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Classism in the therapeutic alliance : implications for clinical social work practice

Taylor Millard
Smith College

Taylor B. Millard
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ABSTRACT

This qualitative study was an exploration of the impact of classism in the therapeutic alliance, specifically from a power, privilege, and oppression framework, and with attention to participants' salient intersecting identities. Twelve clinicians, who identified with working class backgrounds and who had engaged in therapy as both clinicians and clients, engaged in semistructured qualitative interviews. The findings indicated that classism was salient to participants' intersectional subjectivities and to their experiences in the field. Significantly, participants all named experiences in which a systemic lack of attention to classism and/or social class identities led them to feel alienated and silenced as students, professionals, and clients. Participants linked their own classist experiences with stronger motivations to remain class-conscious as therapists and to address class differences openly in order to strengthen their therapeutic alliances. Implications for future research, social work education, and clinical social work practice are discussed.

CLASSISM IN THE THERAPEUTIC ALLIANCE:

IMPLICATIONS FOR CLINICAL SOCIAL WORK PRACTICE

A project based upon an independent investigation,
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Taylor B. Millard

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

Introduction

The study of classism in clinical social work practice is a relevant and much-needed area of research in the mental health field; to date, researchers cite that classism has been a neglected aspect of psychology research and clinical training, in spite of its importance in clinical social work and counseling practice (Appio, 2013; Cook, 2014; Liu, Pickett, & Ivey, 2007; Liu, Ali, Soleck, Hopps, Dunston, & Pickett, 2004a; Lott, 2002; Ryan, 2006; Smith, 2005). Significantly, Lott (2002) points out that because social class permeates across all other aspects of identity, it is inevitable that clinicians will work with clients who identify as working class or poor; yet, despite the inevitability of the work, a lack of attention has been given to insuring that clinicians are able to attend to class differences in practice. Thus, the following qualitative study aimed to address the current literature gap by exploring the following question: *How do perceptions of classism impact experiences of the therapeutic alliance for clinicians who both self-identify with a working class background and who have engaged in psychotherapy as a clinician and client?*

Not only have classism and social class identity development been largely ignored in the literature and in clinical training, working class and poor clients' voices have been missing from the literature to date (Appio, 2013; Cook, 2014; Smith, 2005; Lott, 2004). In other words, even when class is explored in psychological research, middle class and upper class individuals are centered in research and educational narratives. Thus, the absence of classism and the absence of working class and lower income clients' voices in the current research, educational, and clinical

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narratives are, in themselves, expressions of a "blind spot" (Liu et al., 2007, p. 194) in the clinical field's current conceptualization of multicultural competence.

Overall, the proposed study was necessary not only because the topic of classism has been underrepresented and largely silenced in the social work field of research and education, but also because, in spite of the lack of attention given to classism, social class is a core aspect of clients' identities. It has the potential to significantly impact experiences of therapy (Thompson, Cole, & Nitzarim, 2012), including therapeutic outcomes (Liu et al., 2007) and retention rates (Ryan, 2006) for working class and poor clients.

Theoretical Framework

Based on my exploration of the relevant literature to date, my research utilized a power, oppression, and privilege framework (specifically, theories of systemic oppression and institutionalized oppression). The concepts of social class stratification, psychodynamic conceptualizations of the therapeutic alliance, and intersectionality theory were foundations for the study. To clarify, I utilized Smith's (2005), Lott's (2002), and Liu et al.'s (2007) theoretical conceptualization of classism as a form of systemic oppression to provide a foundation for my exploration of classism in clinical social work practice. Within my theoretical conceptualization, the systemic concepts of "power" and oppression" were the focal points used to explain how those with class privilege (including class privilege via cultural capital, economic capital, and social capital) benefit at the expense of those without class privilege and are complicit in maintaining the classist power structures within which those with class privilege benefit.

Augmenting my systemic oppression framework, I incorporated aspects of intersectionality theory in order to maintain awareness of the "mutually reinforcing vectors of race, gender, class, and sexuality" (Nash, 2008, p. 3) in clients' subjectivities and sociocultural

positions. Finally, I incorporated aspects of psychodynamic theoretical to ground my understanding of the therapeutic alliance in clinical social work practice. A more in-depth discussion of my theoretical framework follows in Chapter II of this thesis.

Empirical Literature

To date, the relevant empirical literature indicates that psychotherapists lack an adequate understanding of class dynamics in clinical practice (Appio, 2013; Cook, 2015; Liu et al., 2007; Smith, 2005; Thompson et al., 2012). Relatedly, the literature summarizes that working class clients often report negative therapeutic experiences resulting specifically from class differences (Appio, 2013; Thompson et al., 2012; Smith, 2005). Significantly, Appio (2013), Liu et al. (2007), and Smith (2005) point out that although most clinicians studied have identified with privileged class backgrounds, clinicians from working class backgrounds have been best equipped to work with class differences in the therapeutic dyad.

While there are several possibilities to explain working class clients' negative and often classist experiences in therapy, Liu et al. (2007) argue that class is "America's blind spot" (p. 194) in multicultural competence literature and in clinical practice. Specifically, Liu et al. point to a lack of class-consciousness—including a lack of awareness around counselors' own White middle-class worldviews—as a primary cause of clients' classist experiences in psychotherapy. Outlining the ways in which counselors alienate working class and poor clients, Liu et al. describe themes of devaluation and/or idealization amongst counselors who work with clients from lower social classes.

Ultimately, Liu et al. conclude that clinicians who identify with lower or working class backgrounds tend to feel more comfortable working with class differences in clinical encounters; consequently, clinicians from lower or working class backgrounds are also less likely to alienate

their clients as a result of implicit class biases. Indeed, a number of other researchers have echoed that middle-class privilege creates oppressive and discriminatory clinical environments when it is not acknowledged and suitably addressed in the therapeutic relationship (Appio, 2013; Cook, 2015; Liu et al., 2007; Smith, 2005; Thompson et al., 2012). Thus, it is imperative for all mental health clinicians to increase their awareness of how implicit classism manifests in the therapeutic alliance. A more in-depth empirical literature review follows in Chapter II of this thesis.

