 1 for the demographic matrix of the research participants. To protect the privacy of each research participant, their names were replaced with a respective number. Each number will be used to reference a particular participant throughout this chapter.

**Table 1**

*Participant Demographic Matrix*

| Participant Code | Gender | Age | Highest Level of Education | Occupation | Annual Income |
|---|---|---|---|---|---|
| 1 | F | 33 | High school | Unemployed | Less than $10,000/per year |
| 2 | F | 46 | High school | Admin-Assistant | Between $20,00 and $22,000/per year |
| 3 | M | 19 | High school | Fry Cook | Between $20,00 and $22,000/per year |
| 4 | F | 28 | Some college | Part-time Bartender | Between $20,00 and $22,000/per year |
| 5 | F | 41 | College degree | Garden Manager | Less than $10,000/per year |
| 6 | F | 49 | High school | Furniture Builder | Between $20,00 and $22,000/per year |
| 7 | F | 18 | Some college | Retail | Between $20,00 and $22,000/per year |
| 8 | F | 40 | Some College | Unemployed | Less than $10,000/per year |
| 9 | F | 39 | Some college | Peer Recovery Coach | Between $20,00 and $22,000/per year |

The research presented within this dissertation was guided by two research questions.

**(RQ1):** Do clients experiencing rural poverty in Maine perceive the social class of their therapist as different from their own and how does that impact their experience and acceptance of therapy?

and

**(RQ2):** What role does racial homogeneity play in the perceptions of social class between white clients and white therapists in rural Maine?

To explore how perceived differences influenced participants overall experience and acceptance of therapy, Research Question 1 focused on both (a) participant experience of rural poverty and (b) their perceptions of their respective therapist's social class. Research Question 2 examined the intricate interplay between racial homogeneity and social class perceptions, and the researcher designed the question to investigate the role racial homogeneity plays on participant perceptions of their respective therapist's social class. Within the context of this research, racial homogeneity was defined as white therapists and white clients. What emerged in the findings were cultural and institutional factors that affected participants ability to access therapy while experiencing rural poverty. The findings found participants' experience of poverty impacted perceptions of their therapist's social class. Additionally, the exploration of the role of racial homogeneity on perceptions of therapists' social class exposed participant perceptions of how therapy would change with a therapist who was not white.

## Presentation of Findings

This section begins with a presentation of the theme of Seeking Therapy within the Cultural Context of Maine. This includes a sub-theme of Privacy Learned from Grandparents. Next, a presentation of the theme of Institutional Context of Mainecare is presented, this includes

sub-themes: Mainecare Does Not Pay, Stigma and Exclusion, and Mainecare and Access. The sub-theme of Mainecare and Access includes a sub-theme of Telehealth. Within Telehealth, sub-themes of Less Connection and Increased Access are presented. Finally, there is a presentation of the theme of Perceptions of Therapists While Experiencing Poverty in Maine which includes the sub-theme of Perceptions of Impact of Racial Differences in Therapy. Within this sub-theme, there is a presentation of Learning and Understanding, and Impact of Race on Behavior of Client.

## Seeking Therapy Within the Cultural Context of Maine

When asked about their experiences of seeking therapy, participants identified powerful cultural norms in rural Maine of not "asking for help," not "telling others about your problems," and not "sharing," reinforced by broad hegemonic cultural values of self-sufficiency and independence. Asking for help elicited feelings of "weakness" and "failure." This led to experiences of feeling isolated when seeking help, causing participants to experience stigma and shame when needing support. Participant 8 described the "isolation and lack of acceptance within the community" by explaining getting therapy was a "don't ask, don't tell" event. She described a perceived bind stating: "So, we want you to get help, but we're not going to give you tools to know how. And it's gonna be stigmatized. So, it's gonna feel like you have to do it all by yourself." She identified that not sharing problems was rooted in rural town values that asking for help was shameful sharing, "I think the idea of, of like not feeling like, you can't say I need help, it's still treated in a lot of small-town areas as a shameful thing to be in need of help." Participant 8 continued:

> I think it is just the understanding that because of rural nature. Everybody does know everybody's business, so people get shamed based on, like, their behaviors or their needs

> by people saying outright, like, "I know you've been told", or "it's likely that you've been told you shouldn't be talking about this? You shouldn't be sharing this."

Participant 3 identified that identifying as "strong and independent" in Maine was rooted in the cultural norm that in "Maine we're raised to be tough" and "if you try to get help, some people will look at that as a sign of weakness." He identified that going to therapy was hard because he liked thinking of himself as strong and independent and getting help contradicted his beliefs that he could "do everything himself" sharing:

> For me, that was the toughest thing because I like thinking I'm a strong, independent person. I can do everything myself. I don't need help. Then when I went to therapy, it was like now I'm getting help. And it's like, man, I thought I could do this all by myself. I didn't need any help.

Participant 1, who had grown up in Maine and self-identified as being "from Maine," associated going to counseling with being "a failure" and identified "feeling weak" for not being able to take care of her own emotional needs. She identified that a larger cultural norm in Maine made going to therapy "not ok" sharing:

> I'm from Maine, you know, so going to therapy felt, kinda, not ok. I felt weak because I don't know, I'm just a person that I feel like I'm, and I'm the one that always tries to keep everything together and doing stuff for everybody else. And I should be able to deal with my own shit and not have to worry about it. Am I a failure because I have to go to counseling? And that's the first word that comes to mind.

Some participants identified that when they did seek help in the form of therapy, knowing people, including therapists, in multiple social and professional domains in rural locations meant risking exposure within the community. Participant 2 identified that her family was large and

well known in the community, leading her to have concerns if she could meet with a therapist who would not know someone in her family. She attributed this to her perception that "In a small town, and rural areas are so much more interconnected, we're not seven degrees separated. It's one or two in every aspect." Participant 4 shared similar concerns, stating, "It was just my own thought of like, I don't, I don't wanna go to somebody, I just didn't wanna go to somebody that knew like, like me and my family."

Participant 9 shared how she knew a lot of people in the community because of her family owning a small business. This led her to want to "not wanna see somebody I knew. I wanted somebody to be kind of like on the outside." Participant 8 also struggled with family connections in her rural location, noting:

> There are a significant amount of therapists in this area that I have other personal connections with … because I either grew up with their kids, or even one of my sister-in-law's is a therapist, so I couldn't see anyone in her practice.

Participant 7 identified that people in her community were too socially close, leaving her needing to see someone outside of her community. Because she lived in a rural location, seeing a therapist who she did not know socially meant "I had to drive for an hour," which was difficult for her because she did not have extra income for gas. Maintaining privacy in rural Maine was important for participants and many identified that they learned to not need help and to maintain privacy from grandparents.

***Privacy Learned from Grandparents***

The cultural norm of not needing help appeared, in part, to be constructed through family beliefs of maintaining privacy when experiencing emotional difficulties. This perception was re-enforced by grandparents. When asked about where the participants learned to not talk to people

about their problems, many participants identified that it was something they learned from their grandparents. Participant 7 said:

> My old fashioned, my grandfather worked at Paper Mill, he was very strict. I could see him being the same though as, you don't need to talk to anybody, you don't tell other people your problems type of person.

Additionally, Participant 9 shared her experience of talking to her grandmother about needing help, telling the story:

> Gram, but what if I need help with something? And she would go, well, you have to figure it out on your own. You shouldn't be involvin' in, as she put it, strangers into your life problem.

Participant 6, who's family had been living in Maine for at least three generations, shared that she was the first in her family to attend therapy. When asked if her family discussed therapy when she was growing up, she replied, "No, no one talked about that stuff, you kept stuff to yourself." When asked where she learned to keep stuff to herself, she said:

> I think it came from my grandmother actually. Because my grand, my grandmother was not one for talking about her problems. And I don't think that, you know, with the way my mother grew up, I think that my mother wasn't really allowed to talk about her problems. So, she was trying to, you know, she only knew, knew what she knew. Basically, she was taught that, you know, if you have a problem, keep it to yourself. You don't need to involve anybody else.

Participant 5, who's family had been in Maine for five generations, shared with her grandmother that she felt like she needed to see someone to talk to. She reported that her grandmother had said to her, "You should just, you know, you should talk to your friends … your counselor

doesn't know you." The experience of maintaining privacy was culturally sanctioned by values passed down through multiple generations.

### Synopsis of Seeking Therapy Within the Cultural Context of Maine

Overall, from the findings, the researcher found that cultural values of independence and self-sufficiency in rural Maine were maintained through cultural norms of not seeking help. Cultural values of not seeking help appeared to be reinforced through feelings of weakness and failure when seeking help. In small rural communities in Maine participants risked exposure of violating cultural norms of maintaining independence and self-sufficiency by seeking help. Participants identified that knowing people, including therapists, in multiple social and professional domains in rural locations meant risking exposure within the community that they were seeking help. Lastly, the participants identified that cultural values of maintaining privacy and not letting people know there was a need for help was learned in relationships participants had with their grandparents.

### Institutional Context of Mainecare

Although maintaining privacy, independence and self-sufficiency appeared to be powerful cultural norms within the lives of participants, these norms did not prevent them from attending therapy. As a result, participants had experiences of seeking therapy and therapists in rural Maine. The demographic qualifications of this study required each research participant to have an income of less than $23,000 per year and/or qualify for Mainecare (Maine Department of Health and Human Services, n.d,). Within this research, all the participants used Mainecare to access therapy. This meant each research participant had to balance an inextricable relationship between Mainecare and therapy. As a result, participant narratives were laden with experiences and perceptions about using Mainecare.

To help illustrate a general context of each research participant and their relationship with public health insurance, Mainecare provides health insurance to adults at 138% of the federal poverty line, for pregnant people at 214% of the federal poverty line and for parents/caregivers at 105% of the Federal Poverty Line. The income qualifications are: $1,677 per month for individuals, $2,268 per month for a family of two, $2,859 per month for a family of three, and $3,450 per month for a family for four, and $592 per month per additional person after the fourth (Maine Department of Health and Human Services, n.d.). In addition, pregnant people are covered at monthly income of $3,517. Parents/caretakers of children qualify as individuals at $1,276 per month, $1,726 for a family of two, $2,176 for a family of three, $2,625 for a family of four, and an additional $450 per month for each additional family member (Maine Department of Health and Human Services, n.d.).

