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Andrew Lawrence Cohen
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about class with their clients?

ABSTRACT

This exploratory qualitative study surveyed practicing clinicians about their experiences engaging in discussions about social class with their clients. There is little research on the topic of social class in the therapeutic setting broadly and on the topic of broaching social class specifically. As such, this research was an initial attempt to begin to fill this gap in the literature. Twelve mental health clinicians voluntarily participated in an anonymous online survey about their experiences and thoughts about engaging in dialogue about social class with their clients. Results included a pattern in the difference between which clients clinicians discussed social class with and which clients clinicians avoid discussions of social class with, who (clients or clinicians) initiates dialogue about social class and why, whose social class identities (clients and/or clinicians) are disclosed, and whether social class identity is viewed as relevant to therapy. While how, when, and why the participants addressed social class with their clients were complex and varied, these findings suggest that they are not consistently addressing social class with their clients in the therapeutic setting. Future research on clinicians' and especially clients' experiences of social class dynamics in therapy could be helpful for the helping professions.

**SOCIAL CLASS IN THE THERAPEUTIC DYAD: HOW DO
CLINICIANS ENGAGE IN DIALOGUE ABOUT CLASS
WITH THEIR CLIENTS?**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2016

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CHAPTER I

Introduction

Social work has long been a field that worked across class boundaries, evolving as an interclass profession with the first American social workers primarily middle- and upper-class college graduates working with impoverished immigrants (Patterson, 2013; Strier, 2009). Currently, the U.S. has some of the greatest disparities in its history between its class, both between the “1%” and the “99%” (The Stanford Center on Poverty & Inequality, 2014) and between the professional middle class and the working classes and poor (Noah, 2013). Social class identity is clearly a fundamental shaping factor both in our psyches and in our realities (Liu, Soleck, Hopps, & Pickett, 2004b), informing how we think and act and defining whether we face structural classism and bias or opportunity and privilege.

The research examining how social class identity impacts therapeutic outcomes shows consistently higher drop-out rates (Reis & Brown, 1999) and less benefit (Falconnier, 2009) for those of lower socioeconomic statuses. Despite these findings and social work’s origin as an interclass profession, social work and the other helping professions has largely left social class identity unexamined (Abramovitch, 2005; Isaacs & Schroeder, 2004).

This study is an attempt to begin to fill this enormous gap in the literature, in particular by focusing on how clinicians think about and discuss social class with their clients. Specifically, this study explores how and if clinicians engage in dialogue about social class in therapy with their clients, how they think about their choices in these discussions, and what their motivations

are in broaching (or not broaching) the subject of social class. It also touches upon their perceptions of how their choices about these discussions impact the therapeutic alliance and their perceptions of what their clients' concerns are during these discussions.

The following chapter begins by reviewing terms essential to this study and over-viewing the theoretical grounding for the current inquiry. Next, the contexts of social work within the arena of social class and U.S. society are briefly reviewed, including a critique of social work's functions and position between the individual and society as well as the field's attempts to build cultural competency. Then the available literature on how social class identity intersects with mental health and the therapy outcomes is reviewed. Lastly, due to the greater availability of literature on race in the therapeutic encounter, specifically on the particular subject of broaching racial identity, this literature is reviewed to provide potential parallels for social class.

CHAPTER II

Literature Review

Introduction

Social work evolved as an interclass profession, with its founders and practitioners generally based in the middle class and its target population coming from the lower class. Yet, the attention of social work to social class has been inconsistent (Abramovitz, 2005) and the counseling research literature at large has only minimally engaged with social class (Liu, Ali, Soleck, Hopps, & Pickett, 2004a). With this in mind, this chapter begins by briefly defining some key terms before exploring the theoretical backing for this study and then exploring contexts shedding light on our understandings of the potential roles and experiences of social class within the therapeutic encounter, the available empirical literature on social class within the therapy the therapeutic encounter, literature on race and broaching racial identity in therapy, and the limitations and challenges present to our current understanding of this topic.

Definition of Terms

Social class, wealth, and culture. First, it is useful to examine what is meant by social class, wealth, and the broader term culture. Within the literature at large, the use of social class is inconsistently defined, assessed and analyzed (Liu et al., 2004a). The empirical literature is inconsistent in its conceptualization of social class and, in fact, Liu and colleagues (2004a) noted the variance in use of words to denote social class, citing 448 different key words in a review of the counseling literature. Typically when operationalizing social class, research relies on

objective measures of class (e.g., income, occupation, education), rather than subjective criteria, to understand social class and classism (Liu et al., 2004b). This conceptualization places people into a hierarchical framework and, though easy to visualize, is severely limited and obscures much of class experience. For example, one's social class is determined not just by access to monetary or material capital, in other words material wealth, but is also informed by social capital (i.e., social networks), human capital (i.e., physical and intellectual resources), and cultural capital (i.e., aesthetics) as well as how all of these forms of capital are valued by one's social environment (Liu et al., 2004b). These operationalizations fail to capture the subjective experience of social class as well as intersections with other social identities. Liu and colleagues' (2004b) more extensive conceptualization of social class is described below.

The National Association of Social Workers (2001) defines culture as the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group. For the purposes of this paper, the term social class will be used in reference to the process of personal social class identity development or consciousness as well as the social meanings given to social class positions. The term culture will include a wider range of social identities (e.g. race, ethnicity, socioeconomic status, gender identity, sexual preference, religion) and ways of being.

Privilege, oppression, and classism. Israel (2012) defines privilege as the unearned advantages that are conferred to individuals based on membership in a dominant group. These advantages are often invisible to those who hold them and the American myth of meritocracy suggests that those with privilege, especially those with access to wealth and a higher social class position, have earned it on their own, and therefore deserve to wield power (Liu, Pickett Jr., &

Ivey, 2007). The advantages of privilege are frequently reinforced through a multitude of arenas, including interpersonal interactions and attitudes, institutional policies, societal beliefs, and laws.

Meanwhile, the Encyclopedia of Social Work from The National Association of Social Work, defines the concept of oppression as such:

Oppression is commonly understood as the domination of a powerful group—politically, economically, socially, culturally—over subordinate groups. Another common definition is that oppression is an institutionalized, unequal power relationship—prejudice plus power (Soest, 2013).

Like privilege, the experience of and reinforcement of oppression may happen at multiple realms: individual, familial, institutional, societal, legal, and cultural.

Classism is a form of oppression based upon one's social class position and can be described as the result of class privilege (unearned advantage and conferred dominance due to a high social class position) and power (Lott, 2002). Though class-based prejudice can occur in any direction (i.e., one can be prejudiced towards those of higher, lower, and similar social classes; Liu et al., 2004b), the term classism as used in this paper specifically refers to the domination by those with class-based power of those without class-based power (Lott, 2002). Classism occurs in a number of arenas and includes individual as well as societal attitudes and beliefs, individual classist behaviors, as well as policies and laws that oppress and disempower those of lower-class positions. Social class and classism, like race and racism and gender and sexism, are socially constructed and co-constructed (Liu et al., 2004b).

Therapeutic alliance. Therapeutic alliance is considered to be a core element of all therapeutic relationships (Horvath, 2006). Constantine defines the therapeutic alliance as the “quality of the interactions between clients and therapists, the collaborative nature of these interactions with regard to the tasks and goals of treatment, and the personal bond or attachment that transpires” (p. 2). Horvath (2001) highlights that a therapeutic alliance involves a

collaborative relationship between the therapist and client that includes an affective bond as well as cognitive elements (e.g. treatment tasks and goals).

Theoretical Grounding

The social class worldview model and modern classism theory. The main theory grounding this line of inquiry is the work conducted by Liu and colleagues (2004b) in developing the social class worldview model (SCWM) as well as the modern classism theory (MCT). According to the SCWM, one's social class worldview is the schema through which one perceives and interprets one's class-based experience. Social class experiences are seen as subjective and as carrying multiple meanings in people's lives, being conceptualized differently depending on past experience, intrapsychic factors, and contextual factors (Liu et al., 2004b). This theory holds that all people have an economic culture within which they are situated and attuned to and which informs how they make meanings of particular social, cultural, and economic capital. This worldview is behaviorally expressed on three levels: 1) material possessions, 2) social class behaviors, and 3) social class lifestyle (Liu et al., 2004b). Liu and colleagues (2004b) suggest that individuals' sense of themselves within their subjective economic culture significantly defines the internal working model of their intrapsychic self. Furthermore, one's social class worldview is the schema through which one perceives, as well as magnifies, distorts, limits and interprets, one's class-based experiences and contributes towards how one makes sense of their feelings, perceptions, economic environment and culture. Liu and colleagues (2004b) extol the SCWM as a tool to understand the intrapsychic experience of social class that can be applied to all forms of counseling. For example, drawing on the social work concept of understanding the "person-in-environment," a client's economic culture is important to understandings a large part of their environment.

Importantly, three assumptions ground this theory: 1) that the experience of class is subjective and socially constructed, 2) that people's perceptions shape their realities, and 3) that everyone is working in a behavioral, emotional and cognitive polarity between states of "homeostasis" and "internalized classism" (Liu et al., 2004b). Homeostasis is defined as when accrued social, cultural and/or economic capital maintain one's social class worldview (Liu et al., 2004b). In other words, a person's external expression of class is congruent with their internal sense of themselves as "classed." In contrast, internalized classism refers to feelings of anxiety, distress, dissonance and frustration that arise when people do not feel adequate within their perceived or desired social class (Liu et al., 2004b). The feeling states and cognitions evoked by instances of internalized classism are deeply uncomfortable and motivate people to strive to reach equilibrium (Liu et al. 2004b). As with any polarity, individuals may be anywhere on the spectrum between homeostasis and internalized classism at any given time.

According to modern classism theory, reacting to internalized classism motivates a person to enact social class-informed attitudes towards others in an attempt to regain equilibrium. Modern classism theory suggests that everyone is always negotiating various class-related dynamics within relationships in order to meet the demands of their economic culture and achieve equilibrium.

Clinicians can better understand their clients by learning which social class lens is the most salient for them, and then addressing conscious and latent content via that lens. Additionally, clinicians would benefit from considering social class as something that is always negotiated within micro- and macroeconomic cultures and within the context of intersectionality, and thus is negotiated within the context of therapy and the context of the therapeutic relationship.

The therapeutic relationship. Another theory central to this study is that the therapeutic alliance is a core element of all therapeutic relationships (Horvath, 2006; Horvath, Del Re, Fluckiger, & Symonds, 2011) and that the most important common factor to the success of psychotherapy is the relationship between the therapist and the client (Elkins, 2012; Horvath, 2005). A number of factors, including treatment techniques and the personal characteristics of the therapist, affect the quality of the therapeutic alliance (Bedi, Davis, & Williams, 2005; Ackerman & Hilsenroth, 2003). Specifically, Ackerman and Hilsenroth (2003) found that therapist qualities that facilitate an environment of trust and respect as well as qualities conveying a sense of clinical competency have a positive impact on the therapeutic alliance. Among these qualities are being flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, open and warm (Ackerman and Hilsenroth, 2003). While the nature of the relationship and alliance between the client and therapist is being defined and developed, the sociocultural identities of both the therapist and the client are also being negotiated. As discussed below, self-disclosure around identity and broaching issues of identity, power, and privilege can impact the therapeutic alliance.