Methodology Overview

To reiterate, the current qualitative study was an exploration of the research question: *How do perceptions of classism in community-based mental healthcare impact* in *experiences of the therapeutic alliance for clinicians who self-identify as coming from a working class background and who have engaged in psychotherapy as both a clinician and a client?* I conducted the study by interviewing a sample of 12 Master's level clinicians who had previously engaged in therapy as a client; who had previously engaged in therapy as the clinician; and who self-identified as coming from a working class background, as indicated by a lower than average household income and by a lack of educational capital in the participants' families of origin. The study participants were recruited via snowball sampling by networking with three colleagues in the clinical mental health field. I developed my own interview guide, based on relevant theoretical and empirical literature, to collect the data. Once the interviews were completed and transcribed, I coded and analyzed the data for relevant themes to answer the overarching research question.

Personal Interest in Topic and Relevance to Social Work

The desired outcome of my research was to shed light on clinical social workers' understandings of social class as a crucial aspect of sociocultural identity that, when neglected, can hinder clients' experiences in therapy. To that end, the study aimed to expand the authenticity validity of the current literature by centering the voices of clinicians who have both been in psychotherapy as a client and who identity with a working class background as the foundation of my research narrative. As a female MSW candidate who came from a working class background, who identifies as being mixed race, and who nevertheless benefits from immense White privilege herself, I recognized the inherent biases in my research interests. At the same time, I maintained that my study was critical to furthering clinicians' cultural sensitivity in the clinical social work field.

Conclusion

Considering the need for greater class-consciousness in clinical social work research, education, and practice (Liu et al., 2007), the implications for this study could not be understated. Significantly, this study actively sought to center working class individuals' subjective perceptions of social class at the center of the research narrative, rather than relying exclusively on the interpretations of clinicians who hold class privilege themselves. While there is still additional research needed to further class-consciousness in the mental health professions, this study both expanded the current body of relevant literature and provided a more authentic conceptualization of the impacts of classism as it operates within the therapeutic alliance.

CHAPTER II

Literature Review

This literature review focuses primarily on research that illuminates components of social class stratification, classism, the therapeutic working alliance, and classism in psychotherapy. This chapter is divided into six sections. Section one provides the theoretical framework on which this research is based. Section two clarifies working definitions of "social class" and "classism," as relevant to this study. Section three sheds light on the relevant impacts of individual and institutional classism as related to the potential for perpetrations of classist microaggressions in psychotherapeutic milieus. Section four provides a working definition and clinically significant components of the therapeutic working alliance, including connections to general therapeutic outcomes. Section five addresses the ways that classism manifests in the therapeutic dyad and how issues of social class affect the therapeutic working alliance. The final section provides a summary of the literature reviewed, including relevant biases/limitations and implications for this study.

Theoretical Framework

When powerful people have the ability to enforce rules, policies, and ideologies that benefit themselves at the expense of less powerful others, the potential for oppression exists (Appio, 2013; Hanna, Talley, & Guindon, 2000). With this point in mind, the theoretical framework for the current study is grounded in social class theories that reflect the ways that higher social classes enforce policies and ideologies that benefit themselves at the expense of those in lower social classes. Overall, this study utilized an oppression and privilege framework,

concepts of social class stratification, social class analysis (including classism), and intersectionality theory as foundations for study.

Broadly, Hanna et al. (2000) describe that systems of oppression are enacted, enforced, and maintained overtly and covertly, directly and indirectly. Overtly, oppression can be enacted through force, either by those in power imposing limitations on marginalized groups or by depriving those groups of necessities, desired outcomes, or power and control. Covertly, oppression is maintained when privileged groups or individuals indirectly benefit from the oppression of less powerful people, even if they do not blatantly oppress the marginalized group; in this sense, covert oppression is maintained by the complicity of those in privileged sociocultural locations.

Within a context of power and privilege, classism is defined as the "oppression of the poor and working class through a network of everyday practices, attitudes, assumptions, behaviors, and institutional rules" (Lott & Bullock, 2007, p. 30). Thus, the term "classism" is used to reference the "operating form of oppression with regards to social class" (Appio, 2010, p. 23). Similarly, just as Sorenson (1994) maintains the importance for sociologists to ground social class research in variables of "class, status, and power" (p. 229) in their analyses, so does this study ground an understanding of social class stratification in variables of status and power.

From a perspective of social class stratification, this study drew from sociological and psychological literature to ground a theoretical framework in classism and social class theories. Based on the psychological literature reviewed, this study utilized Smith's (2005), Lott's (2002), and Liu et al.'s (2007) theoretical conceptualizations of classism as a form of systemic oppression to provide a foundation for an exploration of classism in clinical social work practice with clinicians who identify with working class backgrounds. Consistently, prominent social

class theorists maintain that classism is an oppressive power structure that allows those at the top of the social class hierarchy to maintain their wealth, power, and privilege by individually and institutionally marginalizing those on the lower ends of the social class hierarchy, through an inequitable distribution of social and economic capital (Beeghly, 2008; Lott, 2002; Smith, 2010; Zweig, 2000). Therefore, in the context of this study, classism is the conceptual focal point to explain how those with class privilege (including clinicians) benefit at the expense of the working class and the poor.

Augmenting my systemic oppression framework, this research incorporated aspects of intersectionality theory in order to maintain awareness of the "mutually reinforcing vectors of race, gender, class, and sexuality" (Nash, 2008, p. 2) in clients' subjectivities and sociocultural position. Moreover, since researchers like Bettie (1995) have noted media's tendencies to focus on portrayals of working-class characters as being women and people of color, the impacts of such intersectional depictions of the working class cannot be dismissed as a possible point of salience for working-class individuals.

Furthermore, this study drew from research on implicit bias as a significant component to providing a theoretical framework for the unconscious dynamics of classism that unfold in the psychotherapeutic dyad. Chiefly, Liu, Pickett, and Ivey (2007) argue that class is "America's blind spot" (p. 194) in multicultural competence literature and in clinical practice. Specifically, Liu et al. (2007) identify implicit bias as a significant factor contributing to the current lack of class-consciousness among mental health professions. Therefore, various researchers argue that it is important for all clinicians to understand how middle-class privilege and implicit class biases can create oppressive and discriminatory environments if not acknowledged and suitably addressed (Appio, 2013; Liu et al., 2007; Lott, 2002; Smith, 2010).

To that end, Strier (2009) provides a theoretical framework for defining "class-competence in social work practice" (p. 237). Chiefly, Strier (2009) provides an explication of the "post-structural approach to class" (p. 238) as a theoretical foundation for class-competence; in this conceptualization, class capital manifests not just economically, but culturally and socially. When considering that economic capital, cultural capital, and social capital all impact social class identity, it is easier to form an understanding of classism, which Strier (2009) defines as, "oppression based on class differences… resulting in a condition of privilege for one group at the expense of the disenfranchisement of another" (p. 240). From this view, Strier (2009) argues that the social work profession has overlooked the relevance of social class in social work practice and that class-competence needs to be increased in the field. Strier (2009) defines "class-competent social work" as "the knowledge, skills, theoretical approach, and critical awareness required to effectively help clients oppressed by class structure" (p. 240).