Some participants shared that finding a therapist who took Mainecare and who was available as a difficult, long process that required significant time and energy. Participant 4 shared that she had been searching for years, stating, “I had been searching for about 5 to 6 years before I was able to start seeing her. It was so incredibly difficult to be able to find anybody that was accepting Manicure and had openings.” Additionally, Participant 1 shared, **“**It felt like I was waiting years to get a therapist with Mainecare cuz you have to wait for them to get it approved, and then there’s also a lack of therapists around here.” Participant 2 identified that the combination of lack of available therapists was compounded when using Mainecare by stating, “I felt like there wasn’t a lot of people who were taking new clients, but the Mainecare thing restricted me more.” As a result, even when she was able to find a therapist who took Mainecare, she stayed with a therapist who wasn’t a fit out of concern that changing therapists would “mess with the system.” She stated:

> Like, but I also was like, she takes Mainecare, so I kept her that entire time. I didn't wanna like mess with the system. So, I definitely had her as my therapist for a longer time than I would've, like if I was paying out of pocket. I would've changed if I was paying out of pocket or thought I could find another therapist who took Mainecare.

Although participants sometimes found a therapist who accepted Mainecare, those therapists often were not immediately available, leading participants to contend with long wait times and being put on waitlists. Multiple participants offered statements such as:

> Participant 2: There's, there's these huge wait lists.
>
> Participant 5: There's always, always a waitlist for therapy.
>
> Participant 7: That's the hard part for me, especially wherever I go, there's always a waitlist for therapy.

Additionally, once research participants were able to wait out the waitlists, two more barriers emerged: (a) geographic location and (b) access to reliable transportation. Participant 4 said, "Transportation to appointments is a huge barrier. We're very rural here in Oxford County, Maine is, is huge and very rural." Also, Participant 1 said, "I don't have a license or a car so I have to get a ride or see my therapist by telehealth."

***Mainecare Does Not Pay***

Some participants wondered if the lack of therapists who took Mainecare was related to the socio-economic impact taking Mainecare had on therapists. Participants wondered if a lack of available therapists was caused by Mainecare not adequately paying therapists. Participant 1 said, "Mainecare isn't the best at keeping them paid." Similarly, Participant 2 said, "Mainecare doesn't pay therapists well, I think, that's why they don't take it." Participant 6 the shared her perception that she also thought Mainecare paid low rates to therapists, stating: "I think

Mainecare kinda stiffs the therapist or provider." Participant 9 wondered if Mainecare therapists "really get paid that much since it's not regular insurance." Participant 7 also wondered how being paid by Mainecare compared to regular insurance, asking the question "Are they not getting paid as much as they would through a regular insurance company?"

***Stigma and Exclusion***

Contending with difficulty accessing an available therapist while using Mainecare left many participants feeling stigmatized and excluded. Participant 6 explained how her experiences using Mainecare made her feel "lower class" because, as she said when discussing how the providers spoke to her, "there are a lot that make you feel crappy." Participant 1 shared that she had been made to feel lower income when using Mainecare stating: "I feel like Mainecare is a lower income, that's how I've been made to feel." Participant 9 shared that she had been treated differently when she called providers because "depending on who you were talking to, kind of made a difference with Mainecare. Sometimes it made me feel kind of, the attitude was completely different. You're lesser." Each of these participant's narratives points to an experience of being stigmatized for using Mainecare. The stigmatization is communicated through the way they were spoken to by providers.

Similarly, when speaking about the affluent community where she lived, Participant 5 said shared a perception of stigma associated with using Mainecare:

> [So and so] is fancy and has a lot of money. So, like they wouldn't think that someone in the community would need to use Mainecare. It seems like they don't wanna serve that community basically.

When navigating the complexities of trying to find an available therapist, participants identified that an amorphous operating system, of which one was either included or excluded,

created a feeling of being demoralized and isolated when contacting a therapist. This contributed to perceptions of exclusion. Participant 4 said:

> You don't know what you need to do to get into that system. You just know you need to get into it. It seems to be that you almost need to already be in that system to get referrals to people who will help.

Not hearing back from providers also contributed to the experience of feeling as though participants could not access help. Participant 8 said, "The combination of not knowing how to get the help" she was encouraged to get and "needing to make cold calls and not hearing back" left her feeling "demoralized." She explained:

> Not knowing how to get the help that people were saying, if you need help, get it, that was a real roadblock for me and then it becomes really demoralizing to do these cold calls and just not hear, not get a call back or an email or something that says I'm really sorry, my list is full.

Although participants had trouble accessing available therapists when using Mainecare, contributing to experiences of stigma and exclusion, some participants were able to access therapists when using Mainecare.

***Mainecare and Access***

Although participants identified experiencing barriers associated with using Mainecare for therapy, when able to find a therapist who was available and accepted Mainecare, some of the research participants identified that Mainecare made going to therapy possible. For example, Participant 1 said, "If I didn't have Mainecare, I wouldn't be able to go to therapy." Participant 5, identified how having Mainecare enabled her to attend therapy when she was pregnant:

> I think that the, like, I felt very, like, like I was pregnant. I was worried about, like more worried about postnatal health, like mental health and I was trying to set myself up for success by finding a therapist beforehand before anything did come up. And I don't think I would've been able to do that without Mainecare.

She continued, sharing that knowing Mainecare would pay for therapy encouraged her to attend therapy:

> I would say like, the reason I felt like I like encouraged myself to seek a therapist was because I knew it would be covered by Mainecare. So, like, honestly, if I had insurance that had a copay or something, I might not even have looked for the support.

Participant 3 said:

> It's just like covered, covered through Mainecare so you like, don't have to worry about it anymore. … Mainecare does have some advantages with therapy. Man, if you can find a therapist who is covered by Mainecare and you have it, yes, go ahead, grab that therapist.

Knowing that Mainecare would cover the cost of therapy encouraged participants to take advantage of the benefit, and some reported reduced feelings of worry. Additionally, participants identified that they often participated in telehealth when they were able to find an available therapist.

**Telehealth**. When participants were able to find an available therapist who accepted Mainecare, they often reported accessing therapy via telehealth. Telehealth is the practice of seeing a provider virtually via technology rather than seeing a provider in person. The use of telehealth has increased since the onset of Covid-19 and has altered how healthcare is provided in rural locations (Freske & Malczyk, 2021). In this research, some participants reported using

telehealth via Zoom or Facetime. Other participants simply used the phone and had never seen or met their therapist in person. Of participants who had engaged in telehealth, some identified that telehealth helped mitigate barriers to access caused by lack of transportation and geographic locations. Although telehealth helped decrease barriers to access for these participants, the impact of using telehealth created distinct experiences. Some of the participants identified that telehealth caused them to (a) feel less connected with their therapist and/or (b) experience increased access to therapy in rural locations.

***Less Connection***. Although participants were able to access therapy via telehealth, some identified that telehealth also created a barrier in quality of care. Participant 3 identified the experience of feeling "less connected" with his therapist and often "wondered about what his therapist was like in person." Participants reported difficulty with being able to "open up" online and were left feeling that telehealth made therapy impersonal. For people who had been to both in person and telehealth therapy, most reported a preference for in person therapy. For example, Participant 1 said, "I know talking face to face with my therapist helps me a little better." Participant 2 said:

> I feel like therapy over the phone or online just isn't as, doesn't make, doesn't help as much as it would in person because I don't know, I feel weird. I have a hard time making eye contact. So, I don't like talking to people about my feelings online because I just wander off and look everywhere else and I lose track.

While describing her experience with telehealth, Participant 7 disclosed she had "only met her previous therapist virtually and never in person." When asked what it was like to have never met her therapist in person, she replied:

> It was weird. It wasn't normal for me. I prefer talking to a person and interacting with them. I'm not good on just phone calls and stuff on FaceTime or whatnot and just talking. It probably ruined it a little bit because I'm not the best at fully opening up online too. That's another thing is I prefer, once they're in person, I can see their emotions and stuff.

Participant 9 also identified that seeing her therapist's "emotions in person" was her preference.

Participant 1 shared that because she was living in a rural location which was "45 minutes from her therapist's office," she was seeing her therapist via telehealth, which was not her preference. To see a therapist in person, for example, she would need to find a therapist taking Mainecare who practiced closer to where she lived. She figured, then, to see a therapist in person, she would need to change therapists, which was problematic because:

> It's like I don't wanna change my therapist because I do get, we get along great and she's helped me out so much, but I just wish there was a way that even if I had to take public transportation, I could go and see her.

Participant 4 identified she had not met her therapist in person due to geographic distance, time, and money. Similar to Participant 2 and Participant 1, she preferred in-person therapy by saying,

> So we haven't had a chance to meet in person. It's working for us to do telehealth right now. It started because her practice is up in [name of place removed], and so the ability and the cost for me to travel to meet her in person was just, just not there. But I tend to have struggles with virtual and video chat meetings. It's partially my age and partially just, it feels slightly impersonal.

Contending with transportation, geography, time and cost impacted participants ability to see a therapist in person. Although there were participants who reported preferring in-person therapy to telehealth, some also identified that telehealth increased access to therapy in rural locations.

***Increased Access***. Although some participants identified a preference for in person therapy, other participants identified how having access to telehealth, even if they preferred in person as the ideal, made therapy possible. Participant 1 stated: "If I didn't have it as a virtual option, I wouldn't have therapy. So, it really is an accessibility tool." Participant 4 shared that telehealth made therapy possible because it was convenient and meant she could maintain her family responsibilities, which she worried about. She identified that if she had been seeing her therapist in person, she would have cancelled if she felt anxious about trying to "get this housework done because the kids have a baseball game tonight." Participant 9 shared that her therapist's flexibility when using telehealth positively impacted her perception of her therapist by stating, "I've really lucked out with my current therapist in that way of. … She's got great flexibility. We're able to meet virtually so. It's been wonderful on that side."

For participants who engaged in telehealth and found it helpful, they identified that it provided flexible access to therapy and helped them to experience reduced anxiety associated with time management. The drawback identified by participants using telehealth was that it did not allow them to meet with their therapists in person, leaving some participants experiencing distraction and difficulty with feeling connected to their therapist.

**Synopsis of Institutional Context of Mainecare**

The operational requirements of this study required that participants have incomes below $23,000 and/or qualify for Mainecare. All participants used Mainecare to access therapy, leading to findings centered on participants' experiences and perceptions of using Mainecare to access

therapy. Findings emerged highlighting that although Mainecare covered the cost of therapy, finding an available therapist who took Mainecare was a difficult task for participants to complete. Some participants perceived Mainecare as not paying providers well, impacting availability of therapists. One participant experienced feeling stuck with a provider who was not a good fit because there were a lack of providers taking Mainecare. Additionally, even when there was a therapist who took Mainecare, participants often experienced long wait times and being put on wait lists. Difficulty accessing therapists was compounded by geography and transportation. Using Mainecare led to experiences and perceptions of stigma and exclusion when seeking a therapist. Some participants however, knowing therapy would be paid for by Mainecare, experienced relief and felt encouraged to go to therapy. Lastly, many participants participated in telehealth to access therapy. The findings showed telehealth increased access to therapy but also decreased experiences of emotional connection with therapists, impacting participants overall experience of therapy. Overall, the institutional context of Mainecare was shown to be central in impacting participants' experience of accessing therapists and therapy and contributed to both positive and negative experiences.