Contexts of Social Work, Social Class, and U.S. Capitalism

Historical roots of social work. Modern American social workers consider the profession to have emerged during the Progressive Era at the end of the 19th century. During this period of industrial growth a new labor force, mostly consisting of southern African Americans and European immigrants, moved to the U.S. and lived together in crowded tenements. Some middle- and upper-class, college-educated people, most of whom were women, considered it their “moral obligation” to help those poorer than themselves (Patterson, 2013). These volunteers are considered to be the first American social workers (Jimenez, 2010). Strier states “Social work

evolved as an interclass profession, with its core target populations coming mostly from the lower classes and its founders and practitioners generally based in the middle class” (2009, p. 239).

Current context. It is important to acknowledge the role that the current economic environment may have on the experiences of clients as well as clinicians. In short, economic inequality is expanding in the U.S., especially the gap between the richest, so-called “1%,” Americans and everyone else (The Stanford Center on Poverty & Inequality, 2014). As median net worth plummeted by 47% between 2007 and 2010, wealth inequality increased for the first time since the early 1980s (Wolff, 2014). In fact, the median wealth of the country’s upper-income families is seven times that of middle-income families and seventy times that of lower-income families (Fry & Kochhar, 2014). However, it is not just the gap between the top 1% and the 99% that is growing. Since 1979 the income gap between those with college or graduate degrees and those whose education ended in high school has grown (Noah, 2013). Noah (2013) argues that this skills-based gap is the inequality most Americans see in their everyday lives. Additionally, following longstanding patterns, the wealth inequality continues to widen along racial and economic lines with whites owning 13 times more wealth than African Americans, and 10 times more than Latinos (Kochhar & Fry, 2014), a phenomenon termed the racial wealth divide.

The presence of social class and capitalism in American society and identity. Despite deep statistical evidences regarding unequal access to resources, class continues to be a force that is often invisibilized as a factor in measuring disparity (Isaacs & Schroeder, 2004). Some scholars suggest that this ignorance of class and the sociocultural impacts of classism are intentional. For example, Glasser writes that money is the last shame in America and that it is

this shame, and even “low-grade terror,” about money that is designed to make us work harder and longer and to accept poor working and economic conditions (Glasser, 2004). Like the use of racism as a tool to disguise and distract from white supremacy, institutionalized classism distracts from the tension between American ideals and the forces and impacts of corporate capitalism (Kasser, Cohn, Kanner, & Ryan, 2007). Yet the tension between America as a free and equal society and as an economic superpower is, at times, extremely palpable: the 1999 protests against the World Trade Organization in Seattle and the Occupy Wall Street movement exemplifying this tension.

Kasser and colleagues (2007) note, “...the aims and practices that typify American corporate capitalism often conflict with pursuits such as caring about the broader world, having close relationships with others, and, for many people, feeling worthy and free” (p. 1). Yet, a powerful cultural message is that cultural and social capital is acquired through the acquisition of objects, in other words consumption (Diwan, 2000; Holt, 1998). Adding to this, researchers suggest that decreased standards of living due to laissez-faire economic policy has resulted in interpersonal anxiety and frustration, overcompensation in the form of material-goods consumption, and the loss of community cohesion due to class-based fissures (Diwan, 2000; Kasser et al., 2007).

Social workers’ position and role within the U.S. economy. It is also important to examine social workers’ position and role within the current economy and power structure within the United States. Social work is typically seen as a middle-class profession and a 2010 survey by The National Association of Social Workers and The Center for Workforce Studies reported that the majority (60%) of social workers in 2006 earned a salary between \$35,000 and \$59,999, placing them within the middle-class (2006). Social workers come from a variety of

class backgrounds and have differing access to wealth and burdens of debt. However, all social workers hold a great deal of cultural capital acquired through their education, operate in their work from an assumed professional middle-class position, and hold a great deal of power vis-a-vis their clients.

As a profession that is situated between the individual and society at large, Abramovitz (1998) points to a tension that is inherent to social work: adjusting people in order to fit their circumstances versus changing the status-quo of society at large in order to better accommodate the reality of people's lives. At the heart of this tension as it relates to economic inequality are the various ideas about how people become and/or remain wealthy or impoverished. The ideology of upward mobility is based on the idea that anyone who works hard enough can "pull up their bootstraps" and move up the economic ladder. Despite structural obstacles to upward mobility that significantly impact and restrict marginalized groups (Jimenez, 2010), the myth of meritocracy has persisted and solidified into an ideology such that those in poverty are assigned blame. Meanwhile, social darwinism and its philosophy of "survival of the fittest" has justified massive inequality and a belief that any help given to those in poverty would keep the entire human race stalled at a low level of development (Jimenez, 2010).

With social work, and the counseling professions at large, positioned as a middle-class profession, several writers have questioned whether social work serves the ruling class or those who make up their caseloads, typically members of the middle and working classes. Kivel (2007) argues that the ruling class, in order to maintain power and avoid directly managing the most disenfranchised, instead utilizes legal, educational and professional systems to create a network of occupations, careers, and professions that then deal directly with the disenfranchised. Kivel (2007) terms those working within this network as occupying the "buffer zone." According to

Kivel (2007), the buffer zone has three primary functions: taking care of the disenfranchised, keeping hope alive for the disenfranchised, and controlling those who want to make systemic change. It is easy to see how social work, especially social work's roles in public agencies (e.g. child welfare agencies), fits within Kivel's concept of the buffer zone.

Other authors agree with Kivel's assessment. According to conflict theory, the very purpose of social policies and structures is indeed social control; they serve to quell hostility among marginalized groups and to reinforce social forces maintaining the recurrent patterns of inequality (Day & Schiele, 2013). Similarly, Abramovitz summarizes social work's role between institutions and individuals as one of mediation, stating "social work has helped to mediate between the conflicting needs of individuals and the requirements of the market economy" (Abramovitz, 1998, p. 518). Meanwhile, Park agrees that social workers, while striving to ameliorate the consequences of unjust government policies, in fact facilitate those policies and actualize social biases (Park, 2009).

However, Abramovitz (1998) also asserts that a study of social work's code of ethics, literature, theoretical orientations, and history form a foundation for its commitment to social change. And Park (2009) argues that the conceptualization of social service versus social control is a false dichotomy and that social control may in fact be inherent in all social service practice. The dynamic of social worker as both helper and controller is an important one to consider and hold in mind, especially when one considers the role of shame, invisibility, and power wrapped up in social class identity.

Cultural competency. The National Association of Social Workers (2008) suggests that social workers should "understand culture" and be able to "demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and

cultural groups”. In 1982, Sue and colleagues presented a model of multicultural counseling competencies when working with a culturally diverse clientele. This model outlined three specific areas affecting the therapeutic process: beliefs and attitudes, knowledge, and skills (Sue et al., 1982). Since this time, multicultural counseling competence has become an important goal of mainstream psychological and counseling standards and clinician education and practice.

The movement towards cultural competency was a reaction to a realization that counseling professionals often rely on theories, ideologies, and techniques that are not congruent with their clients’ own worldviews (Hayes, 1996). Further, factors related to cultural conflict and mistrust can stem from a perceived insensitivity to the personal and cultural meanings of clients’ experiences, the consequences of which may include underutilization of resources and premature departure from counseling (Sue & Sue, 2003).

Social class does not receive sufficient attention within social work education or research, including within cultural competency work. In fact, the 2001 NASW Standards for Cultural Competence in Social Work Practice identifies social class as an area within which the field must gain further and deeper competence (NASW, 2001). Yet, in the most recent revision to the code in 2008, a clause was added to “Social Workers’ Ethical Responsibility to Clients” that has a conspicuous lack of discussion about poverty or social class as a dimension that requires cultural competence:

1.05 Cultural Competence and Social Diversity

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability (NASW, 2008).

Despite these oversights, a preliminary model of class-competent social work has recently been published (Strier, 2009). The model suggests a 4-part comprehensive framework for class-competency:

Class-competent social work should be defined as the knowledge, skills, theoretical approach and critical awareness required to effectively help clients oppressed by class structure.

First and foremost, class-competent social work requires class knowledge. Social workers should have the capacity to understand the dynamics inherent in their client's class situation and be able to analyze the inter-connectedness of class with other diversity components such as race, culture and gender. Social workers must have the knowledge needed to identify the systematic barriers associated with class constraints. This understanding must exceed the scope of the economic sphere and should include cultural, social and symbolic aspects related to it.

Second, class-competent social work demands the acquisition of specific professional skills in order to assist clients in challenging class oppression. Skills include a wide range of practices used in social work, such as case and policy advocacy, participatory action research, group work, community practice, consciousness-raising methodologies oriented to address the personal, interpersonal, organizations and political aspects of class issues. Additionally, given the inter-class nature of many worker-client encounters, social workers should deploy skills and methodologies aimed at developing more egalitarian worker-client relationships.

Third, class-competent social work entails a certain theoretical approach that acknowledges the structural nature of social problems, recognizes the essential influence of the clients' class situation on their personal and collective lives, and is cognizant of the class-based nature of social policies.

Lastly, class-competent social work also implies a sense of critical self-awareness. Social workers should be aware of their own class biases and assumptions, and they must be open to critical debate on how these biases and assumptions may affect the cross-class nature of worker-client relationships. They must be conscious of the extent to which power and class conflicts are involved in the interactions between clients and social workers. Furthermore, social workers must be prepared to critically identify and deconstruct class-based discourses of different theoretical perspectives in social work. Most important, class-competent social workers must be able to promote their clients' class awareness and be ready to support their class interests (2009, p. 241).

Social Class, Mental Health, and Therapy

Why study social class in therapy? It is useful to pause here to reflect on why we should be interested in studying social class as it relates to and impacts psychotherapy specifically. Broadly speaking, Liu and Pope-Davis (2003) argue that as we live in a capitalist society, an individual's motivations within such an environment is to gain and maintain control over resources that are valued within their particular environment. Resources include not just wealth, but also behaviors, relationships, and attitudes accumulated and utilized to support one's social class position and worldview (Liu et al, 2004b). Liu and colleagues also point out that classism is situated within a network of other oppressions, especially race-based and sex-based oppression, and understanding social class and classism can provide links to better understanding racism and sexism, for example (Liu et al., 2004b). In summary, Liu argues that understanding the intersections of a client's context, including their subjective experience and understanding of social class, and intrapsychic world is of primary importance in multicultural counseling (Liu et al., 2004b).

Furthermore, a disconnect exists between our understanding of social class and counseling with counseling treatment models and research (Liu et al., 2004b). It is broadly understood that the meanings and values of certain capitals (including human, social, and cultural capital as produced in behaviors, attitudes, and relationships) vary between environments and contexts (Liu et al., 2004b). And although numerous authors have suggested that social class is an essential component in counseling, the ongoing practice of clinical diagnoses, treatment methods, and counseling research favors (and assumes) a middle-class, educated worldview (Liu et al., 2004b).

With this in mind, the conceptualization of social class as a purely objective construct and the assumptions of middle-class status and worldview so common within counseling

research, training, and practice both invisibilizes and distorts a great deal of client meanings and experiences, with potential negative impacts on therapeutic alliance and treatment outcome. Especially when working with cross-class clients, clinicians may be at risk for conducting inappropriate assessments, interpretations and interventions as well as committing class-based microaggressions.