Definitions of "Social class" and "Classism"

As mentioned previously, the mental health professions have largely neglected issues of social class and classism when conducting research on sociocultural identity factors and cultural sensitivity in a clinical context (Liu et al., 2007; Smith, 2008). Perhaps a consequence of the field's neglect of classism in multicultural research and practice, there is a significant amount of inconsistency around the working definitions of "social class" and "classism" in the literature to date. Chiefly, Liu et al. (2004) performed a systematic review of 710 articles that have used the concept of "social class" in counseling journals between the years 1981 and 2000. Results of the review showed that "social class" was used more theoretically than empirically, that there was immense inconsistency in researchers' understandings and measures of "social class," and that 448 different words were used to describe the construct of social class. Given the findings, Liu

et al. (2004) argue that although social class is an "important cultural construct" (p. 3), it is poorly utilized in research. Thus, the researchers recommend that future researchers integrate more subjective measures of social class—such as self-identification, rather than a reliance on measures such as income—and to focus on classism as a salient form of oppression in people's lives.

Similarly, Smith (2010) defines social class as "a spectrum of positions that is associated with differences in access to power and different assignments of social privilege" (p. 6). That is, unlike socioeconomic status (SES), researchers emphasize that social class must be understood to represent "social groups arising from interdependent economic relationships that are defined by the social and economic power they have in relation to each other" (Krieger, Williams, & Moss, 1997, p. 344). Within this definition, the contextualization of societal inequality and an oppression/privilege framework is crucial to unpacking the nuances of social class issues in a clinical context.

To further break down social class stratification, Gilbert (2008) identifies three significant factors when considering and understanding social class identify in the context of power and privilege: a) economic factors, including income, occupation, wealth, and poverty; b) social factors, including social mobility, prestige, associations, and socialization; and c) political factors, including degree of agency/control, access to political power, and class consciousness (p. 30). According to Gilbert, it is important to view all three factors – including the relationships among them – in order to accurately understand one's social class location.

Characteristics of the "Working Class" Identity

Given the dynamics of the oppression/privilege framework and social stratification theories outlined above, social class theorists conceptualize four basic locations in the United

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States' social class hierarchy: the owning class, the middle class, the working class, and the poor (Kimmel & Aronson, 2009; Zweig, 2000). Social class theorists and scholars further agree that those in the owning class and middle-class are considered privileged due to their access to power, control, and ascribed social status (Appio, 2013). Still, disparities continue among researchers regarding the specific parameters and definitions of each social class location in various contexts. For example, various sources in the literature commented on the limiting tendencies of researchers to use only SES measures of social class (such as gross income, or median household income) to assess social class location for study participants (Liu et al., 2007; Smith, 2005; Smith, 2010; Smith 2013). Unfortunately, the tendency to rely on SES measures alone minimizes the complexity of social class stratification as a more nuanced identity stemming from a complex system of power, privilege, and oppression (Smith, 2010).

To illustrate, the median household income in the United States was estimated at $53,653 in 2015 (De-Navas-Wait & Proctor, 2015), yet researchers like Appio (2013) point out that even measures like median income can encompass factions of both middle class and working class individuals. For example, middle school teachers, boilermakers, nutritionists, and pile driver operators earn similar incomes, yet some of those jobs are considered middle class professions based on the social status and educational capital associated with them (Appio, 2013). Thus, SES measures, while considerably relevant to social class identity, do not fully capture the relationships between other variables of status and power in social class analyses (Sorenson, 1994).

Indeed, economic capital and other measures need to be taken into account to give a portrait of the working class. For example, Beeghley (2008) elaborates that working class people

tend not only to have lower incomes than the middle class, but they tend to occupy professions of lower social/cultural status that are usually (though not always) compensated by hourly wages rather than a salary; working class jobs most commonly consist of manual labor, factory work, and service jobs that often have lower wages and fewer benefits than middle class occupations. To that end, Smith (2010) elaborates that those in the working class tend to lack educational capital (i.e., they have lower educational levels) than more privileged classes.

Just as importantly, working class people tend to have less access to professional benefits and have less power and control over their work (Zweig, 2000). Those in the working class are also less able to access institutional systems (such as educational opportunities) that would contribute to increased power and upward social mobility (Smith, 2010). Likewise, because political systems are designed for those in the middle and upper classes, working class people lack access to legislative decision-making process that impact their access to educational, health, social, cultural, and legal resources.

Finally, Zweig (2000) points out that poor people are most often working class people who, because of their location in a more vulnerable social class with a fragile sense of financial security, do not have enough financial resources to provide for their household's basic needs. Most often, such downward social mobility occurs as the result of life crises, low wages, unemployment, or underemployment (Appio, 2013). Critically, Zweig's (2000) findings reflect that the working class is defined by much greater financial instability and a much higher likelihood for downward social mobility than is experienced by those in more privileged classes.

Impact of Classism on Working Class Individuals

Consistent with other forms of systemic oppression, Lott and Bullock (2007) reflect that classism occurs at both an individual level and at an institutional level in the United States. To clarify, individual classism encompasses individual negative beliefs, stereotypes, and prejudices held about poor and working class people; institutional classism reflects the policies and procedures enacted by social institutions (i.e., the education system, legal system, political system) that disproportionately impact, marginalize, and harm poor and working class people. Given that this study focused on the therapeutic working alliance in a psychotherapeutic dyad societal impacts of individual classism are particularly relevant for helping professionals who wish to engage in more class-conscious clinical practice, as depicted in this study.

Impact of individual classism. For several decades, researchers have verified that poor and working class individuals are viewed with negative implicit bias and are judged more harshly than those in more privileged social class locations. Not only are poor and working class people viewed more negatively than middle class people, but particular groups of poor people (i.e., welfare recipients) are judged more negatively than other marginalized groups in society (Fiske, Xu, Cuddy, & Glick, 1999). After reviewing the literature, individual classism consists of negative attitudes towards those who lack class privilege, internal attributions for poverty, and classist microagressions.