### Perceptions of Therapist While Experiencing Poverty in Maine

When participants had access to available therapy and therapists, many discussed perceptions of their therapists and how their perceptions impacted their experiences of therapy. Some participants identified how an office was decorated or how a therapist disclosed personal information about vacations or family created feelings like jealousy. Other participants identified that how they were spoken to had an impact on their experience and perceptions of their therapist. Appearing to be embedded within the narratives were perceptions of economic

differences between participants and their therapists. Participant 9 shared how seeing her therapist have a separate space to work elicited jealousy, stating:

> She has a little space in her outside of her home, a little shed type of space that she does her therapy. … It was a little hard, seeing that that she had that space that was just devoted to therapy, like I had that moment of like, okay, I don't. I don't have a space in my home that's mine. Every space that's in this house is shared, and it kind of rubbed against me. A little bit of it must be nice to be able to detach from that home space and be able to be focused on a different space. And there was some jealousy that came out of that as well.

Having to share every space in her house, being able to detach by herself from others; was not something available to participant 9. The difference between her socio-economic status and that of her therapist was exposed by her therapist having access to a separate space to work and served to create feelings of jealousy.

Participant 2 also identified feelings of jealousy and experiences of economic disparities between herself and her therapist when her therapist disclosed going on vacation. She shared this experience by stating:

> My family personally hasn't ever had much money. So, when she would tell me things, one time she was telling me a story of how her family went on vacation, and it just kind of made me feel bad. It made me feel, I guess jealous because she was talking about her experiences and … I couldn't relate.

Participant 1 reported that her therapist's disclosure about going to a concert exposed economic disparities between her and her therapist. This caused her to think her therapist was better than she was and left her not wanting to do therapy, stating "I didn't wanna do it." She shared that the

money she had did not allow her to attend “luxury” events, something she perceived her therapist did not understand. She identified that although therapists were supposed to be helping, her experience left her feeling her therapist was not helpful and therapy “was hindering” her. She articulated this experience by sharing:

> One particular time there was a concert that I wanted to go to, but I, I just never have the money to go to concerts because I always focus on my money towards what needs to be paid instead of luxury. And she, she would, um, go, oh, I’ve been to that concert before. It’s a great concert. You know, she bragged about it. Which that didn’t make me feel any better about my situation. It was like, this was something that I really want to go to, and here I am telling you how this is making me feel and not being able to go. And you’re just sitting here bragging about you’ve been to one, that makes me feel like you’re better than me.

Participant 3 shared how his perception of his own social class status was impacted by his experience of his therapist’s office décor, which he perceived as “high-end stuff.” This caused him to feel that he could not relate to his therapist. He expressed this by sharing:

> I didn’t fully feel comfortable with opening up to him completely I think it’s because my family’s always had, we’ve been in the middle. Okay. We’re not high class, we’re not bottom class, we’re in the middle. And whenever I was looking into his room and stuff, it would always look like he always had the high-end stuff. Whereas me, it was like I’ve never had had high end stuff. I’ve had to make it work with stuff that have been below average.

Participant 7 identified her therapist’s use of “big language” made it difficult to understand what her therapist was trying to communicate. She said, “I have a very small

vocabulary, so most of the words I was hearing were gibberish" leaving her to perceive that her therapist was "not helpful." Participant 6 identified how the way her previous therapist spoke to her seemed snobby, stating, "I would be in there to talk about my daughter and how things were going. And she just looked down at me, she was snobby and kind of made me feel like she was just asking questions." This left her feeling that the therapist "didn't really care what I thought or how I felt."

When speaking about a past therapist, Participant 1 described how her therapist dressed, the cleanliness of the office, and the white noise machine made her feel uneasy, sharing:

> Like my past therapist I had, she was dressed very elegantly. Like she was always in a nice blouse, a skirt or a nice pair of dress pants with a blazer. And she would sit, you know, her office was like all spic and span. We always have like this little noise, um, yeah. And I kind of felt with that setting, I felt very like, uneasy.

Participant 8 identified that "the compounding issues she had to confront as a result of poverty" put her experience outside of the depth of her therapist's knowledge. She identified that she spoke with her current therapist about their mutual experience of having children with IEP's, which was meaningful for her, but she identified a perception that her therapist did not understand the structural violence (Galtung, 1990) of poverty when she noted:

> But I also have the awareness of like, it's a lot easier to work through those things if you're not also food insecure, housing insecure or have a repo letter coming for your only car, like there's only so much capacity to handle, and there are times when I think that the depth of her knowledge around what it's like to be handling those and all of these other things that that really do feel like life threatening longer term like it's a slow type of life threatening, but it's still life threatening.

Participant 9 described a perception that because her therapist had money, she did not understand this participant's lifelong experience of not having money and her mother not having a job. When she tried to explain to her therapist why her mother did not have a job, participant 9 perceived that her therapist told her she was lying. She described her experience, sharing:

> A lot of the problems I come from is I have is no money, and my mom not having a job. And so I would tell her, we have no money and my mom doesn't have a job, but my mom doesn't have a job for certain reasons. And she just would basically say, I'm lying, saying, oh, your mom can do that. And I don't know. She's like, yeah, she didn't understand. She didn't have no money. She had money, so she didn't experience what I was experiencing.

Although many participants experienced challenges with their therapists, impacting their perceptions, some participants also identified helpful experiences. Some participants perceived that their therapists were able to authentically validate their experience, leaving them feeling more understood. This appeared to allow them to perceive their therapists as understanding and caring. Participant 8 identified feeling frustrated with a broken system that lacked resources to help her with socio-economic support but her therapist's honesty and willingness to hear about living with poverty was "reassuring and validating" for her. Participant 4 was concerned when first starting with her therapist that her experiences of poverty and trauma would not be something that her therapist would be able to relate to. Her concerns were decreased when her therapist made herself more human, even though her therapist did not have the same life experiences as she did. This helped her feel connected to her therapist. She shared:

> She humanized herself for me in a way that I'm like, okay, she may not get my other experiences, she may not have lived my other experiences. But we found a lot of things

> that we could connect on. But at first it was, there was definitely the thought of how this person can even help me like if she hasn't, if she hasn't experienced it, how can she help guide me through it?

Participant 6 identified that being spoken to "like a normal person" helped her feel like her therapist just wanted to know her. The questions asked and tone of voice her therapist used helped her perceive her therapist as "just a really nice person who knew what she was doing … we clicked instantly." She continued to explain that her therapist said "if there's any time you think we're not clicking, let me know and I'll help you find someone who does" helped this participant feel her needs and preferences were being centered. Her therapist's desire and willingness for the participant to experience a proper "fit" helped her feel at ease quickly and reduced anxiety she had from previous encounters with therapists.

Understanding participants experience of poverty and creating a relationship of authenticity seemed to be important in shaping the experiences and perceptions of therapists by clients in white racially homogenous therapeutic relationships in rural Maine. To understand the role racial homogeneity played in forming perceptions and experiences of therapist's social class, participants were asked about how they thought having a therapist who was not white would theoretically impact their experience of therapy. What emerged from the findings exploring racial homogeneity were participant perceptions about race and specifically how having a therapist who was not white would potentially impact their experience of therapy.

### *Perceptions of Impact of Racial Differences on Therapy*

In rural Maine, racial homogeneity seems to be often taken for granted and is a phenomenon that extends to therapy, as Participant 5 highlighted when she stated, "I probably have never considered that I would have a non-white therapist up here." Because all the

participants were white and had white therapists, the role racial homogeneity had on participants' perceptions of their therapists' social class was explored through a theoretical lens. This was done by asking participants how they imagined therapy might have been different if they had had a therapist who was not white. Although participants identified that having a therapist who was not white would not have mattered to them ideologically, participants identified that the experience of therapy would be different with a therapist who was not white. Participant 2, who had never had a therapist who was not white, perceived that although she did not know if and what would be different by having a therapist who wasn't white, she thought the experience would be different, reflecting, "it would probably change something, but I don't know what that is."

Participants identified that while they did not have a preference about having a white therapist, many believed that a therapist who was not white would better understand their experience of poverty. Participant 7 articulated this by stating:

> Somebody who's not white, might understand better because they have been through the hardships that some of their clients that are white are going through, like food, not having enough food and having to go to food banks or, you know, they don't have the luxury of having a nice house or a nice car or even have a license or something. You know, they would understand it a lot more, in my opinion, than a white therapist.

Participant 7 perceived that her experience of poverty in rural Maine would have been better understood with a therapist who was not white because she perceived that all people of color had experience with poverty. Participant 1 also perceived that therapy with a non-white therapist would be different from therapy with a white therapist. She shared her perception that most of the white population experienced "access to luxury." But as someone who was experiencing

poverty, this was not her experience. As a result, she thought therapists who were not white would be more understanding of poverty because in her perception, non-white people generally experienced more poverty. She shared:

> Actually I think it probably would've been a lot different. For me, um, and I, I'm not saying that to be as, you know, be mean about it but I just think that they would be more understanding. Somebody who wasn't white would be more understanding…I don't have a nice car, nice house, you know, I have to go to food banks to help get food from my house. My family, I have, I only get $131 in food stamps. And then I have, I'm on SSI from my mental disabilities, so I only get $914 out of that. I don't get to go and have all those nice things that most of the white population does so they do understand for someone else who is white like me why we don't have all that luxury leisure stuff opposed to someone else. They might understand.

Many participants perceived that having a therapist who was not white would have changed therapy, especially in relationship to understanding the experience of poverty. This was due to participants' perceptions that people who were not white experienced higher levels of poverty. This led participants, to perceive that having a therapist who was not white would help them feel validated in their own experience of poverty and oppression.

**Learning and Understanding**. Some participants also identified that having a therapist who was not white might allow them to learn or be exposed to other ideas and experiences about being a person who was not white. Participant 5 shared that she perceived working with a non-white therapist would be an opportunity to maintain her practice of being exposed to broad experiences, sharing her perception of potential advantages associated with having a therapist who was not white, stating:

> I think it would be an opportunity to gain perspective…I think it would provide an opportunity for like, what I would assume, I mean, this is making broad conversations. I would like to think that it would be an opportunity to have some pretty valuable conversations about how race impacts life and, and what it feels like from a different perspective that I can't know.

Participant 6 perceived that people from other cultures and ethnicities would have an ability to "think outside the box," stating, "I think different race, different culture, ethnicity might be able to think outside the box when it comes to different tools and techniques." Participant 9 also shared this perspective, stating, "I feel it would've been different because I feel like different races have different point of views on things, and sometimes people have better answers than others."