Social class and mental health. As we have seen social class is a socially-constructed and subjective aspect of identity. Though a large body of research exists exploring associations between objective socioeconomic status and mental health, there has been little research looking at the impact of one's subjective experience of their social status. One exception is an international study by Scott et al. (2014). In this study subjective social status was operationalized as where participants place themselves on a ladder, where the top rung are those who are the best off and the bottom rung are those who are worst off. Within a large, international sample of individuals, including the U.S., the measure of subjective social status was significantly inversely associated with numerous DSM-IV mental disorders even after correcting for objective socioeconomic status (Scott et al., 2014). One limitation of the study is the simplicity with which subjective social status was operationalized and measured and the possibility of the impacts of other factors. For example, participants may want to see themselves as higher up on the social ladder especially when interacting with a researcher and the decision as to where to place oneself in comparison to others may be influenced by a number of personal, contextual, and cultural factors.

Social class and access to (effective) therapy. There is a great bias within psychotherapy, and reflected within society, that lower-income people cannot benefit from psychotherapy (Smith, 2005). In fact, a review of 22 years of research within the PsychLIT

database (1974-1996) found that lower-income clients were referred to psychotherapy less often (Garb, 1997). Additionally, in a review of research on psychotherapy dropout, Reis and Brown (1999) found that lower socioeconomic status and ethnicity were the only two consistent predictors of dropout, suggesting that therapists' ability to engage lower-income clients in therapy and build a therapeutic alliance with them was hampered. And even if lower income clients are able to access to ongoing therapy, they may not benefit as much. For example, in a large sample of clients of varying social class backgrounds, Falconnier (2009) found that empirically-validated treatments for depression performed poorly among individuals of low socioeconomic status.

Social class bias among mental health providers. Dougall and Schwartz (2011) examined the impact of the client's socioeconomic status on the psychotherapist's countertransference reactions within a sample of 141 clinicians via a web-based case study and survey. In this quantitative study, each clinician received an analog vignette about a client with either a low or high socioeconomic identity. The study found that the vignette of the client from a high socioeconomic position evoked countertransference reactions within the clinicians of feeling dominated while clinicians more readily diagnosed those from a lower socioeconomic position as having more severe problems than those from a higher class (Dougall & Schwartz, 2011).

In a 1970 quantitative study, clinicians judged the appropriateness and success of psychotherapy for two different analog case studies, one with a person who identified as middle-class, and other person who identified as working-class (Vail, 1970). The results from the study suggested that a client's perceived potential appropriateness for treatment and potential success through treatment is not influenced by race or the assessing social worker's level of experience,

but instead by the client's socioeconomic class (Vail, 1970). While some further research has corroborated these results, other research refutes it (Mitchell & Atkinson, 1983; Siassi & Messer, 1976).

Negative countertransference may especially play a part in cross-class therapeutic dyads; with the higher the clinician's social class, the more irritation and anger the clinician may feel toward clients who are financially challenged (Patterson, 2013). Patterson (2013) speculates that those in higher social class positions may have fewer practical skills to alleviate economic hardship and fewer skills in meaningfully relating to those in poverty, in other words less social class competence. Others have suggested that all clinicians are potentially classist because of their privileged status as white-collar professionals, their use of theories based in an middle- or upper-class perspective, and due to the simple fact that they are living and working in a classist society (Lott, 2002; Smith, 2005). Counselors, particularly those with class privilege, must be aware of their bias to see those who are not upwardly mobile as lazy, unmotivated, or pathological (Graff, Kenig, & Radoff, 1971). Conversely, counselors must be wary of idealizing those of different classes, of seeing the poor as noble or as victims without agency (Liu et al., 2007).

Social class and clients' experiences of the therapeutic encounter. Though limited, there has been some research as to how social class identity influences therapy. Thompson, Cole, and Nitzarim (2012) used qualitative methods to explore the subjective experiences of sixteen clients who self-identified as low-income or working class. Respondents reported that their perceptions of their therapist's class were always a factor in how comfortable and known they felt in sessions (Thompson et al., 2012).

Another investigation that included interviews with six white, working-class women about their experiences in psychotherapy with non-working-class therapists revealed similar insights (Chalifoux, 1996). Of note, participants expressed discomfort discussing their values and lifestyle with their therapist and participants often felt that the therapist could not attune to the client's basic life experiences and decision-making rationales (Chalifoux, 1996).

Race in the Therapeutic Encounter

Due to the lack of research on the role of social class identity in therapy, it is useful to use the analog of race to frame the impact of social identity and power within the clinical dyad. DiAngelo (2012) addresses the way in which being White is an experience of being *just normal*, or outside of race altogether. DiAngelo (2012) suggests that this position functions as a kind of blindness or an inability to think about whiteness as an identity that has or could have an impact on one's own life. Therefore, it is possible that White therapists who address race only if and when clients-of-color broach the subject of race may perpetuate a sense that race is something people-of-color have and that Whites are somehow immune to. Being a social worker (i.e. a middle-class professional), and especially being a social worker with a middle-class upbringing, is similarly an experience of being just normal and, as such, this position impedes looking at one's social class identity.

Cross-racial therapeutic dyads. The research on the effectiveness of cross-racial therapy as compared to ethnic matching for therapy is mixed. Some research indicates that cross-racial therapeutic interactions can be anxiety-provoking, even creating potentially negative psychological and physiological outcomes for both majority and minoritized participants (Dovidio, Gaertner, Kawakami & Hodson, 2002; Goff, Steele, & Davies, 2008; Pearson, Dovidio & Gaertner, 2009). Farsimadan, Draghi-Lorenz, and Ellis (2007) looked at the process and

outcome of therapy in ethnically similar and dissimilar therapeutic dyads and suggested that ethnic matching can have a significant positive impact on treatment outcomes due its impact on the therapeutic alliance. However, Wintersteen, Mensinger, and Diamond (2005) found that race did not appear to be a deciding factor in developing the early therapeutic alliance after two sessions when looking at cross-racial therapy. However, in both studies white therapists treating clients of color had notably lower retention rates than other therapeutic dyads. Similarly, a recent meta-analysis indicated that while ethnic match is associated with attendance frequency and a decrease in drop-outs, ethnic match alone is not a strong predictor of attendance or dropout, and concluded that “therapists of all ethnicities may be able to deliver culturally competent psychotherapeutic services” (Maramba and Hall, 2002, p. 295). Though matching on social class identity is not possible due to social work’s position as a middle-class profession, matching on social class background is possible, though not yet researched.

Separately, in their assessment of 311 white counseling trainees, Spanierman, Poteat, Wang, and Oh (2008) found that those who were in personal touch with their affects regarding race privilege, as measured by white empathy and white guilt, had higher levels of multicultural competency in their practice. While this research focused on race as a mediating factor of the therapeutic relationship, its results suggest that middle-class and upper-class therapists must be in touch with both empathy and guilt regarding their class position when working with clients, especially lower-class clients.

Self-disclosure in cross-racial therapy. According to Burkard, Knox, Groen, Perez, and Hess (2006), in building positive relationships with clients-of-color, White therapists need to be open to discussing racial and cultural concerns, to validate clients’ experiences of discrimination, and to demonstrate a willingness to self-disclose their own experiences and reactions in such

discussions. White therapists who are able to communicate their sensitivity to racial concerns and be open with clients about their own perceptions and attitudes may help build an effective cross-racial therapy alliance (Burkand et. al., 2006). In fact, Burkand et al. (2006) found that when race is addressed in cross-racial therapy, self-disclosure by White therapists has the potential to strengthen the therapeutic relationship.

Broaching race in cross-racial therapy. The literature shows that successful therapy relies on a strong therapeutic alliance and suggests that talking about race in cross-racial therapeutic relationships can help to strengthen the therapeutic alliance. In light of these findings, how might therapists best broach the subject of race in order to facilitate a strong therapeutic alliance?

Cardemil and Battle (2003) discuss supporting an open dialogue with clients about race and ethnicity and outline reasons therapists may choose not to discuss race with their clients. These reasons include fear of raising emotionally charged issues, concerns about saying something offensive, not knowing when and how to address race, and waiting for clients to initiate discussions about race. The authors suggest that not acknowledging racial differences could send an implicit message to the client that the therapist is uncomfortable discussing race or does not view issues of race as important. Cardemil and Battle (2003) suggest questioning clients about how they identify rather than making assumptions and that therapists should consider how racial difference affects the therapeutic relationship and the therapeutic process. The authors recommend that therapists discuss race rather than being more passive or conservative and that therapists continue learning about race and ethnicity through introspection, experience and education.

Day-Vines and colleagues (2007) coined the term broach to refer to “the counselor’s ability to consider the relationship of racial and cultural factors to the client’s presenting problem” (p. 401) and note that these factors are often unexamined in counseling if not explicitly broached. Broaching creates opportunities to heal a legacy of silence and shame by providing an environment of emotional safety within which the counseling relationship can transition from superficiality toward intimacy (Day-Vines, et al. 2007).

Day-Vines and colleagues (2007) go on to examine the various ways in which counselors broach racial, ethnic, and cultural differences in the counseling process. The authors describe broaching behavior as, “a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity” (Day-Vines et. al., 2007, p. 402).

Day-Vines and colleagues (2007) describe a continuum of five different broaching styles including avoidant, isolating, continuing/incongruent, integrated/congruent and infusing, which are also associated with progressive levels of racial identity development. For example, an avoidant broaching style is characterized as one in which the therapist gives little attention to race due to a color-blind stance. The isolating broaching style addresses race superficially or out of obligation. Therapists with an isolating broaching style may hesitate to discuss race out of fear that it will be offensive or a belief that race is a taboo subject. Day-Vines et al. (2007) suggest that clinicians who have a continuing or incongruent broaching style may have an understanding of how sociopolitical factors affect clients personally, but they are limited in their understanding of how to explore race and racism with openness within the therapy. Integrated/congruent counselors are described as having a well-established awareness of diverse racial, ethnic, and cultural norms and their impact on clients’ presenting concerns. “Infusion”, the most advanced

broaching style, extends the broaching behavior beyond the clinician's professional identity to a greater personal commitment to social justice.

Day-Vines et al. (2007) assert that those therapists who are more advanced in their own racial identity development are more likely to foster open and trusting therapeutic relationships with their clients. Therapist responsibility is highlighted throughout this article as critical: it is the therapist's responsibility to understanding their own racial identity as well as to provide opportunities for the client's exploration of race and racism and their personal impact (Day-Vines et al., 2007).

Challenges and Limitations of the Literature

Unfortunately, there are a number of limitations within the literature reviewed above and within the literature on social class and counseling at large. Within the literature at large, as well as within the included studies, the use of social class is inconsistently defined, conceptualized, assessed and analyzed (Liu et al., 2004a). In fact, Liu and colleagues (2004a) noted the inconsistent use of words to denote social class, citing the use of 448 different key words in a review of the counseling literature. In addition, typically when operationalizing social class, research relies on objective measures of class, typically income, education, and occupation; however, these operationalizations exclude the subjective experience of social class as well as intersections with other social identities.

Another major limitation is the fact that the literature within the counseling fields at large is so limited in its attention to social class. Liu and colleagues (2004a) reviewed 3915 articles and found that only 18% included social class as a variable and social class was typically mentioned only peripherally. Among the subset of articles that included social class as a variable, only 31% integrated social class into the methods section and only 10% included social class in

the discussion (Liu et al., 2004a). Even within these discussion sections, social class was often pointed to as a limitation to the study (i.e., an extraneous variable distorting the data of the study) or as a parenthetical cultural construct to be flagged for future research (Liu et al., 2004a). Importantly, almost no work has been done as to how social class becomes evident in the therapeutic encounter. Though there is some limited research into clients' (specifically lower-income clients') experiences of social class in therapy, there are even bigger gaps in the literature regarding therapists' experiences of social class in therapy.