Attitudes towards working class and poor individuals. Empirical evidence of the impacts of individual classism date back to at least the 1980s. For example, Landrine (1985) explored attitudes towards working class women from a sample of 44 undergraduate students Landrine's study found that participants tended to judge middle class women positively and working class women more negatively. More recently, Cozzarelli, Tagler, and Wilkinson (2001)

mirrored Landrine's study by comparing attitudes towards poor, working class, and middle class people in a sample of 209 middle class, mostly White undergraduate students. The researchers found that, when given both positive and negative characteristics in various vignettes of individuals from agent and target social class statuses, participants attributed only positive characteristics to individuals in the middle class vignettes, yet almost uniformly deemed working class and poor individuals as "uneducated, unmotivated, lazy, and criminal" (p. 225). Thus, Cozzarelli et al. concluded that using relatively privileged samples (i.e., White, middle class undergraduate students) illuminated both the explicit negative attitudes and implicit class biases that college students harbor against the poor and working class.

Taking Cozzarellini et al.'s (2001) conclusions further, Lott and Saxon (2002) recruited 1,063 participants from a sample of college students and teachers affiliated with the Parent-Teacher Organizations (PTO). Lott and Saxon surveyed the participants about their first impressions of a woman running for PTO Vice President, based on a vignette and a picture. Lott and Saxon manipulated the woman's ethnicity and social class location in the vignettes in order to compare participants' reactions to candidates who were equally qualified yet presented with different sociocultural identities. When comparing responses to ethnicity, the Latina woman in the vignette was deemed less suitable for the Vice President position than were her White Anglo-Saxon or Jewish American counterparts. Likewise, when comparing responses to the women based on social class identity, all of the working-class women in the vignettes were deemed less suitable, competent, and intelligence than their middle-class counterparts, regardless of ethnicity.

As a follow-up to the first series of studies, Lott and Saxon (2002) then surveyed 432 undergraduate students. The students were again given a vignette and were asked to imagine

what it would be like for either a middle class or working class woman to be introduced as their brother or cousin's girlfriend. Verifying their previous findings, participants responded much more negatively to the working-class woman in the vignette, deeming her "cruder" and more "irresponsible" (p. 485) than the middle-class woman. Based on their findings, Lott and Saxon conclude that social class biases lead to both "institutional and interpersonal exclusion" (p. 495) in which working-class individuals are viewed as more undesirable in both leadership and decision-making roles (as in the first series of studies) and in interpersonal relationships (as reflected in the second series of studies).

Attributions for poverty. The implicit biases that elucidate views of the working class and poor as undesirable are connected to attributions for poverty. Notably, Cozzarellini, Tagler, and Wilkinson (2002) conducted a study from a sample of 206 undergraduate students; among the sample, 92% reported that they did not experience poverty growing up and identified as middle class. When assessing participants' attitudes towards the poor, Cozzarellini et al. (2002) discovered that participants who held more negative attitudes towards the poor were also more likely to make internal attributions for poverty (i.e., the poor person's own level of virtue, motivation, or other personality trait); likewise, participants who reported more positive feelings towards the poor were far more likely to make external attributions for poverty (i.e., holding institutional, social, and economic systems responsible).

Overall, one relevant impact of individual classism is that implicit class biases contribute to one's understanding of the attributions of poverty and, reciprocally, one's attributions for poverty fuel either negative or positive attitudes towards poor or working-class individuals (Cozzarellini et al., 2002). Furthermore, middle-class participants across all studies reviewed were more likely to make internal attributions for poverty than were their less class privileged

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peers (Bullock, 1999; Cozzarellini et al., 2001; Cozzarellini et al., 2002; Lott & Saxon, 2002).

Although such results are unsurprising given that those who hold titles of privilege tend to be

least aware of those privileges (Sue & Sue, 2013), the findings are significant in verifying the

importance of middle-class individuals – including mental health professionals—taking the time

to engage in more self-reflection of their own beliefs about social class, attributions to poverty,

and their implicit biases towards working class or poor individuals (including clients). Thus,

researchers stress the importance of engaging in future studies that will better clarify the

variables that can predict external attributions of poverty, particularly among middle-class

participants (Cozzarellini et al., 2002).

Given the relationship attitudes towards the poor and attributions to poverty and given the

knowledge that middle-class individuals may be more likely to both endorse internal attributions

of poverty and to hold negative attitudes towards their less privileged peers, the importance of

engaging in more self-examination and more class-conscious education in the helping

professions cannot be understated. For example, Toporek and Pope-Davis (2005) found that,

when studying attributions for poverty endorsed by 158 masters-level students in the counseling

psychology field, even budding mental health professionals were not immune to endorsing

internal attributions for poverty.

Classist microaggressions. One of the most common and relevant manifestations of

individual classism occurs in the form of classist microaggressions. Microaggressions are

understood as the subtle, everyday expressions of implicit bias and/or denigrating messages

communicated to marginalized groups of people (Sue, Bucceri, Lin, Nadal, & Torino, 2007; Sue

& Sue, 2013). According to Sue, Capodilupo, and Holder (2008), microaggressions can manifest

as verbal comments, nonverbal behaviors in interpersonal exchanges, and/or environmental cues

in a physical setting that communicate negative messages to or about marginalized groups. Although the microaggression literature to date has focused primarily on racial microaggressions, researchers have increasingly recognized the prominence of classist microaggressions and have called on other scholars and professionals to study the impacts of classist microaggressions on their work with poor and working-class individuals (Smith, 2013; Smith & Redington, 2010).

To date, a number of researchers have documented the impacts of classist microaggressions that are experienced by working class or poor clients attempting to access public assistance and by undergraduate college students from working class or poor backgrounds. For example, qualitative studies by Collins (2005) found that poor people who sought public assistance experienced significant stress when engaging with social service agencies due to their chronic experiences of being treated disrespectfully by social service staff who seemed to hold negative beliefs about their clients. Consistent with other definitions of microaggressions (Sue et al., 2007; Sue et al., 2008; Sue & Sue, 2013), the participants in Collins' (2005) study often described their experiences as subtle, confusing, stressful, and otherwise difficult to define; on woman seeking assistance described the constant feeling of being evaluated as if under a "giant microscope" (p. 18), while other women spoke of verbal classist microaggressions in which staff communicated that they were not fit to be parents.