Findings emerged that some participants perceived that a therapist who was not white would be positioned to engage in conversations about race differently than a white therapist, contributing to perceptions that therapeutic interventions with a therapist who wasn't white would be "less conventional." Participants attributed this to a perception that therapists who were not white would have broader world views as result of being from different cultures, leading to a capacity to "think outside the box."

**Impact of Race on Behavior of Client**. Lastly, when explaining how they thought therapy might be different with a therapist who was not white, some participants reflected on an awareness of their positionality as a white person. They considered the impact their whiteness might have on a therapist who was not white and shared nuanced reflections revealing their evolving understanding of the impact of their behavior as a white person, and reflected about how that understanding would impact the way they would behave in therapy.

Participant 8 identified awareness about the impact of language and behavior in non-racially homogenous relationships and reflected that therapy would have been different because she would have felt self-conscious about perpetuating racist micro-aggressions when she spoke. She wondered if that would cause her to censor herself and potentially decrease her ability to engage in effective therapy. She explained this by sharing:

> I think I would have felt more concerned that I was going to behave in a way that was upsetting to them because I would be concerned that I was going to do something that would be a microaggression, something that would be a like, unknown to me, a racist comment. And I think I would have been a lot more protective of how I spoke, which wouldn't have allowed me to relax and open up to the level I needed to get therapy until like I think, it would have taken a few more sessions for me to get to that point of like actually relaxing and letting go enough to have effective therapy.

Participant 4 shared her perception that if she had a therapist who was "a different race, I maybe would've gave them more grace … because, I'm like, you know, trying to be a good white person." She explained that being "a good white person" meant she "would be like more accepting of things that I feel like maybe, I feel, less acceptable with a white person new to me." She specifically identified therapist disclosure of personal information as something she would be more tolerant of, stating, "like too much personal information or something like maybe I wouldn't like, think as deeply about it or something." She shared her perception that her increased tolerance for behaviors she didn't like might be caused by her excitement "to have a non-white person therapist or something." She reflected that her excitement about having a therapist who was not white combined with her sense that she would be more tolerant of behaviors she might not tolerate in a white therapist was her own behavior of "like a weird white

person trying to be a good white person thing." Acknowledging that her response might differ based on the race of her therapist, this participant perceived that she would be "trying to be a good white person" by not challenging something she disagreed with if she was working with a therapist who was not white. Her perception that she would be "trying to be a good white person" showed an unconscious bias that not being racist would mean being more permissive of behavior, such as self-disclosure in therapy, she did not agree with.

### Synopsis of Perceptions of Therapist While Experiencing Poverty in Rural Maine

Elements such as office decor, communication style, attire, and the management of self-disclosures related to vacations and family all played roles in engendering feelings of discomfort, jealousy, and condescension for some participants. These experiences were instrumental in diminishing participants sense of relatability with their therapists. Additionally, these encounters contributed to the participants' perceptions of socio-economic disparities between themselves and their therapists. Conversely, instances where therapists offered validation and empathy regarding participants' experiences of poverty, engaged in self-disclosure that centered the participant, and actively sought to establish a therapeutic alliance resulted in heightened levels of comfort and relatability. In such cases, participants viewed the therapists as kind and caring, emphasizing the impact of these positive interactions on the overall therapeutic experience.

Although some participants identified that having a non-white therapist would not have mattered to them personally, there were participants who also identified that the experience of therapy would be different with a non-white therapist. Embedded within their responses were perceptions about race and poverty. These participants identified that having a non-white therapist would have changed therapy by stating that if their therapist was not white the therapist may have better understood issues of poverty and oppression. Additionally, for participants who

thought therapy would be different if their therapist wasn't white, some also perceived that they would be able to learn about race and the experience of not being white from a non-white therapist. Lastly, there were participants who identified that their own positionality as a white person may have impacted their experiences and perceptions of therapy with a non-white therapist.

## Conclusion

Using an intersectional methodology that combined Discourse Historical Analysis (Reisigl & Wodak, 2016) with Critical Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021), this research sought to explore perceptions and experiences of white therapists' social class by white clients experiencing poverty in rural Maine. Using data collected through semi-structured interviews, the findings revealed a complex intersectional experience of culture and healthcare that contributed to participants' experiences and perceptions of both therapy and therapists within racially homogenous rural Maine. These experiences and perceptions were impacted by availability and accessibility to therapy.

Cultural values of independence and self-sufficiency in rural Maine were maintained through culturally sanctioned normative practices of not seeking help. Many participants identified their learned cultural norms of not seeking help were rooted in beliefs of maintaining privacy in relationships, which they had learned from their grandparents. Seeking help in rural locations elicited feelings of shame and experiences of stigma. Knowing therapists in multiple social domains in small towns meant risking exposure of asking for help and led to participants seeking therapy outside of their communities.

All participants paid for therapy using public health insurance. In Maine, public health insurance is provided by Mainecare. Mainecare appeared to be central in impacting participants'

experiences of accessing therapists and therapy, contributing to both positive and negative experiences. Although Mainecare covered the cost of therapy, finding an available therapist who took Mainecare was difficult for many participants and Mainecare was perceived by some participants as not paying providers well. Some participants experienced waiting lists and long wait times when attempting to access therapists, as well as barriers associated with geography and transportation. There were also perceptions and experiences of stigma and exclusion associated with using Mainecare by some participants. Although there were barriers with Mainecare, because Mainecare paid for therapy, some participants experienced relief and felt encouraged to go to therapy. Lastly, telehealth increased access to therapy but also decreased experiences of emotional connection with therapists, impacting the overall experience of therapy for participants who engaged in telehealth.

For some participants, their experience of poverty, and how therapists understood the impact of poverty on the lives of participants, impacted perceptions of therapists and therapists' social class. Therapist self-disclosure that revealed disparities in socio-economic status between therapist and client were instrumental in diminishing participants' sense of relatability with their therapists. When therapists were able to validate and express empathy regarding participants' experiences of poverty, engaged in self-disclosure that centered the participant, and actively sought to establish a therapeutic alliance, some participants reported heightened levels of comfort and relatability. Some participants perceived that people who were not white experienced higher levels of poverty than white people and contributed to perceptions that a therapist who was not white may have better understood the experience of poverty. Lastly, some participants identified that their own positionality as a white person could impact their experiences and perceptions of therapy with a non-white therapist.

Overall, the findings exposed complex, multi-layered, intersectional processes that contributed to the experience and perceptions of white therapists' social class by white clients experiencing poverty in rural Maine. To further illuminate these findings, it is important to engage these findings through a critical lens. By situating the analysis within the frameworks of critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005), and critical white theory (Nylund, 2006), it is possible to examine the power dynamics, social constructions and systemic inequities that underpin these processes. In the following discussion, a deeper examination of the implications of these findings is presented. This will explore how the findings intersect with broader socio-political-economic structures, offering insights into recommendations both on the institutional and cultural levels.

# CHAPTER V

# DISCUSSION

The purpose of this qualitative study was to explore two aspects of the experiences and perceptions of white clients in therapy in Maine. First, whether participants, who were white and experiencing rural poverty perceived a difference in social class between themselves and their white therapists. Second, how this perceived difference influenced their experience and acceptance of therapy within this population. Additionally, this research sought to explore the role racial homogeneity played in perceptions of social class between white therapists and white clients in rural Maine. The objective of this chapter is to examine the findings presented in Chapter IV through the conceptual lens of Critical Theory (Carspecken, 1996; Kincheloe & McLaren, 1994), Critical Care Theory of Nursing (Falk-Rafael, 2005), and Critical White Theory (Clement & Mason, 2020; Nylund, 2006) and to provide theoretical and practical applications from the findings to the practice of therapy in racially homogenous rural Maine.

This chapter contains discussion to help answer the research questions:

**(R1):** Do white clients experiencing rural poverty in Maine perceive the social class of their white therapist as different from their own and how does that impact their experiences and acceptance of therapy?

**(R2):** What role does racial homogeneity play in perceptions of social class between white clients and white therapists in rural Maine?

Using an intersectional methodology that combined Discourse Historical Analysis (Reisigl & Wodak, 2016) with Critical Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021), a rich methodological framework contributed to a more robust theoretical understanding of this topic. Using data collected through semi-structured interviews, the findings revealed a complex intersectional experience of culture and mental healthcare that contributed to participants' experiences and perceptions of both therapy and therapists within white racially homogenous rural Maine. In an examination of the findings, what appeared to motivate participants' experiences and perceptions of therapists' social class was multi-dimensional and comprised of three broad themes: (a) cultural context, (b) institutional context, and (c) perceptions of therapists in general.

Overall, a combination of institutional barriers and cultural norms appear to impact participant experiences of the availability, accessibility, and acceptability of services, contributing to participants' perceptions and experiences of their therapist's social class. Within this chapter, a presentation of the theoretical frameworks guiding the research inquiry is presented first. Then, the major findings of the study as related to the literature on availability, accessibility, and acceptability of mental health care in rural locations for people experiencing poverty with consideration of the theoretical frameworks is presented. This chapter concludes with a discussion of the limitations of the study and other recommendations, a discussion of researcher positionality and conclusion.

## Theoretical Framework

This research centered institutional and cultural contexts which contribute to the marginalization and oppression of people experiencing poverty in rural Maine who were seeking therapy. The theoretical structure of this research, to expose a greater understanding of the

consequence of individualist values within psychology, draws on critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005), and critical white theory (Clement & Mason, 2020; Nylund, 2006). This framework allowed an examination of the findings that begin to challenge notions of whiteness as the normative standard and questions structures of power and oppression that often go unseen but serve to sustain power, marginalization, and oppression. Utilizing a critical theoretical framework in concert with an intersectional epistemology encompassing liberation psychology (Martín-Baró, 1994), critical pedagogy (Freire, 1970), and critical psychology (Fox et al., 2009), the research endeavored to uplift collective understanding of structural oppression and catalyze social change. Advocating for a holistic approach that considers socio-political-economic structures and conditions, this intersection of epistemology and theory provided a holographic lens whereby I was able to explore the pervasive individualistic narrative in psychology, enabling me to recognize and challenge societal contradictions perpetuating oppression. Critical theory provided a lens to explore the impact of the socio-political-economic systems identified within this study, highlighting social inequities, and exploring the intersections of power, culture, and personal agency. Moreover, critical theory allowed for an examination of the inherent biases within those systems and how power was expressed and withheld (Carspecken, 1996). By deconstructing hegemonic systems of care through a lens of critical theory (Carspecken, 1996), critical care theory in nursing (Falk-Rafael, 2005) allowed examination within the research of the diverse ways in which care was given, shared, and received by participants, emphasizing the socio-cultural context in which care occurred. This process helped inform the exploration of participants' experiences with mental health care accessibility and acceptability, advocating for a care framework centered on emancipation and liberation. Critical white theory (Clement &

Mason, 2020; Nylund, 2006), supported an examination of normative clinical, institutional, and cultural practices centering notions of white supremacy and white privilege, and how white identity informed an understanding of social class (Nylund, 2006). The examination of the findings within this framework provided the recognition that challenging mainstream psychology's dominant practices and institutional affiliations, which disproportionately harm members of marginalized groups, has the potential to bring about change in oppression and marginalization.