As discussed, attrition is very high among clients of lower social class. One limitation of the research above is that it ignores the experiences of those who drop out of therapy and instead relies on the experiences of those engaged in psychotherapy. Another limitation is the focus of the literature on the experiences of poor clients with therapists (who are assumed to be middle-class). Social class influences everyone's subjective experience and is a factor in every therapy. Another bias is that majority of the available literature is written from the lens of a white, middle-class clinician. Meanwhile, there is a bias in that much of the research on social class presented above utilized samples that were primarily white and female. Another severe limitation is that within the limited empirical and theoretical literature quoted above, most of the work has been done within the field of psychology, not social work.

Lastly, another major limitation within the above literature review is its reliance on research on cross-racial therapy. Though some of the insights on cross-racial therapy, including the impact of self-disclosure and styles of broaching, may similarly be at play in cross-class therapy, simply put racial identity is not social class identity. The history and current context of racial identity and racial oppression, though intersecting with social class identity and class oppression in many ways, is distinct and unique. Social class is constructed and negotiated

within the therapeutic encounter in both similar and dissimilar ways from other identities and is both separate from and intersects with other identities.

Summary

As shown in the review above, there is a great need for an increased attention on the role of social class identity within the therapeutic process. This need exists at the levels of social work education, training, research, and policy. The research described below attempts to begin to elucidate the role of social class identity within therapy by examining the experiences of clinicians in broaching the subject of social class with their clients.

CHAPTER III

Methodology

The current study asks how and if clinicians engage in dialogue about social class identity with their clients. Specifically, the study asks clinicians to reflect on how their decisions regarding discussions about social class with their clients. Participants were asked to recall, if possible, instances when they broached social class identity with their clients and to reflect on the factors influencing their choices in broaching social class identity as well as their perceptions of how such discussions impacted the therapeutic relationships. Participants were also asked to reflect on possible factors influencing their decisions in broaching, or not broaching, social class identity.

A qualitative approach utilizing open-ended questions was used in order to gather narrative data from participants. This approach was chosen in order to gain the greatest breadth of data from participants. Furthermore, a search of the literature revealed no similar research had been conducted. A qualitative approach was thought to best allow for the capture of new data and the emergence of new understandings in an area of inquiry unrepresented in the literature.

Sample

The primary inclusion criteria for candidates to participate in this research study were individuals who hold at least one clinical credential such as Social Work, Psychology, Psychiatry, Mental Health Counselor, Marriage and Family Therapist or any other credential that allows for work as a psychotherapist. Participants may have been working under supervision or

independently. Participants must currently be conducting ongoing psychotherapy and be willing to respond to questions regarding their work with their clients.

Potential participants were first identified through listings of clinicians in the local geographic area of the researcher. In addition, Robin DiAngelo, research advisor for the study, supplied contact information for several professional contacts as potential participants. Additional participants were recruited through a snowball method in which interested individuals contacted other clinicians who might have interest in the study. Once identified, potential participants received an introductory email briefly explaining the study and its purpose. If a reply was returned to the researcher, the informed consent was sent electronically to the potential participant. The informed consent form outlined the study and their participation in greater detail. Through the informed consent process, potential participants learned about the potential benefits and risks of participation, the ethical standards and safeguards used to protect confidentiality, and received the researcher's contact information in case questions or concerns arose. Once the signed document was received, a unique online link to the survey was sent to the participant.

The snowball sampling technique employed in this study may have limited the diversity of experiences and backgrounds of the individuals in the sample. It is possible that a more random sampling technique could have resulted in a more diverse sample of participants.

Ethics and Safeguards

Participation in the study was voluntary. Participants had the option to refuse to answer any question on the survey and to withdraw from the study at any point during the recruitment, informed consent, and survey process. Participants who had already completed the survey had a deadline by which to formally withdraw from the study. If anyone had decided to withdraw, all

of the data gathered from that participant would have been removed from the study and destroyed. No participants chose to withdraw from the study.

Potential benefits of participating in the study included the opportunity for participants to reflect on and communicate thoughts and feelings related to their professional work around social class. Potential risks to the participants included the risk that individuals may experience complex and difficult emotions while reflecting on their clinical work around social class or may feel uncomfortable disclosing or sharing their experiences in regards to this topic. In addition, because of the non-probability snowball sampling method used to recruit participants, some participants may have disclosed to each other that they were participating in the study. In order to mitigate any vulnerability this may have produced, it was made clear to all participants that all identifying information would be held in confidence. Several steps were taken to protect confidentiality and participants were informed of these steps through the informed consent process. For instance, participants were cautioned not to reveal identifying information that may be associated with them or with a client. Any identifying information was removed from the survey responses. In addition, participants were notified that all research materials including recordings, transcriptions, analyses and consent/assent documents would be stored in a secure location for three years according to federal regulations.

Data Collection

Data collection began upon receipt of the Smith College School of Social Work Human Subjects Review approval letter (Appendix D) for this study. After receiving a copy of the participant's signed consent form, the participant was sent a unique link to the online survey hosted on the website Qualtrics. Participants first answered a series of prompts regarding their psychotherapy credentials and experience and their sociocultural identity. Participants then

answered in writing to a series of open-ended questions, such as the following: “Please think about your experience conducting individual therapy. Did you discuss social class in therapy with any of your clients?” and “Considering your experience talking about social class with client(s), please discuss how you think talking about social class has affected the therapy relationship between yourself and your client(s)?” The complete survey can be found in Appendix B.

Data Analysis

After all data was collected, a thematic analysis was conducted. First, the data was organized by question and read and re-read in order to become familiar with the data and to notice any patterns that occur in the data. Then an initial list of codes was generated from the data set that held a reoccurring pattern. Next, themes as well as sub-themes were identified in the data and the codes. Themes and sub-themes were reviewed before being refined, clarified, and defined. Data that did not fit within thematic areas were also noted. Any quotes from the participants that best illustrated emergent themes were noted for use in the findings and discussion chapters. The strengths of this analytic approach include the flexibility it allows as well as how it allows themes to emerge directly from the data. Limitations to this approach include concerns regarding reliability due to the subjectivity of one individual’s interpretations of the data as well as the possibility for the discovery and verifications of codes and themes to mesh together.

CHAPTER IV

Findings

The purpose of this research project was to explore how clinicians engage in discussions about social class with their clients. Specifically, it explores how clinicians think about these discussions, their impacts on the therapy and the therapy relationship, as well as their choices to initiate these conversations (or not) and to disclose their own identity (or not).

This chapter presents findings from a survey of open-ended responses solicited from 12 clinicians. The chapter begins with a presentation of the findings related to participant demographics as collected by the survey. It proceeds with findings presented according to four themes that emerged from the data during analysis. Each main theme encompasses several subthemes. Examples of participants' responses are utilized to highlight the findings. The four major themes are the following: *Social Class is Broached with Clients of Lower Social Class*; *Whose responsibility is it to bring up social class? (And what are the motivations?)*; *Clients' Identities are Discussed, Clinicians' are not*; and *Is Social Class Relevant to Therapy?* Findings are presented with examples from the interviews using participant IDs for the purpose of anonymity.

Demographic Data

A total of 12 participants completed the study, including 4 participants with a LCSW, 3 with a LICSW, 2 with a MSW, 1 with a LMHCA, and 1 with both a PsyD and a MSW. Participants had, on average, 9.83 years of experience (range = 0.5 to 35 years, SD =11.42

years). The average age of participants was 41 years old (range = 26-61 years; SD = 11.92 years). Of the 12 participants, 10 identified their gender identity as female, 1 as male, and 1 as genderqueer. 11 of the 12 participants identified their racial and ethnic identity as either Caucasian or white and the remaining participant identified as Jewish American. Regarding social class, participants were given the options to self-identify their social class upbringing with the following options: low income or poor background, working class background, lower middle class background, professional middle class or upper middle class background, or upper class background. Four participants identified as being from a working class background, four as being from a professional middle class or upper middle class background, three as being from a lower middle class background, and one as being from a low income or poor background. No participants identified as being from an upper class background.

Theme 1: Social Class is Broached with Clients of Lower Social Class

The first major theme is that social class is brought into a discussion in therapy most frequently with clients who are perceived by their clinician to be of a lower social class background and experiencing financial stress.

More relevant for clients in lower class positions. The first subtheme is that a majority of clinicians felt that discussions of social class identity and experience are more relevant for clients who are struggling financially. When asked if they noticed any patterns regarding the clients for whom social class becomes a salient issue and is addressed in therapy, ten of the eleven participants who answered (10 out of 11 or 91%) responded that social class becomes a salient issue and/or is addressed more often when working with clients of lower social class positions.

For example, Participant 8 shared “I think social class feels more relevant to people who come from lower social economic class background” and Participant 10 added “I have noticed that social class is discussed mainly with clients who are in a lower social class and who are struggling financially.” Participant 12 summarized this view in their statement: “In my work it is hugely disproportionately addressed, almost entirely with clients of lower SES. It seems like it is brought up by a client or I bring it up only if it's a source of stress/absence of resources, it doesn't really come up or get expatiated on if someone has a lot of SES privilege.” Meanwhile, Participant 6 wrote that the clients they work with who hold social class privilege struggle as well, but acknowledges that it is easier for them to bring up issues related social class with their clients who hold lower social class identities:

All classes struggle with their stuff. My upper middle class kids struggle with similar and different issues. Their privilege is a burden as well in regard to connection with peers at times. It is easier for me to bring up class with disempowered people.

Two participants also wrote that social class has become particularly salient with clients who are transitioning to either a lower or higher social class position. Meanwhile, one participant (Participant 9) was an outlier and responded that social class is discussed more often with those in higher social class positions:

I would say that social class is discussed more often with those of upper class positions. Many clients will openly discuss social capital, ie. their connections, even the coping strategies that have been afforded to them because of their social class like yoga, access to EAPs, etc.

Participant 9 does not elaborate on whether these clients specifically name these resources as a function of class, or whether the therapist simply recognizes them as such. That distinction—does social class emerge in therapy implicitly or explicitly—would be relevant to the question of how and when social class is raised.

In addition, when prompted to reflect on specific instances when they had a discussion about social class with one of their clients, all but one of the participants wrote about instances when they were working with a client who was of a low social class background or was struggling financially.

Avoiding discussing social class privilege. A second, related sub-theme was that for some participants, a client's holding their client's social class privilege dissuaded them from incorporating discussions of social class. Specifically, when participants were asked to reflect on instances when they were aware of social class as salient but chose not to address it, three participants identified examples when they chose not to address social class due to their client's holding a privileged social class identity position.

One participant (Participant 2) believed that the client would have viewed them as less competent had they disclosed their social class identity: "A client who is from a higher family SES may view me as less competent if I disclose my family of origin's SES." And two participants noted that they believed their clients would have experienced their broaching social class identity as a criticism or as invalidating. Participant 8 wrote, "At times I thought of it but not discussed it is when I perceive my client's social economic class as being higher than mine and I assume that they do not have any practice at analyzing such issues or they will perceive my analysis as a personal critique." And Participant 11 responded to the prompt by writing, "Possibly when class privilege has been the salient issue. The therapeutic alliance would have to be very strong to go here, as it can often be experienced as invalidating of one's struggles." The implication from these participants' responses seems to be that addressing class privilege would be harmful to the client as well as to the therapeutic alliance. In addition, Participant 6's response, quoted above, that social class is easier to bring up with disempowered (i.e., lower

class) clients suggests that additional participants may also avoid the topic of social class with economically privileged clients.