Nicolas and JeanBaptist (2001) came to similar findings when they engaged in a series of studies interviewing women who were receiving public assistance and found that classist microaggressions were pervasive in the lives of the interviewees. Specifically, many of the women reported condescending, "humiliating," and "degrading" (p. 305) interactions with social services staff and disclosed many instances of being "talked down to" by caseworkers and other

professionals. Significantly, these studies highlight that helping professionals are not exempt from harming clients through classist microaggressions; in fact, helping professionals are located in positions of relative power in the social class hierarchy and are, as these studies suggest, likely to perpetrate classist microaggressions in clients' lives. While the findings reflect clients of social services specifically and do not capture experiences in psychotherapy, one can hypothesize that other mental health professionals would not be exempt from enacting similar classist dynamics with poor and working-class clients.

In fact, despite the immense education required of masters-level clinicians, the institutional and individual classism that characterizes higher educational institutions—and particularly those characterized as elite or prestigious—may actually serve to fuel the potential for classist microaggressions to be perpetuated by graduates in the professional world. To clarify, researchers have increasingly concluded that colleges and universities are forefronts for experiences of verbal, nonverbal, and environmental microaggressions towards students from poor or working-class backgrounds **(**Ostrove, 2003; Stewart & Ostrove, 1993; Wentworth & Peterson, 2001). For example, in Stewart and Ostrove's (1993) qualitative study, college students who identified with a working-class or poor background described an education environment of academic and social intimidation and pervasive feelings of alienation while attending an elite women's college. Wentworth and Peterson (2001) validated Stewart and Ostrove's (1993) findings; among a sample of college women who identified with working class or poor backgrounds, participants emphasized pervasive feelings of not belonging and being presumed less competent or intelligent than their peers while attending their educational institutions (Wentworth & Peterson, 2001).

Furthermore, in Wentworth and Peterson's (2001) study, women described decreasing self-confidence as a result of the social and academic alienation they experienced at elite colleges where the participants disclosed their perceptions of being insulated in their middle and upper-class peers' intellectual self-confidence, class privileged backgrounds, and communication of "entitlement" (p. 17); some women were able to identify that their peers were the type of people who were "expected" to be in an elite institution, while students from working class and poorer backgrounds were not (p. 17). Again consistent with Sue et al.'s (2007) description of microaggressions as subtle and often ambiguous, participants in all three studies often found it difficult to define the specific sources of their pervasive sense of exclusion, marginalization, and alienation.

The findings of classist microaggressions experienced by working class and poor students navigating higher education highlight the ways that classism has remained unexamined even in liberal colleges that advertise diversity and acceptance to their students. For example, it is worth noting that many of the women in both studies reviewed attended prestigious, seven sisters colleges that are known, on the surface, for being inclusive and liberal. That is, these findings by class-conscious scholars conclude that across the board, colleges and universities are not inclusive of working class and poor students (Stewart & Ostrove, 1993; Wentworth & Peterson, 2001).

In other words, even attending a liberal or elite psychotherapy program may not exempt helping professionals from both perpetrating and maintaining classist ideologies, particularly when programs themselves have largely left classism out of their curriculum and have alienated working class and poor students (Liu et al., 2007; Smith, 2005; 2010). Moreover, when considering the pervasive classism embedded in elite institutions, one can surmise that clinicians

who have been insulated by such elite and classist systems may be particularly blind to the ways classism operates in environments both inside and outside of psychotherapeutic milieus.

Given that middle class and upper class individuals are more likely to hold negative attitudes towards working class and poor people (Lott & Saxon, 2002; Cozzarellini et al., 2001; Cozzarelini et al., 2002), that those who hold titles of privilege are less likely to notice or acknowledge those privileges (Sue & Sue, 2013), and that a majority of masters-level clinicians come from backgrounds of class privilege (Lott, 2002), these findings on classism in education have critical implications for clinical and professional practice. Namely, understanding the ways that classism insidiously impacts higher education and, as a consequence, the sociocultural diversity of masters-level clinicians, may be a first step in understanding the pervasive presence of classism in psychotherapy. Finally, it is crucial to note that the daily experiences of exclusion and marginalization experienced by working class and poor people echo the microaggressions experienced by people of color (Watkins, LaBarrie, & Appio, 2010), particularly as working-class and poor people are made to feel that they do not belong in certain spaces (Appio, 2013). In fact, Smith and Redington (2010) argue that subtle classism can be just as psychologically damaging as racial and gender microaggressions, which have been shown to severely impact psychological well-being (Sue & Sue, 2013).

The Therapeutic Working Alliance

Given the pervasive impacts of implicit bias and microaggressions on those located within marginalized identities, it is perhaps unsurprising to note that clinicians are not immune to enacting their own implicit assumptions and microaggressive behaviors in clinical contexts (Liu & Pope-Davis, 2005; Safran & Muran, 2000; Sue & Sue, 2013). In fact, many researchers, such as Safran and Muran (2000), describe the therapeutic relationship as a microcosm of larger

relational dynamics and societal contexts. For example, Ivey et al. (2002) explicitly argues that clinicians' awareness of their own implicit biases is critical to establishing a strong therapeutic alliance with marginalized clients because "counselors' prejudicial attitudes will certainly manifest as some reaction to the client" (p. 154). Essentially, Safran and Muran (2000) argue that it is inevitable not only for those larger dynamics and contexts to arise in psychotherapy, but for the enactment of clinicians' implicit biases to put the therapeutic working alliance at risk. Therefore, it is crucial for clinicians to assess the contexts and value assumptions that may inhibit the ability to both build and sustain an effectively therapeutic working alliance with clients who experience marginalization and oppression (including classism).

Definitions and characteristics of the therapeutic working alliance. Of course, it is relevant to clarify the working parameters of the therapeutic working alliance before further explicating the threats that may arise from a lack of cultural sensitivity and, in this study, from a lack of class-consciousness. Defined psychodynamically, the working alliance has been conceptualized by Safran and Muran (2002) as the reasonable alignment or "joining" (p. 12) of the client's and clinician's egos for the purpose of the psychoanalytic work. However, in more simple terms, Liu and Pope-Davis (2005) define the therapeutic working alliance as the "counselor's capacity with the client to negotiate collaborative goals and tasks in the therapy relationship for the expressed purpose of achieving a post-therapy state that is better than the pre-therapy state" (p. 154).

For the sake of clarity and accessibility, Liu and Pope-Davis' (2005) definition of the therapeutic working alliance is used most readily in this study, particularly as it has been identified as consistent across various psychotherapeutic modalities. Additionally, Sue and Sue (2013) contribute to the working conceptualization by taking Liu and Pope-Davis' (2005)

definition further. Namely, Sue and Sue (2013) identify three elements of a therapeutic working alliance: a) an emotional or interpersonal bond between clinician and client; b) mutual agreement on therapeutic tasks and goals; and c) intervention strategies or tasks that are viewed as relevant and important by both the clinician and the client. Within this conceptualization, parameters of collaboration, connection, and the negotiation of tasks/goals are re-emphasized.