## Interpretation of the Findings

Previous scholarship has shown the need for research that focused not simply on how people in similar social positions construct the place and nature of rural identity they experience, but also how those constructions of place and identity create class formation and domination (Shucksmith, 2012). While individual lives may include variations of experiences in rural Maine when seeking mental health care, each of the three themes (e.g., cultural context, institutional context, and perceptions of therapist) presented in this section were prominent factors impacting perceptions and experiences of white therapists' social class by white clients experiencing poverty in rural Maine. These themes highlight multi-dimensional, intersectional factors that contributed to participant experiences and perceptions. Each theme is discussed in the following sections.

### Cultural Context

Community and cultural socio-political attitudes towards mental illness and treatment have been shown to lead to the internalization of stigma and subsequent lack of engagement with treatment related to mental health (Magnus & Advincula, 2021). The scarcity of providers,

services, and resources in rural areas has been identified as indicative of broader social and cultural disparities faced by rural residents in the United States (Tickamyer et al., 2017).

In rural New England, chronic economic need can result in social exclusion and research has shown that families experiencing extreme poverty hide their needs to save face in an effort to maintain social capital (Bischoff et al., 2014; Carpenter-Song et al., 2016). Additionally, in rural New England, engaging in acts of care that compromise self-sufficiency and independence has previously been shown to potentially threaten an individual's social standing within the community, and maintaining perceptions of self-sufficiency is often prioritized over getting care for this population (Carpenter-Song et al., 2016). In this study, some participants expressed their perceptions of broad hegemonic cultural values of self-sufficiency, independence and maintaining privacy in rural Maine as cultural values that had often been taught to them by their grandparents. To avoid community exposure and social exclusion for seeking mental health therapy, some participants identified a desire to seek mental health care outside of their communities.

### *Grandparents*

Like previous research which has shown that behavior which seeks to avoid social exclusion have caused divisions within communities, leaving residents who need the most help feeling ostracized (Magnus & Advincula, 2021), the findings of this research identified some participants contending with perceptions of potential social exclusion for seeking help. Additionally, in this study, some participants identified that knowing people, including therapists, in multiple social and professional domains in rural locations in Maine meant risking exposure within the community where they were seeking help. Thus, seeking mental health

therapy was perceived by some as violating cultural norms of maintaining independence and self-sufficiency and doing so meant the possibility of risking social exclusion.

Previous research has identified, that in rural locations, values of self-sufficiency and independence are informed by cultural morals that mental health deservingness is shaped by the extent to which people maintain self-sufficiency and independence when seeking care (Carpenter-Song et al., 2016; Carson & Mattingly, 2018; Jensen et al., 2020). In other words, if seeking mental health care requires a person in a rural location to appear less independent and self-sufficient, they may be deemed less deserving of mental health care by members of the community. In rural racially homogenous Maine, findings in this study emerged that participants perceived self-sufficiency and independence within communities were values often taught by grandparents and the act of maintaining self-sufficiency and independence in rural Maine appeared to be connected to cultural discourses passed down from generation to generation. Within this research, many participants identified that grandparents taught values of both maintaining privacy and that it was not culturally acceptable to ask for help.

Examining the values of independence, self-sufficiency, and privacy through the theory of Critical Care in Nursing (Falk-Rafael, 2005), an emancipatory approach that considers multiple ways care is provided, exchanged, and received, sheds light on understanding these values within the specific socio-cultural contexts where they are practiced. Historically, settler-colonial puritanical practices in New England closed off community to outsiders and enacted oppressive punishment for “standing out,” practices that were culturally sanctioned to maintain social order (Dunbar-Ortiz, 2014; Hardesty, 2019). To maintain social inclusion within Puritanical society, community members adhered to strict rules of piety to avoid social exclusion (Hardesty, 2019).

Privacy, for example, within the historical context of settler-colonial New England was a discursive practice employed to ensure safety from dominant, oppressive punishment caused by challenging social order (Hardesty, 2019). Discourse strategies refer to deliberate plans involving discursive practices and tactics employed within discourses to attain specific social, political, psychological, or linguistic objectives (Reisigl & Wodak, 2009). These intentional strategies are conveyed through both spoken and written language as part of broader discourses aimed at achieving social, political, psychological, or linguistic goals (Reisigl & Wodak, 2009). Practices of self-sufficiency and independence were discourse strategies that served to maintain privacy.

For many participants in this study, grandparents appeared to teach that deservingness of care may be dependent on the extent to which a person maintains cultural values of independence, self-sufficiency, and privacy. This could suggest that the role of grandparents in teaching cultural values of maintaining self-sufficiency, independence, and privacy, may contribute to feelings of weakness and failure when seeking help and serve to reinforce experiences of shame and stigma for this population. But within the historical-cultural context of rural Maine, self-sufficiency, independence, and privacy have possibly been discourse strategies used as discursive ways to maintain safety.

While settler-colonial practices enacted by Puritanical beliefs rooted in piety are highly problematic (Hardesty, 2019), within the cultural context of mental health care in rural Maine, the cultural value of privacy, independence and self-sufficiency taught by grandparents may be indicative of caring attempts to maintain social inclusion for grandchildren. This may imply that while the intention of teaching these values may be well intended, it appears they may have the opposite effect for people seeking therapy in rural Maine. Strategies that were once helpful for residents of this place appear to no longer be helpful but instead may be contributing to

experiences of stigma and isolation, further increasing mental health disparities for this population. Understanding the role grandparents' beliefs about maintaining privacy played in many participant experiences of seeking mental health support, contributing to experiences of social exclusion and stigma for this population, offers an expanded theoretical understanding on the cultural foundations that shape the experiences of individuals in this population.

**Institutional Context**

Previous research has shown availability and accessibility are two of the most prevalent concerns when identifying barriers to mental health services for adults experiencing rural poverty (Bischoff et al., 2014; Crumb et al., 2019; Jensen & Mendenhall, 2018; Magnus & Advincula, 2021; Thorne & Edener, 2020). Previous research examining mental health care for adults in northern New England living in rural poverty has identified emergent issues including lack of providers, availability of transportation, difficulty with insurance, and mental health literacy (Bischoff et al., 2014; Buck-McFadyen et al., 2018; Magnus & Advincula, 2021; Thorne & Ebener, 2020; Wilson et al., 2018). Within the findings of this study, the experience of accessing available therapeutic services occurred within larger institutional contexts of geography and transportation, lack of available providers, difficulty with health insurance (i.e., Mainecare and mental health literacy). The findings within this research aligned with this previous research, and overarching challenges including shortage of providers, difficulty knowing how to access service, and transportation obstacles and difficulty with health insurance all contributed to the formation of participant experience of accessing available therapy. Within this research additional findings emerged within the role of mental health literacy and difficulty with public health insurance (i.e., Mainecare), contributing to a broader understanding of these barriers for people in Maine.

***Mainecare***

Prior research exploring the role of mental health infrastructure in rural locations has demonstrated that when rural residents sought mental health support, the fragile mental health care infrastructure in rural areas could heighten experiences of stigmatization, ostracism, and mental health challenges(Carpenter-Song & Snell-Rood, 2017) Similarly, the internalization of stigma and shame has been shown to contribute to a reluctance to seek help in rural locations (Bischoff et al., 2014; Magnus & Advincula, 2021). Lack of publicly funded health insurance has been shown to create gaps in service availability for low-income rural residents and previous research has highlighted a need for increased access to public health insurance (Bischoff et al., 2014; Carson & Mattingly, 2018). Difficulty with public health insurance was a considerable concern for participants in this study.

Participants in this research used Mainecare to attend therapy, and the institutional context of Mainecare played a pivotal role in shaping and governing therapy dissemination for individuals experiencing poverty in Maine. The findings showed Mainecare was central in impacting participants' experience of accessing therapists and therapy, contributing to both positive and negative experiences. Although some participants identified that using Mainecare made therapy possible because it covered the cost of therapy, within the findings of this research, providing Mainecare did not significantly increase access to therapy, nor did it significantly reduce the marginalization and stigma participants experienced in trying to access therapy. Within this research, many participants identified the experience of using Mainecare as an additional barrier to availability of providers. Many participants attributed a lack of providers accepting Mainecare with a perception that providers did not want to take Mainecare and they attributed this to a perception of low reimbursement rates for therapists. Moreover, participants'

perceptions regarding whether a provider would accept Mainecare was connected to participant perceptions of their own social class positionality and how their class positionality was perceived by providers when they used Mainecare to pay for therapy. This connection seemed to play a role in shaping participants' feelings of being stigmatized when utilizing Mainecare, contributing to a cycle of stigma, shame, and perceptions of social exclusion. Examining these findings through the theoretical lens of criticality, which examines how socio-economic and political systems serve to replicate oppression for marginalized populations (Fox et al., 2009), it is possible to consider that (a) the use of Mainecare in rural Maine reinforced participants' experiences of class oppression and (b) the institutional practices and policies embedded in Mainecare seem to create barriers to availability and access for participants inducing enactments of structural violence (Bourdieu, 1984; Galtung, 1990).

From these findings, the researcher uncovered potentially interconnected socio-economic-political structures that sustain and reinforce existing power dynamics within therapy at large (Baima & Sude, 2019; Cottrell-Boyce, 2021) and within Maine's mental health care system. Although the monetary operational qualification for participation in this research was that participants made less than $23,000 per year and/or used Mainecare to attend therapy, in the context of this research, poverty was not simply a monetary value and included the degree to which participants had power to access available services. When examining the findings from a critical perspective, barriers created within the bureaucratic system of Mainecare may serve to reinforce systemic oppression by replicating exclusion to care and simultaneously privileging health care access for people who experience socio-economic privilege in the form of money and social class instead of empowering people who are experiencing rural poverty. Mental health

literacy and the extent to which participants perceived they knew how to access mental health care within the bureaucratic system of Mainecare is a possible example of systemic oppression.