Theme 2: Whose Responsibility is it to Bring Up Social Class? (And what are the Motivations?)

A second main theme was the topic of whose responsibility it was to bring up the topic of social class identity and experience and what are the motivations for initiating such a discussion.

A topic in the hands of the clients? Ten participants (10 out of 12, 83%) indicated that they initiate discussion of social class with clients at times. However, in their responses to the question probing a specific instance of a discussion regarding social class with a client, the majority (9 of 12, or 75%) of participants wrote that it was the client, not them, who initiated the discussion.

For example, Participant 3 writes about waiting for the client to initiate such a discussion: “If a client is struggling with issues of social class, I would not identify that as a problem/issue and wait for the client to initiate whatever discussion he/she wanted to engage in.” And one participant (Participant 11) wrote that they cannot recall a time when they discussed experiences of social oppression without their client prompting them: “Clients have discussed social oppression more generally. I do not recall a time when I have initiated this topic unprompted.”

In two cases (2 out of 12 or 17%), participants described discussions wherein they raised the subject of social class identity and experience. In a case where a client relapsed on drugs, the participant highlighted to the client—who worked a minimum wage job—how their social class position interacts with their relapse and how this intersection could potentially lead to more dire consequences than for someone who was middle- or upper-class. In the second case, the participant (Participant 12) asked the client generally about their access to resources and their

current stressors, opening up a larger discussion of how their social class position and related experiences intersect with their mental health:

I asked generally about access to resources as well as current stressors. The client expanded upon this subject when we discussed family history as well as recent events, notably dropping out of school and moving several times, which he felt were contributing to and maintaining the acuity of his depression.

In the remaining case, the topic of social class emerged through a discussion that led to a client's childhood experiences living in poverty and how they affected her in the present.

Also relevant to this sub-theme of who initiates the conversation is the question of who participates in the conversation. In most responses (7 out of 12 or 58%), when writing about a specific incident of discussing social class with a client, participants included information only about how the client engaged in the discussion, leaving one to wonder how (and if) participants contributed to the discussion.

Clients' motivations and concerns. A second sub-theme was the topic of the motivations and concerns involved in the discussions around the topic of social class. Participants were asked to write about what they thought their clients' motivations and concerns were in these discussions. In analyzing participants' responses to this question, I divided clients' perceived concerns into several categories. Some participants wrote about concerns they thought their client's had that touched upon more than one category and so numbers add up to more than 100%.

Concrete: meeting their needs for living. Four responses (4 out of 12 or 33%) included concerns related to the clients' ability to meet their needs to live the life they want to live or to live at all in some cases. I call this category of concerns "concrete." Among the concerns were the ability to earn an income, accrue assets, further one's education, dress and maintain oneself

as one wants to, remain non-incarcerated, avoid being homeless, stay alive, not overdose, and afford food. For example, Participant 1 wrote:

The client's concerns were regarding how being on disability was impacting her life. The client described how her disability payment allowed her only to get her basic needs met and how she was not allowed to amass any assets (beyond \$2,000), which never allowed her to build resources, which she was concerned would keep her in a state of perpetual financial need.

Relational: being seen, heard, known, understood, and respected by the therapist.

Another category of concerns fit within a category I will call “relational” and includes clients’ concerns as to whether they are seen, understood, respected, and validated by their clinician. Five responses (5 out of 12, or 42%) included concerns in this category. Among the concerns were whether the client was being seen and understood by their therapist, whether their therapist could really relate to them and their experience, whether they were being taken seriously, whether they were being judged or blamed, and whether their discussion of classism was being dismissed or invalidated by their therapist. Participant 12’s response captures this category well:

I think he was concerned about whether I would judge him or blame him for his circumstances, and whether I could understand the complexities of his experiences and the ways they have informed who he feels he is and can be in the world.

Personal: understanding of self and one’s position, experience, and relationships. The next category of concerns captures how the discussions may touch upon clients’ understandings of themselves and their experience. I term this category “personal.” Three responses (4 out of 12 or 33%) contain concerns that fit within this category, which include furthering understanding of self and emotions as well as exploring feelings of inadequacy, self-esteem and self-worth. For example, Participant 5 wrote:

Early in treatment, my client was trying to understand why they felt unstable, trying to make sense of the perceived or real differences between their inner and outer world/realities. Recently, I think my client was concerned about their feelings of stability and safety--emotional, relational, and economic.

Societal: how are they viewed by others, by their community, by their society? The last category of client's concerns is designated "societal" and includes clients' concerns regarding how those around them perceive them as well as more generally their community and society. Four responses (4 out of 12 or 33%) included concerns within this category such as losing relationships due to changes in financial resources, concerns about how one is seen in society, feeling invisible in society, feeling that they do not fit-in, feeling that they are seen as unintelligent, are not being seen or heard by others, feeling judged, feeling powerless, and feeling disrespected.

For example, Participant 6 named their client's concerns as, "not being seen or heard, being invisible, feeling judged, feeling powerless and disrespected that he should be able to feed himself for a month on \$130." And Participant 10 wrote, "if I were to sum it up I would say that one of the most difficult things for her about her social class was feeling 'invisible' in our society."

Clinician's motivations and concerns. The last sub-theme captures the wide range of factors participants wrote as motivators for initiating conversations about social class with their clients.

Client's understanding. Three participants indicated that they are motivated by a desire to help their clients understand and make sense of their experiences as they may be related to social class. Two of these participants focused on helping clients understand how they may be oppressed or privileged by their social class identity. For example, Participant 5 wrote, "I think of social class as a fundamental identity category, important in helping clients make sense of their experience of oppression and/or create awareness of their privilege." And one participant (Participant 8) focused on how they connect clients' thoughts and feelings to their social class

identity: “When someone wonders where certain thinking or feeling comes from and I see a connection to their history of social class.”

Clinician’s understanding. Two participants indicated that they are motivated to initiate discussions so that they (clinicians) can better understand their clients. Participant 6 wrote, “I want to hear their experiences...I want to hear their voices. I do not want to be blind and uninterested to their stressors.” And Participant 9 responded, “I think I am motivated by healthy curiosity. In order to evaluate a client in the context of their presenting issue, it is almost always important to understand their locus of control and the factors that influence that. While my training leads me to ask questions about social class, I also think that I lead with my curiosity.”

The therapy relationship. Three participants indicated that they are motivated by relational concerns, such as a sense that their client feels that they (clinician) do not understand their experience. For example, Participant 2 wrote, “A client may feel that I do not understand how social class impacts their choices and their access to viable options.” Others wrote that they are motivated by a desire to communicate that they are interested in their client. For example, Participant 6 responded, “I want my clients to know I am interested in hearing their stories and struggles...I want them to know I care about their struggle.”

As a therapeutic tool. One participant (Participant 12) shared that he is motivated to discuss social class with clients due to its importance in their clients’ experiences and also as a therapeutic tool:

It's an inherent part of their experience in the world, and always linked to how they see themselves and are seen. I'm often motivated to discuss it with oppressed clients as a way of externalizing shame and holding systems accountable for how they support or fail to support clients, and to try to restore a sense of agency to the client who has lost that to capitalist oppression.

A desire to be honest. Lastly, one participant (Participant 4) wrote that he was motivated by a desire to be honest: “To have the courage to be truthful, which I feel is essential for mental health and human flourishing.”

Of the three remaining participants, one did not give a specific motivating factor, other than that they only initiate such conversations with clients who are struggling financially. And two indicated that they do not initiate conversations about social class with their clients.

Theme 3: Clients’ Identities are Discussed, Clinicians’ are not

The third major theme is that clients’ social class identities are disclosed and discussed, while clinicians overwhelmingly did not disclose or incorporate their own identities or experiences.

Unsurprisingly, all participants (12 out of 12, 100%), when reflecting on an instance of discussing social class with a client, noted that aspects of their client’s social class identity were part of the discussion. Meanwhile, ten (10 of 12, or 83%) participants reported that their social class identity was not discussed in these instances. Most (9 of 10) of these participants did not provide a reason for why their social class identity was not discussed. However, Participant 7 wrote that discussing their personal identity could be a distraction: “I tend to only give personal information if I think it will be helpful to the client and most of the time I’ve found that it’s more of a distraction than a support.”

Only two participants (2 of 12, or 17%) reported discussing their social class identity and experience. Participant 2 wrote, “I will disclose my working class (free lunch) status and that I understand how income and family SES impacts how we relate to the world/society and that what is adaptive in our home environment may not work outside that environment.” And Participant 12 wrote:

We discussed my social class identity, probably in the third session. He brought up feeling that he was comparing himself to me because of other similarities in our social identities, particularly our age and overlap in some queer communities. He talked about feeling that I had more things in life than he does because I have a career and a professional degree, and he felt shame that he had dropped out of undergrad and not been able to return/is unemployed. We talked about our different class experiences and current levels of access to privilege and capital, and I disclosed to him that I had similar experiences growing up low-income and that I have significant debt.

Of note, both of the participants who disclosed their social class identity identified themselves as being from either a low income or working class background.

Half-disclosures and “clients know about me.” A second sub-theme can be found in clinicians’ responses and reasons in not disclosing their social class identity. Two participants noted that they did not discuss their social class identity directly, but alluded to their clients that they have had different life experiences and come from a different social class upbringing, in a way making a disclosure that they come from a different (and likely higher) social class background. Participant 7 wrote, “It wasn’t discussed directly...I did acknowledge that it’s true, I’ve had a very different life experience and can’t understand exactly what it was like to go through that level of trauma, yet what I can do is be present to her.” And Participant 9 responded, “Good question. It was not directly. I think I said something like, ‘I can only imagine what it could have been like for you....’”

Two participants suggested that though they did not disclose their social class identity, their clients naturally intuit their social class position. These participants did not write further as to whether their clients’ perceptions of their social class identities were ever made evident or whether they feel that their clients’ intuitions of their identities, without their actual disclosure of their identity, is perceived as helpful or harmful for the therapeutic process. Participant 3 wrote, “I cannot recall a time when my own social class was discussed. However, I do think that clients

may know ‘about me’ and that they may have some "ideas, or assumptions" based on what they may think about my social class.” And Participant 4 responded:

No, not directly, but I think it is safe to assume he views me a person occupying a more comfortable and secure middle-class position than he does, and he knows that I am operating under a professional license that requires an advanced degree. If so, those assumptions are true.

Though not explicitly stated by other participants, it may also be the case that other participants felt that their clients could discern their class identity.

Theme 4: Is Social Class Relevant to Therapy?

The fourth and final major theme identified in the findings is the question raised in some responses as to whether social class ought to be discussed with clients. Is it clinically indicated, appropriate, and useful to have discussion about social class identity and experience with clients?

Though not asked directly in the survey, a number of participants wrote about their reasons and arguments for holding (or not holding) such discussions.

Not an issue. Only one participant (Participant 3) discussed their belief that struggling with issues related to social class position and experience are not a problem or issue. They write that they would leave the responsibility for initiating a discussion in this area in the hands of their clients: “If a client is struggling with issues of social class, I would not identify that as a problem/issue and wait for the client to initiate whatever discussion he/she wanted to engage in.”

This participant later wrote:

In general, I don't find that individuals identify that social class (other than materially) directly impacts their particular problem, although indirectly it may...I would say that most of the time, other than material resources, the issue of social class does not come up as much.

For this participant, with the apparent exception of how social class impacts access to material resources, social class is not relevant to therapy.