Finally, in more concrete terms, Sue and Sue (2013) describe a number of characteristics that have been found to empirically support the development of a strong therapeutic working alliance. Specifically, researchers have indicated that a strong working alliance is characterized by the core conditions for effective treatment, including empathy, respect, genuineness, and warmth (Rogers, 1957; Sue & Sue, 2013). Clients additionally report the importance of feeling close and connected with their clinicians and cite relational connectedness as a universal prerequisite for an effective therapeutic alliance (Safran & Muran, 2000). Relevantly, Sue and Sue (2013) are quick to point out that core conditions for an effective therapeutic alliance go beyond a clinician's therapeutic orientation or modality; rather, the core conditions for effective treatment and a strong therapeutic alliance help create an environment within which clients "feel understood, safe, and encouraged" (p. 245) to disclose and engage in the therapeutic process. Ultimately, the more helpful therapists appear, the more therapists seem able to facilitate the development of a strong therapeutic alliance (Safran & Muran, 2000).

Importance of the therapeutic alliance on treatment outcomes. In addition to serving as a prerequisite for clients to engage fully in the therapeutic process, research on empirically supported relationship variables (ESRs) in psychotherapy consistently identify the importance of a strong therapeutic working alliance on client engagement, client retention, and on overall treatment outcomes (Liu & Pope-Davis, 2005; Safran & Muran, 2000; Sue & Sue, 2013). In

fact, studies indicate that the effectiveness of any therapy – regardless of modality, theoretical conceptualization, or interventions – is dependent on the therapeutic relationship (Liu & Pope-Davis, 2005; Safran & Muran, 2000; Sue & Sue, 2013). Specifically, studies cite that the client-clinician relationship accounts for an estimated 30% of the variance in therapeutic outcomes and symptom reduction (Safran & Muran; Sue & Sue, 2013).

Not only is the client-clinician relationship crucial for positive therapeutic outcomes, but Safran and Muran (2000) assert that the therapeutic alliance is, in particular, "the most robust predictor of treatment success" (p. 1). Likewise, Liu and Pope-Davis (2005) cite that the therapeutic working alliance is perceived to be the most important aspect of the therapeutic relationship if the work is to proceed and be effective. Strikingly, these findings have held consistent across a wide range of treatment modalities and theoretical modalities and across a half-century of psychotherapy research (Safran & Muran, 2000). Since the therapeutic alliance represents the negotiated tasks and goals between counselor and client, it is sensible that the strength of the alliance will necessarily impact the outcomes of therapy (Liu & Pope-Davis, 2005).

Relatedly, studies related to poor therapeutic outcomes consistently cite "negative interpersonal processes" as a prime predictor of poor outcomes" (Safran & Muran, 2000, p. 2). However, at a more nuanced level, the scholars clarify that in some studies, processes of ruptures and other conflicts were only predictors of poor treatment outcomes when the developed therapeutic alliance was not strong enough to repair them (Safran & Muran, 2000). Thus, Safran and Muran (2000) summarize both that a) negative process via ruptures in the alliance are inevitable and b) one of the most important therapeutic skills is the ability to deal with ruptures and repair the therapeutic alliance in order to achieve positive outcomes in treatment.

In fact, from a relational perspective, Safran and Muran (2000) argue that the therapeutic working alliance is not only a valuable construct, the experience of a "constructive relational experience with the therapist is a critical component of change" (p. 13). Relationally, the writers assert that developing a strong therapeutic working alliance, navigating ruptures in the alliance, and constructively repairing ruptures encompass "the very *essence* of the change process" (p. 13) rather than simply a prerequisite for change to occur. Similarly, Liu and Pope-Davis (2005) highlight that when clients perceive a strong working alliance and clinicians remain flexible and accepting, ruptures are likely to be repaired; reflexively, those clinicians who had a poor therapeutic alliance, were unable or unwilling to discuss or allow the client's negative feelings, and who had a general lack of awareness of the client are more likely to encounter premature termination. Ultimately, if the working alliance is strong, then a therapy relationship is more likely to withstand ruptures and incongruent agendas (Liu & Pope-Davis, 2005), and thus, it is more likely for the dyad to engage in a reparative change process.

Implications for working with culturally diverse clients. Although a strong therapeutic working alliance is clearly critical in all clinical work, Sue and Sue (2013) stress the increased importance of establishing a strong therapeutic alliance when working with marginalized and/or culturally diverse clients. Liu and Pope-Davis (2005) echo Sue and Sue's sentiments, asserting that the therapeutic working alliance has "strong connections to counseling with culturally diverse individuals" (p. 154) because of its reliance on the collaborative relationship and on negotiating goals and tasks. In other words, the stronger the therapeutic working alliance (i.e., the collaboration towards tasks, needs, and goals), the better able clinicians are to navigate areas of diversity and difference in the psychotherapeutic process (Sue & Sue, 2013).

Liu and Pope-Davis further note that the working alliance's emphasis on "joining together to work on negotiated tasks and goals" (p. 155) is relevant to notions of cultural competence because therapists may project agendas that are not congruent with the client's needs or purposes for being in psychotherapy. In such instances, the researchers assert that "culturally based therapy impasses or ruptures" (p. 147) can threaten the therapeutic alliance. Defining culturally based therapy impasses as "stalls and problems in the therapy relationship between client and counselor resulting from inappropriate or ineffective use of culture in therapy by the counselor" (p. 148), Liu and Pope-Davis (2005) argue that working to better comprehend incongruities in the therapeutic alliance may help clinicians to both understand premature termination among minority clients and to strengthen the therapeutic working alliance in   cross-cultural dyads. Indeed, when considering that working class clients have much lower rates of retention and much higher rates of premature termination than middle class and upper class clients (Ryan, 2006), it stands to reason that working class clients' lower levels of retention in therapy may be related to culturally based impasses and, more specifically, to clinicians' projected incongruities in the therapeutic working alliance.