**Mental Health Literacy**. Mental health literacy, defined in this research as the extent to which a person understands how to access mental health care, has been shown to have more impact on rural adults' willingness to access services than concerns about confidentiality, religion, or self-sufficiency (Magnus & Advincula, 2021; Thorne & Ebener, 2020). For rural residents experiencing poverty, access to health services, from primary care to mental health, relies on the extent to which residents have power to access care resources (Bischoff et al., 2014). Critical theory espouses that laws, economic and social policies, and institutional practices that perpetuate unequal power dynamics and marginalize specific populations create structural systems of oppression (Carspecken, 1996; Kincheloe & McLaren, 1994). This results in disparate rates of disease, illness, disability, and other adverse health outcomes within these marginalized groups (Galtung,1996; Smith, 2010). When examining mental health literacy from the perspective of critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), understanding how to access mental health care may be connected to the extent to which individuals have power to access care. Thus, for rural residents experiencing poverty, mental health literacy and the extent to which it is conveyed within institutional practices and social policies may serve to reinforce unequal power dynamics, leading to unintended marginalization for this population.

For individuals experiencing poverty in rural locations, their limited power to access care resources has been shown to be deeply rooted in these oppressive systems and has not only led to, but also reinforced, class oppression (Galtung, 1990). In this study, when navigating the complexities of trying to find an available therapist, some participants identified difficulties in

knowing how to access a therapist within their communities and perceived the existence of an amorphous operating system that made it impossible to access a therapist. In the context of experiencing rural poverty, they identified a perception of exclusion in this amorphous operating system. This contributed to their experience of feeling demoralized and isolated when contacting a therapist. For participants in this study living in rural poverty, the experience of feeling demoralized and isolated when seeking therapy may suggest that mental health literacy and the extent to which participants perceived they had access to mental health literacy within the institutional practices and social policies of rural therapy could serve to reinforce marginalization for rural residents experiencing poverty.

**Perceptions of Therapists**

Previous research has identified that a client's perception of a class disparity with the provider is an concern for clients (Bischoff et al., 2014) and the use of psychological language, regional accents of providers, which can indicate variations in educational levels between provider and client, due to larger social constructs of how academic education is privileged over experiential models of education, impact perceptions and acceptability of services by clients (Ballinger & Wright, 2007). Research has shown that clients have identified therapists who engaged language that centers class privilege as not relatable, untrustworthy, and emotionally distant (Trott & Reeves, 2018). Thus, the therapist's use of language can reduce clients' acceptance of services (Ballinger & Wright, 2007; Trott & Reeves, 2018). Additionally, previous research has identified when counselors have a better understanding of how class and race impacted clients' worldview, they improved their empathy and connection with clients (Crumb et al., 2019).

Social class structures enact implicit social control by regulating what is “normal” through socio-political-economic structures such as health care, education, housing, and family structure (Lott & Bullock, 2007). Social class has been implicated in the identities of client and counselor, and social stratification is often exacerbated in mental health treatment (Ballinger & Wright, 2007). Social class hierarchies and the language used to convey these hierarchies, are political discourses employed to maintain institutional power (Smith, 2010). Classism, the taken-for-granted social mechanisms that place obstacles in the paths of poor and working-class people, creates subtle, often invisible bias (Smith, 2010). For people experiencing poverty, awareness of their own class positionality has been identified within settings where class privilege has gone unmarked, and people experiencing poverty are highly attuned to classist micro aggressions (Smith, 2010). In this research, participants appeared to be aware of classist micro aggressions enacted by therapists. Further, participants appeared to associate these classist micro-aggressions with language, how therapists dressed, the way they talked about going on vacation or engaging in extra-curricular activities and how their offices were decorated. These classist micro aggressions were identified by participants as markers of therapists’ economic status in comparison to poverty experienced by participants. This appears to highlight the possibility that participants’ awareness of their poverty impacted their perceptions of their therapists’ social class positionality and was impacted by their therapist’s lack of awareness about their own positionality.

Examination of the findings with an understanding of classism as a taken-for granted social mechanism expressed through socio-economic markers of class positionality (Smith, 2010) points to the possibility that the class bias of the therapist, enacted within the white, racially homogenous context of whiteness in therapy, was expressed through language, dress,

office décor and disclosure of extra-curricular activities. Examining how unmarked whiteness operates in therapy, Lee and Bhuyan (2013) found that, despite ethical opposition to perpetuating white privilege, white therapists inadvertently marginalize clients by imposing Western normative values of whiteness in treatment and assessment. This perpetuation of whiteness limits client autonomy and contributes to oppression within the clinician's dominant paradigm, decreasing client self-determination. This perpetuation of whiteness caused clients to exert resistance or compliance within the framework of the clinician's dominant paradigm of whiteness, decreasing their autonomy of self (Lee & Bhuyan, 2013). In this research, when participants were asked about their perceptions of therapy with a non-white therapist, many envisioned that a therapist who was not white would better understand poverty compared to a white therapist.

Building upon prior research highlighting the impact of unmarked whiteness on therapist-client interactions (Baima & Sude, 2019; Cottrell-Boyce, 2021), the findings of this study added to prior scholarship by exposing that participants' associated various socio-political-economic elements--such as therapist attire, communication style, office decor, discussions about vacations with white class privilege. Within this research, participant perceptions of micro-classist behavior by their therapists suggests that within white racially homogenous therapeutic settings in Maine, some therapists may lack of awareness of how they may be enacting social class oppression by perpetuating values of white privilege through disclosures and class signifiers associated with language, dress, office décor and extra-curricular activities, appeared to impact participant experiences of therapy.

Recognizing when clients have limited access to resources, and appreciating their existing support systems, has been shown to help counselors more accurately reflect their clients'

resourcefulness (Crumb et al., 2019). When considering the findings of perceptions of therapists from the understanding of critical white theory (Nylund, 2006) and critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), the findings suggest that therapists' ability to understand their social class position, which situates them with power, could serve to reduce stigma for this population. Within this study, some participants identified that when their therapists were able to authentically validate their experiences of being frustrated with lack of socio-economic resources, participants felt more understood, leading them to perceive their therapists as understanding and caring. Additionally, when therapists spoke and treated participants in ways that participants perceived as understanding, some participants perceptions were linked to therapists' kindness, problem-solving approaches, and authentic empathy towards poverty, mitigating identification with social class signifiers and class hierarchies. Lastly, some participants identified that therapists' honesty and willingness to hear about living with poverty was validating and reassuring and appeared to increase therapeutic alliance.

**Theoretical Implications of the Findings**

These findings highlight the complexity in participant perceptions and experiences of their therapists' social class in rural Maine. Addressing gaps in current literature related to rural poverty and mental health in Maine, particularly for white clients experiencing poverty, this research provides insights into participant experiences when seeking therapy and their perceptions of therapists in the rural Maine context. The findings appeared to underscore the intricate interplay between individual self-perceptions of poverty and impact of therapist's social class positionality on understanding social class in rural Maine. The results provide an in-depth, critical understanding of participant experiences, enriching the academic discourse on mental health within this specific demographic.

Recognizing that perspectives and experiences of this population are missing from the research, the implications of this research could be a reduction in the levels of stigma and reduced levels of acceptability of care experienced by this group. Recognizing that stigma is one of the leading barriers to acceptability for rural populations (Jensen & Mendenhall, 2018), understanding how stigmatization is operationalized through social class practices in therapy in rural Maine for people who experience poverty, and the role racial homogeneity plays in this particular form of stigmatization, offer an opportunity to create policy and training for clinicians to expressly create pathways of care. The impact of this research could support increased understanding of the nuances associated with working as a mental health provider in rural Maine because there is no existing body of research examining the perceptions of social class of therapists by clients for rural Maine.

This research contributes to existing critical theory frameworks by shedding light on the intricate interplay between institutional and cultural practices in shaping the perceptions and experiences of white therapy clients facing rural poverty in Maine. Guided by critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical theory of care in nursing (Falk-Rafael, 2005), and critical white theory (Nylund, 2006), the findings provide a nuanced understanding of the socio-political-economic systems impacting participants within rural Maine. The findings suggest a possible need for expanding current theoretical perspectives, particularly within the domains of rural poverty, mental health, and therapeutic encounters. Additionally, the findings appear to extend the existing theoretical consideration by broadening the understanding of perceptions and experiences among this population. Thus, contributing to a broader theoretical understanding of the ways perceptions and experiences of therapists' social class by white clients experiencing poverty in rural Maine are exhibited in the therapeutic setting.

## Limitations

The purpose of this section is to present the limitations of this study to illuminate what this research is and what it is not. First, a presentation of limitations of location and time are presented. Then, a presentation of researcher positionality is presented. The purpose of this is to acknowledge that this research is situated within the subjective bias of the researcher's positionality. This will be followed by an examination of the research questions as limitations. Further, an examination of the methodology used for this research is examined within the context of limitations. Lastly, to further acknowledge the researcher bias (e.g., that this research is an extension of the researcher's positionality), this section will use both first-person and third-person pronouns.

### *Time and location*

This research centered the lived experience of participants experiencing poverty in rural Maine. Although there may be similarities to other rural locations, this research is limited by its specificity of location. This specificity reduces the generality of the findings beyond Maine. Additionally, this research is limited in its scope due to time. This study was conducted within the structure of a dissertation. Thus, I was limited in the time available to conduct the research. Had the research been part of a longer study, with additional resources, the scope of the findings may have broadened.

### *Researcher Positionality and Reflexivity*

This research was motivated by my personal experiences as a practicing mental health therapist in rural Maine. I chose this topic because I recognized that my lived experience as a white, middle-class, educated woman differed from the lived experience of my clients, the majority of whom experienced rural poverty. My role as a therapist situated me within the

system of mental health care as someone who was an expert and held power. I wondered how my lack of awareness about my positionality and privilege might impact the experience of therapy for my clients. While a reasonable motive, I did not know what I did not know. However, having completed the task, I now understand how designing the research with this understanding in mind (from the beginning) can drastically impact the way a researcher chooses to structure a study. My positionality, both as a therapist and as a person not experiencing poverty, seemingly resulted in huge blind spots as a researcher. When I began this research, for example, I structured this study around previous research centering rural poverty, mental health, and social class. The choices I made about what literature to include and exclude was, in some part, informed by my own positionality and bias. After conducting interviews for this study, I observed how each insight and discovery about the data and the research process itself was impacted by my bias. Having this understanding in mind, the complexities of qualitative research began to impact the structure of the research. I started to understand that the choices made in the research process served a dual purpose of making a certain kind of research process possible and they limited what the research and researcher could discover. For example, while I understood that a certain theoretical lens or methodology would lead to uncovering certain kinds of data as opposed to other kinds of data, I did not foresee how nuanced and far-reaching the consequences would be. At first, this was an almost overwhelming realization. By reflecting on my positionality, I came to understand that my researcher bias was not negative. Rather, it contributed to a nuanced understanding of the data and that understanding is consequential. This led me to recognize and understand not only my bias, but also allowed me to expand my capacity to consider other research more critically, with a recognition that all research is informed by researcher bias and positionality.