Connections with mental health. A few participants wrote about how social class is connected to mental health. Participant 12 wrote about a direct connection between social class and mental health: “My client identifies as poor and has a strong analysis of how his class identity and experiences inform his mental health, and he has brought this up throughout therapy from our first session.” Meanwhile, Participant 5 also found connections between social class and mental health and wrote about their clinical perspective on addressing it:

Sometimes my client's internal instability can get located in their fears/anxieties about money/class related categories, so as I understand it, our work is to identify and sometimes re-locate the source of their fear and anxiety, whether real or perceived, helping my client to recognize the resources they have and resources they need.

Influence on the therapy relationship. Related to the question as to whether discussions about social class are clinically useful is the question of how such discussions influence the therapy relationship. Participants were directly asked to reflect on the impacts of talking about social class on the therapy relationship between them and their clients. Six participants (6 out of 12, or 50%) discussed positive impacts on the therapy relationship as a result of discussing social class with their clients. In their responses, these participants noted that discussing social class has strengthened, deepened and improved the therapeutic relationship.

One participant (Participant 12) noted these discussions have not only improved their connection, but also opened up new ways of working: “I think our discussions have allowed us to connect more and work relationally with a sense of deeper understanding of his experiences.” Another participant (Participant 9) wrote about their opinion regarding not talking about social class with their clients: “I would say that talking about it grows the therapeutic alliance while leaving it out of the conversation has the opposite result. It is the elephant in the room when it is left out.” Meanwhile, Participant 10 wrote, “I think the discussion around social class has worked to strengthen the therapeutic relationship by diminishing some of the shame associated

with social class.” One assumes that participant 10 is speaking about clients’ whose shame is located around a lower social class identity and not about clients who hold middle or upper social class identities.

Significantly, all remaining participants (6 out of 12, or 50%) did not directly answer the question by discussing how talking about social class has affected the therapy relationship. Instead, several participants wrote about how discussing social class impacts such things as their understanding of the impact of class, their client’s understandings of the impact of class, and their empathy with clients. No participants replied that discussions regarding social class identity negatively impacted the therapy relationship or had no impact or a neutral impact.

Summary

The four major themes that emerged from this qualitative study exploring how clinicians engage in dialogue about social class with clients are the following: *Social Class is Broached with Clients of Lower Social Class; Whose responsibility is it to bring up social class? (And what are the motivations?); Clients’ Identities are Discussed, Clinicians’ are not;* and *Is Social Class Relevant to Therapy?* These themes and the supporting quotes suggest that clinicians make a variety of choices as to how and when to broach the subject of social class (or not) in therapy. These include whether it is only for clients with a lower social class identity that it is relevant or useful to broach social class and who (clients or clinicians) broaches the topic of social class and for what reasons. The findings also reveal whose social class identities are disclosed and whether and how social class identity and experience are relevant to therapy. The implications of these findings are discussed in the next chapter. The following chapter also discusses the context of these findings within the literature as well as the strengths and limitations of the study.

CHAPTER V

Discussion

The purpose of this exploratory, qualitative study was to examine how, when, and why clinicians discuss social class identity and experience in their work with their clients. This chapter first discusses the findings of the study within the context of the available literature. Next, the strengths and limitations of the study will be presented. Finally, the implications of the study for social work education, practice, and policy as well as on future research directions will be discussed.

Key Findings: Comparison with the Previous Literature

The complexities of social class in therapy were explored through the narratives of 12 currently practicing mental health professionals. This section explores the results of this study in comparison to and within the context of the previous literature. It is divided into the following sections: *competence and the use of broaching*; *internalized classism and silence, shame, and guilt*; and *being seen: social class and the therapeutic alliance*.

Competence and the use of broaching. This first section begins by addressing how the findings of this study line up with the current literature on social class competence. Next, I apply the literature in broaching racial identity in therapy as a way to evaluate the current study's findings regarding broaching social class identity.

Social class competence. Liu argues that understanding the intersections of a client's context, including their subjective experience and understanding of social class is of primary

importance in multicultural counseling (Liu et al., 2004b). Liu and colleagues (2004b) argue that clinicians applying their own social class lens as opposed to learning their clients' social class lens will fail to accurately address conscious and latent content. Though most participants in this study wrote that they do initiate discussions about social class, when writing about such discussions the majority of clinicians responded with instances of discussions where their clients were the instigators and main contributors. By not initiating discussions of social class identity and experience, clinicians are largely working from their own social class lens and, as such, may fail to accurately understand and address their clients' lens. Interestingly, this may especially be true when clients hold a higher social class position than their clinician, as most clinicians reported that discussing social class is most salient with clients who are financially struggling, and several clinicians reported that they avoid these discussions with clients of a higher social class position.

Strier's (2009) preliminary model of class-competent social work as a 4-part framework is relevant here. Each of the four parts will be examined as they relate to the findings of this study. The first part encompasses holding class knowledge, including class dynamics, how class intersects with other identities, knowledge of systematic barriers, and an understanding beyond the economic sphere that includes cultural, social and symbolic aspects (Strier, 2009). The second component includes acquiring skills to assist clients in challenging class oppression, such as advocacy and consciousness-raising, as well as skills to develop a more egalitarian worker-client relationship (Strier, 2009). Third, class-competent social work includes a theoretical approach that recognizes the structural nature of social problems and the essential influence of the clients' class situation (Strier, 2009). The last component involves self-awareness of one's

own class biases and assumptions and awareness of biases within the field and theory, as well as directly supporting clients' own class awareness and class interests (Strier, 2009).

Using Strier's model, there are a few instances where we can see our sample performing well and not performing quite as well in terms of class-competence. Many participants speak about holding class knowledge, in particular of the systematic barriers impeding their clients (e.g. the restrictions of being on disability) and most participants were able to write about how their thinking about social class is connected with their thinking about other identities, when prompted. However, many participants wrote solely about the economic sphere and didn't include a critical analysis of the cultural, social, and symbolic aspects of social class. In addition, few participants wrote about challenging class oppression, supporting clients' class interests, or specific tactics utilized to develop more egalitarian relationships with their clients. Several participants did write about supporting their clients' class awareness, whether by asking them explicitly about their class experience and how it's impacted them or by suggesting connections between their class position and current struggles. However, this only occurred when the client was of a lower class than the clinician.

Generally, clients who were of a higher social class position were not asked about or guided in an analysis of how their social class upbringing and current position impacts them. In part, this discrepancy is related to the perceived relevance of the client's social class position to their presenting problems. The conditions of poverty and associated negative experiences (e.g. higher rates of trauma) have a highly visible impact on mental health and current functioning. However, other factors contribute to this finding as participants not only focus these discussions with clients of lower social class position, but also actively avoid these discussions with clients of higher social class position. In part, this finding is related to the social etiquette of not talking

about money (Glasser, 2004), yet (a lack of) money is discussed with clients of lower social class positions. As such, it is likely that this avoidance of talking about social class with clients of higher social class position is more accurately an avoidance of talking about privilege. In participant's responses we see that talking about client's unearned benefits resulting from their social class position is viewed as not therapeutic as well as not possible. Participant 8 writes, "I assume that they do not have any practice at analyzing such issues or they will perceive my analysis as a personal critique." Participants claim to avoid the topic of privilege for the sake of their client's egos and the therapeutic relationship. The client's more pressing concerns and reasons for attending therapy take precedence, yet connections between these and privilege may exist and largely go unexamined. Furthermore, Dougall and Schwartz (2011) found that clients from high social class positions evoke countertransferential reactions within the clinician of feeling dominated. Such a reaction may also predispose clinicians to avoid the topics of social class and privilege.

Evaluating broaching behavior and style. Next, we will examine the specific field of broaching or "the counselor's ability to consider the relationship of racial and cultural factors to the client's presenting problem" (Day-Vines et. al., 2007, p. 401). This author is aware of no prior research regarding broaching social class. There has been some literature on broaching racial and ethnic identity, especially within the context of cross-racial therapy. As such, in order to attempt to best understand the findings of this study in how clinicians broach social class identity, prior research in the field of broaching racial and ethnic identity will be utilized as an analog. Clearly racial identity and social class identity cannot be equated and there are limitations to the interpretation of the findings using this approach. At the same time, racial and

class identity cannot be separated and therefore, using a racial model can be useful in addressing class identity.

Day-Vines and colleagues (2007) describe a continuum of five different broaching styles, from least skillful and most skillful, named avoidant, isolating, continuing/incongruent, integrated/congruent and infusing. Here, I consider how these five styles may be represented in the study.

The avoidant broaching style. The avoidant broaching style, which is considered the least skillful and least conducive to therapeutic alliance and effectiveness, is characterized as one in which the therapist gives little attention to race due to a color-blind stance (Day-Vines et. al., 2007). It is also characterized by a therapist minimizing racial differences and denying White responsibility for understanding White racial identity and White privilege (Day-Vines et. al., 2007). Applying this style to social class, one could say that it is epitomized by giving little attention to social class identity, minimizing the impact of social class identity and social class identity difference, as well as denying responsibility for understanding social class identity, including one's own.

The avoidant broaching style is well represented in this study. For example, avoidance is evident in Participant 3's approach in waiting for their clients to initiate discussions about social class and their belief that "if a client is struggling with issues of social class, I would not identify that as a problem/issue." Generally speaking, this style is represented in participants who gave little attention to their client's or their own social class identity, including not initiating discussions about their clients' social class identity and not disclosing their reactions to such discussions or their own identity. For example, Participant 11 wrote both, "I do not recall a time when I have initiated this topic unprompted" and "I don't think I've overtly disclosed my social

class history” and Participant 3 wrote, “I cannot recall a time when my own social class was discussed. However, I do think that clients may know ‘about me.’”

The isolating broaching style. The next broaching style is the isolating style, which involves addressing race superficially or out of obligation (Day-Vines et. al., 2007). Therapists with an isolating broaching style may hesitate to discuss race out of fear that it will be offensive or a belief that race is a taboo subject (Day-Vines et. al., 2007). Again, applying this to our current study on broaching social class, the isolating style would involve addressing social class only superficially or out of obligation and a hesitation to address social class due to a fear that it will be offensive or a belief that social class is a taboo subject. Again, the findings of this current study support the notion that the isolating broaching style may be a common broaching behavior among some clinicians. For example, a belief that discussing social class would be offensive is evident in Participant 8’s response: “At times I thought of it (social class) but not discussed it is when I perceive my client’s social economic class as being higher than mine and I assume that...they will perceive my analysis as a personal critique.”

The finding that clinicians largely reported that they discuss social class most often with clients struggling financially and that they believe such discussions are most salient for these clients, may suggest that many of the clinicians in this study broach social class with such clients out of obligation. In addition, several participants wrote that they are less prone to initiating discussions of social class with clients who hold a higher social class position, in part because they fear that it would be experienced as offensive. Participant 8 wrote that in such a case their client “will perceive my analysis as a personal critique.” In addition, the finding that in the majority of cases the client initiates conversations about social class indicates that clinicians hesitate to broach the topic.

Although a detailed analysis of the actual conversations are beyond the scope of this investigation, many clinicians' descriptions of instances of discussions about social class with clients are quite short and suggest a lack of depth and actual dialogue. For example, when asked to describe an instance of discussing social class, Participant 6 tersely wrote, "Client brought up his SNAP issue." In fact, in most responses (7 out of 12 or 58%), when writing about a specific incident of discussing social class with a client, participants included information only about how the client engaged in the discussion, leaving one to wonder how (and if) participants contributed to the discussion. Though most clinicians don't directly state that they are impacted by beliefs that discussing social class is taboo or offensive, it seems likely that these beliefs, consciously or otherwise, are present and do impact their behavior.