Relatedly, Sue and Sue emphasize that cultural differences in therapeutic preferences and lack of attunement to cultural differences can negatively impact the development of the therapeutic working alliance. In fact, Sue and Sue (2013) list a number of assumptions that may lead to ruptures in the therapeutic working alliance, including culturally bound values of individualism, expectations of verbal and emotional expression, insight, and self-disclosure. Moreover, Sue and Sue (2013) specifically cite "class-bound assumptions" (p. 249) as a particular threat to both the therapeutic working alliance and to therapeutic outcomes (such as symptom reductions and retention). Thus, Sue and Sue implore clinicians to be "adaptable with

their relationship skills" (p. 246) in order to address the preferences and expectations that come up with clients who identify with targeted sociocultural identities.

Overall, the literature highlights that the development of a strong therapeutic alliance is rooted in the clinician's ability to stay attuned to a client's needs and to collaborate relationally to negotiate relevant agendas and therapeutic tasks (Liu & Pope-Davis, 2005; Safran & Muran, 2000; Sue & Sue, 2013). In turn, the literature extensively illustrates that positive outcomes associated with a strong therapeutic alliance are tied to a clinician's ability to recognize and resolve culturally based ruptures and impasses (Liu & Pope-Davis, 2005; Sue & Sue, 2013). Specifically, the literature maintains that positive outcomes are predicted when the clinician has developed the cultural consciousness and self-awareness to recognize their own biases, to remain attuned to their clients' responses, and to work flexibly towards reparation when culturally based impasses, microaggresions, or other enactments of oppression have occurred (Liu & Pope-Davis, 2005; Safran & Muran, 2000; Sue & Sue, 2013).

Conversely, the literature implies that clinicians who have not fostered an awareness of their own oppressive behaviors, values, and/or implicit biases are more likely to perpetrate microaggressions against minority clients (Sue & Sue, 2013) and are more likely to experience culturally based impasses in the therapeutic working alliance (Liu & Pope-Davis, 2005). Furthermore, if clinicians are unable to recognize their implicit biases, are not attuned to client responses, and are therefore unable to recognize the impact, then clients may be less likely to continue in the therapy. Illustratively, Liu et al. (2007) found that clinicians who were unable to recognize ruptures around racial and cultural issues in therapy tended to experience a weakened working alliance and a strained relationship with clients until termination. Essentially, it can be hypothesized a lack of awareness around class-related issues in therapy could be just as

threatening to the therapeutic working alliance as a lack of awareness of racial issues experienced by participants in the literature to date.

Classism Enacted in Psychotherapeutic Contexts

Just as the general literature emphasizes the need for clinicians to demonstrate awareness and recognition of culturally based ruptures in the therapeutic alliance, so does the literature related to classism in psychotherapy illustrate the potential for clinicians' unexamined class biases to negatively impact the therapeutic alliance, treatment outcomes, and overall retention for working class and poor clients (Appio, 2013; Chalifoux, 1996; Cook, 2014; Goodman et al., 2007; Lott, 2002; Patterson, 2013; Ryan, 2006; Smith, 2005; Thompson, Cole, & Nitzarim, 2012). In fact, as suggested previously, part of the need for the current study is rooted in the field's pervasive neglect of social class as a salient sociocultural identity that may influence the ability for clinicians to develop a strong therapeutic working alliance and collaborate with clients to meet therapeutic outcomes.

Lott (2002) conducted a comprehensive systematic review about classism in the United States; namely, Lott (2002) examined responses to poverty and poor people by those who do not identify as poor, and specifically argued that psychologists are complicit in maintaining classism as a result of their own prejudiced beliefs about lower class clients. In her review, Lott (2002) found that the dominant response to poor people is distancing—that is, separation, exclusion, devaluation, discounting, and designation as "other" (p. 99). Furthermore, consistent with previous reviews, Lott was able to identify "distancing" responses in both institutional and interpersonal contexts; therefore, the researcher deemed her findings to be "classist discrimination" (p. 100). Moreover, Lott (2002) discovered that psychologists—many of whom come from backgrounds of class privilege themselves—equally responded to poorer clients

through "distancing," and coded psychologists' views of the poor as being either "negative" or "characterized by pity" (p. 101) as specific manifestations of clinicians' complicit classism through "distance" (p. 101).

Ultimately, Lott (2002) illustrates the tendency for therapists to exhibit classist beliefs, attitudes, and values towards poor people and, as a result, treatment with poor clients may be negatively effected. Lott (2002) encourages future researchers to center their inquiries about the roles that psychologists can play in disrupting classism in therapeutic dyads that feature clients from working class and poor backgrounds. Overall, Lott's (2002) systematic review is valuable because it is comprehensive (various empirical studies are included in the data analysis) and relatively heterogeneous (the sample analyzed is diverse in ethnic/racial identity, age, and gender identity). At the same time, a significant limitation of this study stems from a lack of construct validity resulting from Lott's (2002) broad definition of "distancing."

Breaking down the systematic reviews to more specific contexts, Smith (2005) discusses how class influences psychotherapy with the poor; namely, she maintains that psychologists are uninterested in working with the poor due to their unexamined class bias. To illustrate her arguments, she uses four qualitative cases studies to support previous findings of classism in psychotherapy and to further argue that "class-related attitudinal barriers" compromise the quality of services offered to poor clients in the therapeutic relationship. While this study offers a thorough literature review and a theoretical conceptualization of "classism" that resonates more with this writer's own conceptualization of class oppression, the case studies involve the perspective of only one clinician whose specific demographic characteristics are unspecified. In other words, while the literature review and theoretical arguments of this study are valuable, the study lacks authenticity validity.

Likewise, Ryan (2006) conducted an exploratory qualitative study that sought to shed light on how social class is experienced and understood among psychotherapists who engage with clients from class backgrounds that are different from their own. Specifically, Ryan (2006) conducted semi-structured interviews with 13 middle-class licensed counselors and noted themes of "stuckness" and "silence" (p. 55) in the counselors' attempts to address class issues with working class clients; that is, most of the interviewees had no framework for articulating class issues in the therapeutic dyad and, likewise, they reported that class issues were not generally discussed in consultation. Thus, Ryan (2006) hypothesizes that the combination of "silence" and "inhibition" (p. 61) among middle-class therapists may contribute to working-class clients' higher percentage of premature endings in therapy. Conclusively, Ryan (2006) argues for a need to focus more on the implications of class differences in psychotherapy and adds that a more specific framework would be useful in professional contexts.