### *Questions as Limitations*

The task of writing Chapter IV and Chapter V also gave me ample opportunity to reflect on what I may or may not have done differently throughout the research process to eliminate or curb certain biases. As I pieced together Chapter IV and Chapter V, the dilemma of qualitative research emerged: it points to additional questions as opposed to concrete answers. As a result of doing this research, I can see things now that I could not see before, which would make me change the interview questions. The interview questions, as they were, seem to be pointing to a bigger study than my research questions may have required. Case in point, I am no longer certain that this research was structured to answer *what* the perceptions of therapists' social class were. Although findings did emerge showing elements of perceptions of therapists' social class, it seems the research was more suitably designed instead to explore under what cultural and institutional circumstances perceptions and experiences were formed for this demographic. To adhere more closely to understanding the role of social class perceptions by participants, I would have asked fewer questions about how participants paid for therapy, how they physically got themselves into therapy, or how their therapists' clothing or office decor impacted their perceptions of their respective therapists. Instead, I would have asked more open-ended questions like, "What did you think of your therapist?" and "Where did the value come from that considered the clothing of your therapist important?" Therefore, it is now obvious to me that any of the questions in-and-of-themselves, whether it be the research questions or the interview questions, function as limitations to the study. With a new understanding of how simple changes to the interview questions could have helped me answer the research questions more directly, I worried that the validity and trustworthiness of this research lacked; however, I have shifted my understanding and now realize that while asking direct questions would likely have focused the

study to a greater degree, the indirectness provided rich descriptions by the participants and exposed data I had not anticipated. This, ultimately, contributed to a broader understanding of the myriad complexities needing consideration about this topic.

### *An Intersectional Methodology as Limitation*

Combining Critical Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021) and Discourse Historical Analysis (Reisigl & Wodak, 2016) limited (a) how the themes and discourses emerged and (b) how the researcher explored and coded them. For example, Critical Constructivist Grounded Theory (Charmaz, 2014; Levitt, 2021) requires the researcher to look at situations through the lenses of political, economic, and cultural practices that maintain and replicate oppression and marginalization. Thus, because this research used a lens rooted in criticality to examine the intersection of socio-political-economic factors like race, poverty, social class, and mental health, the research was designed to explore some aspects of how oppression and marginalization show up within the given intersection in therapy. Additionally, using Discourse Historical Analysis, a methodology that examines the historical, political, and cultural ways language and discourse is historically created and disseminated (Reisigl & Wodak, 2016), limited the scope of research to specific socio-political-linguistic discourses. Using a different method, adopting an alternative theoretical lens, or conducting research in a different geographic location might have produced different outcomes.

## Recommendations

The following section presents recommendations generated from the findings of this research. First a presentation of recommendations for practices within mental health care in rural Maine. This is followed by future research recommendations.

## Recommendations for Use of Culturally Competent, Socially Just Frameworks

In terms of practical applications, the theoretical insights gleaned from this study highlight opportunities for systemic change and intervention within mental health services for this population. Recognizing the influence of cultural values and institutional practices, stakeholders can leverage this understanding to tailor interventions that address the unique needs and challenges faced by white therapy clients experiencing rural poverty in Maine. This research highlighted a need for increased cultural competency by institutions and therapists with regards to the lived experience of white residents experiencing poverty in rural Maine by presenting the ways that practices of self-sufficiency and independence, common in rural communities in Maine, perpetuate systems of social class hierarchies.

In approaching care, previous researchers have identified the need for culturally sensitive, socially just approaches that center the client's experience (Bischoff et al., 2014; Crumb et al., 2019; Jensen et al., 2020; Wilson et al., 2018), and holistic practices (Crumb et al., 2019) have previously been identified as effective strategies. The findings presented in this study suggest a need for socially just, culturally competent providers and institutional structures of mental health care that center barriers to acceptability of care for clients. These approaches are recommended here to prioritize socially just and culturally competent practices within mental health care in rural Maine.

Embracing a framework that prioritizes the psychological, interpersonal, and cultural acceptability of care involves recognizing that the acceptability of care is influenced by participants' perceptions (Jensen & Mendenhall, 2018; Penchansky & Thomas, 1981). These perceptions encompass the adequacy and appropriateness of care, access to care, providers' cultural competence, and attitudes toward mental health treatment from friends and family

members (Bischoff et al., 2014; Parr & Philo, 2003) and acknowledges a multi-layered, intersectional relationship that also involves providers' perceptions (Penchansky & Thomas, 1981). Embedded within this comprehensive framework is a holistic care model, emphasizing understanding and dedication to working with clients facing poverty, previously advocated by Wilson et al. (2018).

Originally identified in research examining the experiences and perceptions of rural women in counseling dealing with poverty, Wilson et al. (2018) presented a socially just model of care identifying three pivotal areas of intervention: the experience of poverty, its impact, and the implications for mental health. Given the alignment of this model with the subject and findings presented in this study, this approach in Maine is not only essential but also a valuable contribution to the field of mental health therapy and is strongly recommended as an essential approach in Maine.

**Future Research**

The findings in this research appear to highlight a need for additional research exploring the influence of cultural and institutional contexts for people seeking therapy in rural Maine who experience poverty. The study revealed new data, prompting a call for further examination of the role of grandparents in cultural value formation, emphasizing self-sufficiency, independence, and the preservation of privacy. Additionally, institutional practices, particularly the availability and accessibility of therapists, and an in-depth exploration of recruitment and retention of therapists within Mainecare, emerged as focal points for future research. Specifically, research exploring the social class positionality of therapists, the role of grandparents in rural Maine, the impact of bureaucratic barriers within Mainecare that may serve to reinforce class oppression and the role of racial homogeneity in therapeutic settings in rural Maine could benefit from additional

research. When considering recommendations for further research, the following topics would benefit from additional exploration:

1. The need for therapists to explore their own social class and its influence on their identity, practice, and power within the therapeutic relationship continues to be a gap in the research (Carson & Mattingly, 2018). In rural Maine, additional research that examines the social class positionality of therapists and its influences on identity, practice and power within therapeutic relationships is recommended. Additionally, a researcher in racially homogenous Maine should account for ways white identity has been formed socially and historically (Lesmire, 2017).

2. Additional research exploring the formation of perceptions of maintaining privacy by grandparents in rural Maine which could include exploration of the impact of intergenerational beliefs of maintaining privacy on bias, stigma and exclusion related to mental health care, is recommended.

3. Within this research, participants use of Mainecare appeared to play a role in replicating stigma, exclusion, and social class oppression. Additional research exploring this population's experiences in rural Maine when seeking therapy using Mainecare and the impact of bureaucratic barriers on perceptions of social class oppression could offer valuable insight when engaging in the practical work of policy creation.

4. The role and impact of racial homogeneity within the therapeutic setting in Maine, appears to need additional research. Research that specifically explores the socio-cultural impact of racial homogeneity within therapy in rural Maine and the extent to which racial homogeneity obscures social class differences between therapist and client may benefit from additional research.

## Synopsis of Discussion

Through an exploration of participant lived experience of seeking therapy and being in therapy, this research sought to understand the ways social class, whiteness, and rural poverty impact participants' perceptions and experiences of therapists in this region. Although many aspects of the findings in this research aligned with previous research, additional findings contributed to an expanded understanding of this topic. For example, the role of cultural and institutional contexts in the formation of perceptions was shown to be an important factor in rural Maine for white participants experiencing poverty. Additionally, perceptions of therapists appeared to be impacted by participants' perceptions of their poverty and social class identity. The limitations of this research highlighted the ways researcher positionality, methodology, theory and interview questions impacted findings in qualitative research. Lastly, the need for further research exploring themes examined in this research was shown to be an opportunity for expanded understanding of the findings presented in this research.

## Conclusion

The aim of this research was to explore the perceptions of white therapists' social class by white clients experiencing poverty in rural Maine to better understand social class structures in racially homogenous therapeutic settings. Through an exploration of participant lived experience of seeking therapy and being in therapy, this research also sought to understand the ways social class, whiteness, and rural poverty impacted people perceptions and experiences of therapists in this region.

Oppression is a multi-faceted, interconnected set of socio/economic-political systems and serves as a cornerstone of a capitalist/settler/colonial society leading people to believe and accept that their position in society is natural, required, and fixed (Freire, 1970; Kincheloe & McLaren,

1994, Smith, 2010). Part of the work of liberation and social/political emancipation is to give precedence to those experiencing oppression from poverty (Freire, 1970). Concerned with social inequities and social structures, power, culture, personal agency and the intersections of these factors (Carspecken, 1996; Kincheloe & McLaren, 1994), this research explored socio-political-economic systems rooted in capitalist/colonial/settler structures to understand perceptions and experiences of white therapists' social class by white clients experiencing poverty in rural Maine.

To better understand how binary understandings of oppressor and oppression contribute to social class perceptions and limit the creation of systems of care in mental health that center a relational community of care (Falk-Rafael, 2005; Freire, 1970), this project centered the experience and perceptions of white people experiencing poverty in Maine who engaged in therapy. Through an exploration of participants' lived experience of seeking therapy and being in therapy, this research sought to explore the ways social class, whiteness, and rural poverty impact people's perceptions and experiences of therapists in this region.

This research was informed by an intersectional conceptual structure that drew on critical theory (Carspecken, 1996; Kincheloe & McLaren, 1994), critical care theory of nursing (Falk-Rafael, 2005), and critical white theory (Clements & Mason, 2020; Nylund, 2006). This conceptual intersection served to identify socio-political-economic inequities experienced by participants and informed an examination of how social and power structures, as well as personal agency, contributed to perceptions and experiences of therapist's social class.

For participants in this research, perceptions were formed through an amalgamation of historical, social, political, and economic discourses that converged to form the understanding participants had of themselves and their communities. Perceptions became the lens through which reality was seen and informed understandings of individual and cultural identities. The

perceptions participants had of their therapists were formed within the distinct cultural identity of Maine (Jensen et al., 2020). This research attempted to make visible the complex circuitry through which historical-cultural structures are enacted in institutional and political systems in rural Maine and the ways those intersections become woven within community relationships and "metabolized by individuals" (Fine, 2018, p.13). Ultimately, this research stood out from prior research for its explicit exploration of poverty, social class, and perceptions of therapists in white racially homogenous rural Maine, thereby expanding the theoretical understanding of experiences and perceptions of therapy clients in this location.

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# APPENDIX A

# CERTIFICATE OF COMPLETION

# CERTIFICATE

## OF COMPLETION

PHRP Online Training, Inc. certifies that

**Roveto Rebecca**

has successfully completed the web-based course "Protecting Human Research Participants Online Training."

Date Completed: **2020-12-01** Certification Number: **2860544**

PHRP
Protecting Human
Research Participants
Online Training

# APPENDIX B

# INFORMED CONSENT AGREEMENT

# INFORMED CONSENT AGREEMENT

This informed consent agreement for the IRB-approved research study "Perceptions of white therapist's social class by white clients experiencing rural poverty in Maine" outlines the purpose of the study, participant involvement, participant rights, and my contact information.