The continuing or incongruent broaching style. The continuing or incongruent broaching style is characterized holding an understanding of how sociopolitical factors affect clients personally, but having a limited understanding of how to explore race and racism with openness (Day-Vines et. al., 2007). This broaching style is best characterized by Participant 4's responses.

Participant 4 speaks at length regarding their understanding of how sociopolitical factors affect clients as well as their commitment as "a psychotherapist who seeks to empower clients" and "to speak directly, honestly, and compassionately about harsh truths." However, Participant 4 writes of an example where a client did not disclose aspects of their social class experience that were central to their presenting problem for a period of seven months. It is unclear whether Participant 4 ever explored aspects of social class identity and experience before this period and if so, why the client did not disclose this aspect of the problem themselves.

In addition, Participant 4 writes, “in some sense I talk about social class in therapy with ALL of my clients for the simple reason that class and social hierarchy is the organizational matrix that intersects with all aspects of their lives (and mine!), including in the domains of race, gender, sex, age, education, opportunity and ability.” Participant 4 seems to be saying that even if they are not explicitly talking about social class, it is still present and part of the conversation. While this author agrees that social class identity (and other aspects of identity) are ever-present, an assumption that communication about an aspect of identity is occurring with a client simply because that identity is present—and the implicit decision to allow such supposed communication to occur at the implicit and latent level as opposed to bringing the conversation to the explicit and manifest level of communication—suggests a limited understanding of how (or willingness to) explore social class with clients.

Like most other participants, Participant 4 did not disclose their social class identity and wrote, “I think it is safe to assume he views me as a person occupying a more comfortable and secure middle-class position than he does, and he knows that I am operating under a professional license that requires an advanced degree.”

The integrated/congruent and infusing broaching styles. Day-Vines and colleagues (2007) describe the most advanced of their continuum of broaching styles as the integrated/congruent style and the infusing style. Integrated/congruent counselors are described as having a well-established awareness of diverse racial, ethnic, and cultural norms and their impact on clients’ presenting concerns (Day-Vines et al., 2007). Infusing clinicians extend the broaching behavior beyond their professional identity to a greater personal commitment to social justice (Day-Vines et. al., 2007). Three participants in the current study appear to operate from these more advanced broaching styles.

Importantly, all three of these participants wrote that social class first came up early in therapy and continued to come up in their work. In addition, each of these participants holds social class as an essential aspect of who their clients are and how they experience themselves and the world. These participants write about holding responsibility for broaching social class and doing so in a manner that is therapeutic. For example, Participant 5 writes, “I think of social class as a fundamental identity category, important in helping clients make sense of their experience of oppression and/or create awareness of their privilege” and “I know from personal experience and ongoing learning/training that issues of class and classism need to be foregrounded in therapy to make sense of my and my client's experience, and to imagine and forge new possibilities.” And Participant 12 adds, “It's an inherent part of their experience in the world, and always linked to how they see themselves and are seen. I'm often motivated to discuss it with oppressed clients as a way of externalizing shame and holding systems accountable for how they support or fail to support clients, and to try to restore a sense of agency to the client who has lost that to capitalist oppression.”

Participant 2 also wrote about their work outside of therapeutic practice addressing social class bias: “I really noticed that APA and psychology training is geared toward the affluent. I wrote numerous papers regarding how SES impacts the pursuit of graduate degrees in certain subjects.” In addition, as an upwardly mobile individual, Participant 2 writes about their commitment to helping others, namely their clients, succeed: “I am a firm believer in reaching back through the door of opportunity to help others through it, rather than slamming it shut.”

In addition, two of these three participants are among the few who write about how they are still learning how to see and talk about social class. Participant 5 acknowledges, “I am still developing my lenses to see how class affects me, my clients, and my relationship with my

clients. Certainly my own class realities--grew up working class, presently middle class, impact how I move or don't move within these conversations, and I still have work to do!" And Participant 12, when responding to a question about instances when they were aware of social class being salient, but did not initiate a discussion, wrote, "There have been times too of course when I didn't know how to talk about class identity and status in a way that felt meaningful even though I think it would have been important and helped me to understand my client and have them feel more understood." In so doing, these participants communicate the humility, on-going reflection, and life-long learning that anti-oppression work requires (Sensoy & DiAngelo, 2012).

Interestingly, even among this group of more skillful participants the tendency to discuss social class primarily with clients of lower socioeconomic positions persists. Participant 12 writes, "In my work it is hugely disproportionately addressed, almost entirely with clients of lower SES. It seems like it is brought up by a client or I bring it up only if it's a source of stress/absence of resources, it doesn't really come up or get expatiated on if someone has a lot of SES privilege." And Participant 2 even writes about avoiding the topic with clients with social class privilege, explaining "a client who is from a higher family SES may view me as less competent if I disclose my family of origin's SES." This avoidance speaks to Dougall & Schwartz' (2011) findings, discussed above, that clients from high social class positions evoke countertransference reactions within the clinician of feeling dominated.

It is also worthwhile to note that all three of these participants identified their social class upbringing as either working class or poor. Growing up impoverished may have contributed to these participants' abilities to discuss social class with their clients: through a shared experience with their impoverished clients, through knowledge and understanding available only through

direct experience, and through practice in having discussions about social class oppression throughout their lives.

Summary. In writing about therapy with clients of color, Cardemil and Battle discuss their support for an open dialogue with clients about race and ethnicity and also outline the reasons that therapists may choose not to discuss race with their clients, including fears of raising emotionally charged issues, concerns about saying something offensive, not knowing when and how to address race, and waiting for clients to initiate discussions about race (2003). From the analysis above, it is evident that many clinicians in this study chose not to discuss social class with their clients for similar reasons. If clinicians avoid discussing social class for fear that broaching the subject may be offensive or is taboo, or even because it is perceived as not relevant or appropriate, clinicians close down opportunities to explore issues of social class in the therapy. Waiting for the client to address social class has the potential to perpetuate a power differential between the therapist and the client in which the therapist, operating from a position of power and presumptively a middle- or upper-middle class position, has the authority to decide when it is time to talk about social class, if at all. In the next section, we look at how research on shame, guilt, and internalized classism may apply to the findings.

Shame, Guilt, Internalized Classism and Silence

In the findings section, I reviewed how a large number of clinicians felt that their client's concerns during discussions about social class were related to their understandings of themselves and their experience as well as how they were perceived by those around them. Specifically, clinicians believed their clients' held feelings of inadequacy and low self-esteem and self-worth regarding their social class position and were concerned about how (and if) they were seen in society. They held beliefs that they did not fit-in, were seen as unintelligent, were not being seen

or heard by others, were being judged, were powerless, and were being disrespected. Clearly, many clients' were negatively impacted by how their social class position was viewed by themselves and by society.

Liu and colleagues (2004b) write about how one may negatively view one's own social class position in their concept of internalized classism. Internalized classism includes feelings of anxiety, distress, dissonance and frustration that arise when people do not feel adequate within their perceived or desired social class and motivates a person to enact social class-informed attitudes and behaviors in an attempt to regain equilibrium (Liu et. al., 2004b).

We are socialized in a hierarchical society where we are continually presented with negative headlines and stories about the poor and working class, who are otherwise invisible in mainstream American culture. At the same time, the ideology of meritocracy is espoused while structural privilege and oppression are denied and silenced. Despite statistical evidence that access to resources is unequal, class continues to be an unnamed societal force (Isaacs & Schroeder, 2004). The literature within the helping professions rarely acknowledges social class and typically does so only as a variable to control for. Furthermore, Glasser (2004) writes that money is the "last shame" in America and that this shame silences us and stymies collective efforts for equity. In fact, Glasser (2004) writes, "silence (about money) is a matter of social propriety."

This study found that in fact, cultural norms of silence (and shame) about social class and money do largely make their way into the therapist's office. Specifically in this study, the clients rather than the therapists initiated the majority of discussions about social class, the topic was especially avoided with clients of higher social class positions, and few clinicians disclosed their own social class identity. Similarly, DiAngelo (2012) suggests that the position of being White

leads to an inability to think about whiteness as an identity that holds an impact on one's own life, suggesting that White therapists who address race only when clients-of-color broach the subject perpetuate a sense that race is something that only clients-of-color have and/or is only relevant to these clients. Similarly, addressing social class identity only if and when clients from lower class positions broach the subject perpetuates a belief that social class is something that only those from lower social class positions have and/or is only relevant to those clients.

In addressing how social class shame and norms of silence impact therapy, it can be helpful to examine clinician's justifications for not disclosing their social class identity. Especially insightful were the testimonies of those who "half-disclosed" their social class identity or assumed that their clients knew their social class position.

Two participants noted that they did not discuss their social class identity directly, but alluded to their clients that they have had different life experiences and come from a different (seemingly higher) social class upbringing. Meanwhile, two other participants suggest that though they did not disclose their social class identity, their clients naturally intuit their social class position. It is interesting to note that these participants seem to utilize this belief as both a way to state that their social class identity is present in the discussion and perhaps also as a justification for not having to or deciding to actually talk about their own social class experience.

These responses also highlight how many people assume that those around them cannot directly see and recognize their social class identity. This positions social class as separate from other identities, such as race and gender, wherein most people assume that they can see and know the racial and gender identities of those around them (even when they may often be wrong in their assumptions). It is unknown whether this assumption, in the context of Liu's concept of internalized classism and Glasser's argument of class as the last shame, contributes to why most

clinicians in this study chose not to disclose their social class position. The implications of this approach for the therapy and the therapeutic alliance are also unknown. The author is not aware of any literature addressing such “half disclosures” of identity and their impact on therapy and the therapeutic alliance. However, “half disclosures” may be complicit with social norms of shame and silence around the topic of social class, invisibilizing social class and classism, and allowing class oppression.

A study of white clinicians showed that those who were in personal touch with their affects regarding race privilege, as measured by white empathy and white guilt, had higher levels of multicultural competency in their practice (Spanierman et al., 2008). As such, it may be that clinicians, perhaps especially those from middle and higher class backgrounds, who are in greater personal touch with their affects surrounding their social class position may be more social class competent.

Paul Wachtel (2002), a contemporary psychoanalytic scholar, has examined the middle and upper-middle class white culture of psychoanalysis and advocates for adapting psychoanalysis to the impoverished (as opposed to the opposite). He urges us to seek to “... deepen our understanding of the needs and dilemmas of those whom society has treated unjustly and dismissively, and how can those insights be applied, not only in direct therapeutic ways but in efforts at social and political reform” (pg. 200).

Being Seen: Social Class and the Therapeutic Alliance

This final section explores the potential interplay between broaching social class and the therapeutic alliance. As discussed in the findings, most clinicians believed that many of their clients had concerns in their discussions about social class identity regarding their relationship with their clinician. Specifically, among the concerns were whether the client was being seen and

understood by their therapist, whether their therapist could really relate to them and their experience, whether they were being taken seriously, whether they were being judged or blamed, and whether their discussion of classism was being dismissed or invalidated by their therapist. For example, Participant 7 wrote, “My client was concerned I couldn't really relate to her and because of that I couldn't help her. We were working for many months together, she was in a difficult space and was thinking of leaving therapy at that time. After about two sessions it hasn't come up in the same way again.”

Clinicians similarly named relational concerns as a motivating factor in initiating such discussions with their clients; however, this motivator is not evident in their actual responses as clinicians were rarely the initiators of discussions about social class. It seems clear that participants viewed social class identity and, perhaps especially, social class identity difference as impacting the therapeutic alliance, but chose not to directly address this concern. In fact, Participant 7's response illustrates this pattern—even when the client raised the topic, the clinician didn't engage with the discussion or revisit the topic later.

This study found that the majority of instances discussed by clinicians involved discussions about social class that were initiated by clients and did not include the clinician's self-disclosure. According to Burkard et al (2006), in building positive relationships with clients-of-color, White therapists need to be open to discussing racial and cultural concerns, validate clients' experiences of discrimination, and demonstrate a willingness to self-disclose their own experiences and reactions in such discussions. In fact, Burkand et al (2006) found that when race is addressed in cross-racial therapy, self-disclosure by White therapists has the potential to strengthen the therapeutic relationship. It is possible that this same relationship carries over to

social class identity, with increased clinician willingness to self-disclose their own identity as well as their experiences and reactions leading to improved therapeutic alliance.

As is well validated in the literature, the therapeutic alliance is the most important common factor to the success of therapy (Horvath, 2005). At the same time, lower socioeconomic status is one of only two consistent predictors of early client dropout from therapy (ethnicity being the other; Reiss and Brown, 1999). The data here indicate that clinicians largely do not initiate discussions about social class identity, instead waiting for their clients to do so, and largely do not disclose their own social class position. These practices may partially underlie poor therapeutic alliance and high dropout rates with clients from lower social class upbringings.

Strengths and Limitations of this Study

This study has a number of strengths. As an exploratory study of how clinicians have conversations about social class identity and experience with clients, a previously unexamined phenomenon, the data provides information and context for an area of therapeutic practice in need of more examination. The use of open-ended questions in an electronic format allowed for participants to write as much or as little as they wanted in an anonymous fashion. Collecting data electronically allowed for an ease and error-free method of data collection and organization and ensured that the findings of the study remained true to participants' responses. In addition, the sample of participants is diverse in terms of experience (ranging from 0.5 to 35 years) and age (ranging from 26 to 61), capturing a swath of clinicians in various stages of their careers. In addition, the sample is also quite diverse in terms of social class background with four participants identified as being from a working class background, four as being from a

professional middle class or upper middle class background, three as being from a lower middle class background, and one as being from a low income or poor background.

This study also has limitations. The study sample suffers from a small sample size of twelve participants who self-selected for participation. In addition, the sample suffers from a lack of diversity. Namely, all but one participant identified as either Caucasian or white, with the remaining participant identifying as Jewish American. The sample is also largely female, with 10 of 12 participants identifying as female and the remaining two participants identifying as male and genderqueer, respectively. The sample is also largely composed of clinicians who have an education background in social work, with only one participant who has a LMHCA and one who has both a PsyD and a MSW. Though otherwise diverse in terms of social class upbringing, no participants identified as being from an upper class background. In addition, the snowball sampling technique employed in this study may have limited the diversity of experiences and backgrounds of the individuals in the sample. It is possible that a more random sampling technique could have resulted in a more diverse sample of participants.

Another limitation lies in the method of data collection. Conducting the survey electronically limited the ability for the researcher to ask follow-up questions and gather additional contextual information. In addition, collecting data online may have predisposed clinicians to provide less information than during an in-person interview.

My social location as a researcher and social work student also has a bearing on the study biases, including my background, education, racial identity and my values as a social worker in training. I am a young, White, heterosexual, able-bodied, Jewish, gender-normative man from an upper-middle class background. I value talking about social class in my therapeutic work and in my personal life and am involved in an organization called Resource Generation that is dedicated

towards organizing young people in the U.S. with wealth and class privilege in efforts toward the equitable distribution of wealth, power and land. In the data analysis, my opinions, emotions and values could have caused me to look for and report on responses that resonate most with my beliefs or to put greater emphasis on responses that reflect or strongly conflict with my personal values.

Conclusion and Implications

The present study explored how, when, and why clinician discuss social class identity and experience in their work with their clients and found that it is largely clients, not clinicians, who initiate such discussions and that, in most cases, clients disclose their identity and experience and clinicians do not. The findings of this study, especially within the context of the available literature, suggest that helping professions need a great emphasis in their education systems, policy structure, and theory on social class identity and experience and on skills for broaching aspects of identity.

Future research should include larger and more racially and gender diverse samples (among other axis of identity), in person interviews, analyzing the audio recordings of clinical sessions that include discussions about social class, as well as quantitative surveys of students and practitioners on their thoughts and practices regarding social class. It would also be useful to focus on better understanding the practices that help trainees and practitioners improve their class-competence and their ability to broach the subjects of social class and classism. Lastly, it is imperative to further study the experience of talking about social class in therapy from the client's perspective.

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Appendix A

Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

November 4, 2015

Andrew Cohen

Dear Andrew,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Robin DiAngelo, Research Advisor

Appendix B

Survey

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Part 1: Demographics

1) Age:

2) Gender Identity:

3) Race/Ethnicity Identity:

4) Social class upbringing. Please choose the descriptor that most closely matches your family's social class identity. If your family experienced a shift in its class, please choose the social class identity descriptor that best describes your family during your early childhood (0-5 years old):

- Low Income or Poor
- Working Class
- Lower Middle Class
- Professional Middle Class or Upper Middle Class
- Upper Class

5) Credentials (degree and license) as a clinician:

6) Years of experience:

Part 2: Open-Ended Questions

When responding to the prompts below, please keep in mind the following definitions for social class and classism.

Social class is defined as one's subjective, relative standing within a society based upon how much capital they hold. Capital includes material capital, social capital, human capital, and cultural capital. Material capital includes current income and assets and also future expected income and assets (e.g. expected inheritances). Social capital includes who we know and how our social networks provide (or do not provide) us access to jobs, opportunities, wealth, and power. Human capital includes our physical and intellectual resources. And cultural capital includes our education and our aesthetics (e.g. style of speech and dress), including the value placed on these by our society.

Classism is defined as the oppression of subordinated class groups and individuals. Classism includes a broad range of experiences, such as the assignment of certain characteristics based on

social class and the denying of resources to individuals and communities. Classism is perpetuated both by individual classist attitudes and behaviors and by institutions and systems of policies and practices that benefit the upper classes at the expense of the lower classes.

When answering the questions below, please do not reveal any identifying information (such as a name) that may be associated with a client or other individual you have worked with.

1. Please think about your experience conducting individual therapy. Did you discuss social class in therapy with any of your clients?
2. In items a-e, please describe a time when you discussed social class in therapy with a client by responding to the following questions:
 - a. When during the therapy did the subject of social class come up? (e.g. first session, second session, last session, etc.)
 - b. How did the subject of social class come up and who initiated this discussion?
 - c. During this discussion about social class, what do you think your client's concerns were?
 - d. Was your social class identity discussed? If so, please describe how your social class identity was brought into the conversation.
 - e. Was your client's social class identity discussed? If so, please describe how your client's social class identity was brought into the conversation.
3. Considering your experience talking about social class with client(s), please discuss how you think talking about social class has affected the therapy relationship between yourself and your client(s)?
4. Is your thinking about social class connected to your thinking about race, gender, or other aspects of identity? How so?
5. If you initiate discussions of social class with clients, what motivates you to do so?
6. Have there been times when you were aware of social class as salient, but chose not to address it with your clients? Why did you choose not to address social class at these times? Please discuss how not talking about social class affected the therapy relationship between yourself and your client(s) as well as any positive and negative consequences you observed as a result of not discussing social class.
7. What, if any, patterns do you notice regarding the clients for whom social class becomes a salient issue and is addressed in the therapy? For example, is social class addressed more or less often with clients of lower-, middle-, or upper-positions?

8. What was influential in the development of your thinking regarding talking about social class in therapy? Please consider your education, clinical supervision, upbringing, friends, family relationships, learning from clients and other factors that may have influenced you.
9. Do you feel that your social class background has influenced your thinking regarding broaching social class with clients? How so?

Appendix C

Recruitment Materials

Introductory Email

Greetings. My name is Andrew Cohen and I'm a second year Smith School for Social Work Masters student. I'm seeking volunteers to participate in my thesis, entitled "Broaching Class: How Do Clinicians Engage in Dialogue about Social Class with Clients?" I'm looking to learn more about how clinicians engage in and think about their therapeutic work with clients around social class. If you are a licensed practicing therapist and are willing to share your thoughts about your work with clients, please email me at acohen@smith.edu. Please also share this email with individuals who may not see this message, but may be interested in participating and meet the inclusion criteria.

Sincerely,
Andrew Cohen

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D

Human Subject Consent Form



Human Subject Consent Form

2015-2016

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Broaching Class: How Do Clinicians Engage in Dialogue about Social Class with Clients?

Investigator(s): Andrew Cohen, Smith College School for Social Work, xxx-xxx-xxxx

.....

Introduction

You are being asked to be in a research study of how clinicians engage in dialogue about social class in their therapeutic work with clients. You were selected as a possible participant because you are a clinician currently working as a psychotherapist. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

Evidence suggests that both clients' and therapists' social class identity impacts client's experience of therapy. The purpose of this study is to explore when, how, and why clinicians address social class in their work. The data collected from this study will be used to complete my

Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Description of the Study Procedures

If you agree to be in this study, you will be asked to reflect on your experience working with clients on a two-part confidential survey administered on Qualtrics. Initially, you will sign and mail or email the Informed Consent form to the researcher and will then receive an email with a link to the survey. You will have 30 days to consider, answer, and submit your survey responses via Qualtrics. You will first be asked to answer five fill-in and one drop-down prompts regarding your social identity and status as a clinician. Next, you will be asked to answer nine open-ended questions regarding your work in therapy with clients around the topic of social class. Given the variety of each participants' experiences there is no way to determine exactly how long the survey will take to complete; however, it is expected that participants will be able to complete the survey in one hour or less.

Risks/Discomforts of Being in this Study

The study has the following risk: it is possible that participants may experience complex and difficult emotions while reflecting on their clinical work or may feel uncomfortable disclosing or sharing their experiences in regards to social class, social class identity, and classism. If you experience distress as a result of participating in the study, it may be helpful to seek supervision, consultation or therapy.

Benefits of Being in the Study

The benefits of participation are that clinicians will have the opportunity to reflect on and write about their clinical experience. Participants may find that this experience facilitates greater insight into their clinical work. The benefits to social work/society of participation include adding to the very limited research currently available regarding how clinicians address social class in the clinical encounter.

Confidentiality

Your participation will be kept confidential. The following steps will be taken to protect confidentiality:

- The survey will not require you to reveal identifying information such as your name.
- You will be cautioned before taking the survey not to reveal any identifying information that may be associated with a client as a means to protect third party identifiers.
- Any identifying information related to the participant in this study will be removed from the survey.
- Confidentiality will be further maintained through the use of codes to identify participants.
- Individuals involved in reviewing surveys or other information associated with the study will sign and adhere to a confidentiality agreement prior to conducting work related to the study. This agreement will be written as a contract.
- Research advisors will have access to data from the study only after it is clear that all identifying information has been removed and excluded from this data.

- In publishing or presenting the data publically, identifying information will be removed. In the case of quotations that may reveal identifying information, they will be paraphrased and changed to preserve confidentiality.
- The records of this study will be kept strictly confidential.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1, 2016. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Andrew Cohen at acohen@smith.edu or by telephone at 781-864-1533. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____