**Purpose of the study:** This study explores perceptions of social class differences by white clients experiencing rural poverty with their white therapists in racially homogenous therapeutic settings in rural Maine. It explores how their perceptions impact their experience of mental health care in rural Maine.

**Involvement in the study:**

You are volunteering to participate in this study via recruitment material shared with counseling organizations, health clinics and/or community mental health clinics. This study includes participating in one interview lasting approximately 60-90 minutes over Zoom or in person. You are being asked about your experience of therapy with a white therapist, what you thought about your white therapist, how you found your therapist, your family history of seeking therapy and how you paid for therapy. You are also being asked to take a brief demographic questionnaire. Participation is completely voluntary and there will be a $25 gift card offered to your choice of Hannaford, Shaw's, Walmart or Amazon. Interviews conducted in person will be audio recorded and interviews conducted via Zoom will be both audio and video recorded. To ensure that the research is accurate and honest, the researcher will make the results of the research available to participants upon request. Upon request from participant, participant will be provided with a summary of the results via secure email and will be offered an opportunity to provide feedback or reflection via phone or email.

**Participant rights:**

Your participation in the research is completely voluntary and you may withdraw from the project at any time for any reason. If you withdraw your information will be eliminated from the study and destroyed. You may stop the interview at any point and decline to answer any of the questions within the interview. Your contributions and any information gathered from you, whether in the demographic form or the interview, will be kept completely confidential.

Interview data, including direct quotes, may be used for academic purposes, such as presentation, published research papers, or articles, but your name and any identifying information will not be associated with any part of the written report of the research and all efforts will be made to uphold the confidentiality of research participants. You will be given a numerical identifier with any identifying information removed or concealed. Numerical identifiers will be used rather than your name on study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.

As part of that process, upon request from you, I will supply you with a summary of the results via secure email or a phone call and offer you the opportunity to provide feedback or reflection. All identifying information will be removed. Recordings, transcripts, and interview data will be stored in a locked file cabinet in my home office. No one else will have a key to the cabinet or password to the computer. Data will be destroyed after 5 years. Any and all of your questions will be answered at any time, and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation. Questions about your participation are welcome and you are encouraged to contact me at any time.

**Risks and benefits:**

Minimal risks are anticipated through your participation in this study. However, it is possible that discussing your experience with therapists could bring up feelings of vulnerability and may bring up distressing or emotional reactions. In addition, participation in this research poses the possibility of feelings associated with racial identity, poverty, social class and mental health. You may stop the interview or decline to answer any question. If you become distressed while talking about this experience, and feel it will be helpful, you will be provided with a resource list of support and counselor/therapists with whom to process the response.

There is no direct benefit from participating in this study, but it may be beneficial to you in that you may gain greater insight into your therapeutic experience and find it beneficial to discuss those feelings and experiences in a non-judgmental setting. Your contributions may also be beneficial to advancing knowledge of therapeutic experiences in rural Maine.

**Questions, concerns, and contact information:**

Please contact me at any time with questions or concerns that you may have. Signing this form acknowledges your voluntary participation, your understanding of your rights, and that you have received a copy of this consent form, so please retain a copy for yourself.

**Researcher: Rebecca Roveto**

**Contact Information:**

| **Researcher** | **Committee Chair** |
|---|---|
| Rebecca Roveto | Dr. Rakhshanda Saleem |
| Email: rroveto@lesley.edu | Email: rsaleem@lesley.edu |
| Phone: 831-239-3660 | Phone: 617-206-7371 |

I am 18 years of age or older. My consent to participate has been given of my own free will and that I understand all that is stated above. I will receive a copy of this consent form.

| | |
|---|---|
| Participant's Full Name/Signature | Date |
| Researcher's Full Name/Signature | Date |

*There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairpersons at* irb@lesley.edu

# APPENDIX C

# RECRUITMENT LETTER

RECRUITMENT LETTER

Hello. **My name is Rebecca and I am seeking white adults ages 18-65 living in rural Maine who have experienced poverty and have been to mental health therapy/counseling with a white therapist.** My research project uses interviews to examine the perceptions and experiences of mental health therapy by white adults living in poverty in rural Maine. The purpose of this study is to understand how experiences of therapy for this population is impacted by perceptions of social class differences between white clients and white therapists. I am sending this to you because you fit this criterion of being eligible for MaineCare or having an annual income below $23,000 before taxes, because you might be interested in participating, and/or because you might know eligible people, and I am asking you to pass this on to them.

**Why is this research important?** This study examines the experience of participating in mental health therapy for white people experiencing rural poverty in Maine. This experience can be impacted by perceptions of belonging, social class, and stigma. Understanding experiences and perceptions of mental health therapy for this population is important for the education of practioners, the practice of therapy, and creating policy and legislation that is equitable. The role of social class in mostly white rural locations is an understudied area of research. Highlighting the experiences of this population increases visability for people experiencing rural poverty and may contribute to more equitable practices of care.

**Who am I?** I am a licensed marriage and family therapist living in rural Maine. I have worked as a licensed mental health provider for 10 years. I have worked in community mental health, schools, and private practice. Prior to becoming a mental health therapist, I worked as a special education teacher. I have a master's degree in Counseling Psychology, and I am currently pursuing a Phd in Counseling Psychology.

**What would this research involve?** Participation would involve a 60-90 hour recorded interview, in a convenient location or on Zoom. Participants would be asked about their experience, expectations and family beliefs about therapy. This study is IRB-approved by Lesley University to protect participants. The interview is completely confidential, with all possibly identifying material removed.

**What are the next steps? Interested or have questions?** Please contact me at rroveto@lesley.edu or call the number 831-239-3660. **Please share this email with anyone who might be eligible for the study.**

Thank you.

Rebecca

Rebecca Roveto, MA, LMFT
Student, Counseling and Psychology, PhD. program
Lesley University
Cambridge, MA. 02138

# APPENDIX D

# DEMOGRAPHIC INFORMATION

DEMOGRAPHIC INFORMATION

Name: _____

Contact information:

Phone _____

Email address_____

Mailing address _____
_____
_____

County of residence:_____

Date of birth or age:
_____

Identity:

Gender_____
Race:
Ethnicity: _____
Sexual Orientation:_____
Religious or spiritual affiliation: _____

Occupation_____Employer_____

Length of time living in rural Maine_____

County of residence_____

Length of time accessing mental health therapy_____

Have you ever used MaineCare to accessed mental health therapy, if so, when and for how long?_____

Do you currently qualify for MaineCare?_____

Annual Income before taxes: (Please mark which one applies)
_____ Less than $10,000 per year
_____ $10,000 to $20,000 per year
_____ $20,000-$25,000 per year
_____ Over $25,000 per year

Have you had a therapist who was white? Yes No

Is there any other information that you think is important and that you would like me to know?

# APPENDIX E

# INTERVIEW PROTOCOL

# INTERVIEW PROTOCOL

Introduction: Introduction and appreciation for participation, brief personal/professional positionality statement, brief overview of the study. Discussion about signed consent, agreement to record, and confidentiality.

QUESTIONS:

**Access**

1. How did you find your therapist?

2. Have you sought therapy before? What was the process like?

**Socio-economic**

3. How did you discuss payment for therapy with your therapist? What was that like?

4. What were your therapist's policy about missing appointments?

5. How did you communicate with your therapist about scheduling?

6. Did you ever meet with your therapist online? Why or why not?

**Race/presentation**

7. What did you notice about your therapist when you first met? Did that change over time?

8. What would it have been like if your therapist had been a different race than you?

**Meaning making/ Acceptability**

9. What did you know about counseling before you saw a therapist?

10. When you were looking for a therapist, what were you looking for?

11. Was it difficult decision to go to therapy, why or why not?

12. What was your expectation of what would happen?

13. How did your experience in therapy match your expectation? How was it different?

14. What did it mean to you to go to therapy?

**Family/community discourse**

15. Do you know if anyone else in therapy?

16. Do you talk about mental health with friends? If so, what is that conversation like?

17. Does your family have a history of being in therapy?

18. Did your family discuss mental health when you were growing up and if so, how was it discussed?

19. Is therapy discussed in your community? If so, how and where and by whom?

CONCLUSION:

Appreciation for participation, offer to answer any questions or add anything that they believe I missed during the interview.

# APPENDIX F

## RESOURCES AND REFERRAL LIST FOR COUNSELING SERVICES

RESOURCES AND REFERRAL LIST FOR COUNSELING SERVICES

**Phone numbers and websites:**

Maine Crisis Line: 1-888-568-1112.
Maine Behavioral Health 1-844-292-0111
https://211maine.org/mental-health/

**NO Fee/ Free Counseling Services:**

NAMI Maine
(800) 464-5767
Info@namimaine.org

Helen Hunt Health Center
1-207-827-6128
242 Brunswick Street
Old Town, ME 04468

**State Wide Mental Health Centers:**

Adult Mental Health Services
**Toll-Free:** 1-800-924-0366
**Hot-Line:** 1-888-568-1112
**Website:** http://www.chcs-me.org
Offers counseling services throughout the state of Maine for a fee, accepts MaineCare

**Counseling Services by County:**

**Aroostook County:**
Fish River Rural Health
**Toll-Free:** 1-888-335-3971
**Website:** http://www.frrh.org/behavioral-health

**Androscoggin County:**

**Franklin County:**
Androscoggin Medical Arts Center
**Address:** 21 Main Street, Livermore Falls, ME, 04254
**Alternative Phone:** 1-800-398-6031
**Fax:** (207) 897-4339
**TTY:** (207) 779-2662
**Business Line:** (207) 897-6601
**Website:** http://www.mainehealth.org/franklin-community-health-network/locations/androscoggin-valley-medical-arts-center

**Penobscot County:**
Hometown Health Center
**Address:** 118 Moosehead Trail, Newport, ME, 04953
**Fax:** (207) 368-2451
**Toll-Free:** 1-866-364-1366
**Business Line:** (207) 368-5189
**Website:** http://www.hometownhealthcenter.org/behavioral-health

**Lincoln County:**
Mobius Inc.
**Address:** 319 Main Street, Damariscotta, ME, 04543
**Fax:** (207) 563-6128
**TTY:** (207) 563-3864
**Business Line:** (207) 563-3511
**Website:** https://www.mobiusinc.org/index.php/our-services/behavioral-health-services

**Kennebec County**

**Knox County**

**Oxford County**

**Sagadahoc County**

**Somerset County**

**Waldo County**
Belgrade Regional Health Center
**Address:** 4 Clement Way, Belgrade, ME, 04917
**Fax:** (207) 495-3353
**Business Line:** (207) 495-3323
**Website:** http://www.belgradechc.org