Similarly, Cook (2014) carried out an exploration of licensed counselors' own degrees of awareness and understanding of social class as a relevant and salient aspect of cultural identity. Cook (2014) used semi-structured interviews to explore nine licensed counselors' understanding of social class. Cook (2014) saw three themes emerged from the interviews: participants used "social class" and "SES" interchangeably and/or imprecisely, they focused "almost uniformly" on finances, and none of the therapists indicated that social class is a significant cultural variable. As a result, Cook (2014) found that understandings of social class and SES were very limited among the sample of counselors studied. That said, there are limitations to this study in its small sample size and relative homogeneity: among the nine counselors, all of them were Licensed Professional Counselors who were geographically located in the southern U.S; thus, the results

lack cross-sample generalizability. Moreover, the demographic data of the nine counselors was not specified, thus further threatening the external validity of the results.

Linking Cook's (2014) exploration of counselors' social class awareness, Patterson (2013) explored how the class backgrounds of 27 social workers and doctoral level psychologists influenced their reactions of negative countertransference when working with poor clients in a clinical outreach setting. Patterson (2013) used quantitative methods of data collection to assess participants' class status and countertransferential reactions (on a Likert scale) based on 10 clinical case vignettes. Overall, Patterson (2013) found that clinicians who disclosed middle and upper class backgrounds experienced greater feelings of "anger/irritation" towards the poor and working class clients in the case vignettes than clinicians who disclosed lower-middle class or working class backgrounds. Furthermore, Patterson (2013) found that participants in the social work field (versus psychology) reported less "anger/irritation" towards the poor and working class clients in the vignettes, but still reported some negative class bias (p.).

Overall, the primary strength of Patterson's (2013) study lies in the heterogeneity of the sample (which varied in age, gender, ethnicity, and social class identity), which may increase generalizability to clinicians' experiences as a whole. At the same time, there were a number of limitations to the study, including the small sample size, a reported lack of re-test reliability, a reported lack of measurement validity, and a lack of construct validity in Patterson's (2013) narrow definitions of negative countertransference (defined only as feelings of "anger/irritability") and positive countertransference (defined only as feelings of "warmth/empathy"). Finally, while Patterson's (2013) results imply relationships between social class and its influence on negative countertransference in outreach therapy, the researcher suggests that future research 1) further explore notions that clinicians from lower class

background are better able to work with lower class identifying clients, and 2) explore the hypothesis that social workers may be more equipped to work with class differences as a result of receiving more focused training working with underprivileged populations.

Although much of the literature reviewed points to a lack of representation of working class and poor clients' voices in relevant research (Appio, 2013; Lott, 2002; Liu et al., 2007; Smith, 2005), Appio (2013) qualitatively explored poor and working class therapy clients' social-class-related experiences in therapy. To conduct the study, Appio (2013) collected data through semi-structured interviews from 22 self-identified poor and working class individuals with experience as clients in individual counseling. In the sample studied, Appio found that some participants reported positive experiences with therapists when the therapist was genuine and attended to class issues in the relationship; however, all of the participants also reported feeling "disconnected," "misunderstood," and "unhelped through counseling" (p. 190) when therapists appeared inauthentic and did not address class issues.

Overall, Appio (2013) recommends further research into how social class and classism operate within the therapeutic process, particularly as it relates to intersectional identities and centering working class and poor clients' voices in the entire narrative. Moreover, there are limitations to this study, including a somewhat homogeneous sample (not much diversity in racial diversity in study participants, not much diversity in therapists described by participants); consequently, the findings of this study may lack cross-population generalizability. Additional implications for training and practice include the need for counselors to incorporate social justice advocacy into their work; suggestions for further research include further exploration of the ways social class and classism operate within the psychotherapeutic process, emphasizing the need for

researchers to attend the intersections of identity and position poor and working-class people's voices and perspectives at the center of their inquiry.

Along the lines of Appio's (2013) recommendation that researchers center poor and working-class people's voices at the center of their inquiry, Thompson, Cole, and Nitzarim (2012) used semi-structured interviews to explore 16 self-identified low-income clients' experiences of psychotherapy. The sample included 12 women and 4 men who had attended at least 6 sessions of psychotherapy within 6 months of the interview. The participants ranged from 31-60 years-old, 11 identified as White, 1 as Latina, 2 as African American, 1 as Black, and 1 as biracial. In the results of the study, Thompson et al. (2012) found that many participants pointed to unattended class differences and classist microaggressions as reasons for negative experiences in therapy; clients who reported positive experiences in therapy appreciated their therapists' explicit acknowledgement of social class and integrations of social class-related content into treatment goals. Unfortunately, most participants in Thompson et al.'s (2012) research reported that social class differences between themselves and their therapists were not made explicit within the therapeutic relationship; thus, social class-related behaviors and cues were instead left up to the interpretation of the client.

There were various strengths to the Thompson et al. (2012) study, including the authors' attention to potential biases as a result of their own "personal SES identities" (p. 219) and knowledge of the therapeutic process; the authors' relatively heterogeneous sample; and the researchers' centering of low-income clients in the research narrative. At the same time, limitations of this study included a lack of generalizability to all low-income clients as a result of geographic limits (all participants come from a midsize Midwestern city); recruitment restrictions (which required participants to have attended 6 sessions and which likely eliminated

a high percentage of potential low-income interviewees); and a lack of representation of client experiences in private practices. Moreover, while the sample heterogeneity may be considered a strength of this study, it is simultaneously a limitation, because it is less possible to tease apart the impact of intersecting cultural identities on the reported psychotherapy experiences. Thus, there may a lack of internal validity or a potential for confounding bias in the results (i.e., some client experiences may be better explained by other intersecting aspects of sociocultural identity).

Connecting calls for more authenticity validity in narratives about working class and poor clients in psychotherapy, Chalifoux's (1996) interrogation of classism in therapy centered the voices of White, working class women. Echoing the later findings previously reviewed, Chalifoux (1996) identified clinicians' implicit class biases, unexamined class privilege, and the consequences on the clients he interviewed. Chalifoux (1996) concluded:

> When the therapist and client come from different class backgrounds, they do not always view situations, family relationships, nor solutions from the same viewpoint… I did not find that these therapists were particularly unsympathetic or knowingly unkind. What I did find was that the therapists… were unaware of their own class values." (p. 32)

Finally, Goodman et al. (2007) found that many participants involved in a study on community-based practice mentioned classist psychotherapeutic dynamics when discussing with interviewers about experiences related to the Reaching out About Depression project (ROAD) project. Most often, participants reflected frustrations with clinicians who expected them to discuss intrapsychic conflicts even when clients presented with significant life stressors (such as homelessness, severe financial instability, unemployment) that were directly influencing their mental health concerns. Poignantly, one participant in the study reflected, "If you don't have a roof over your head, if you don't have your electric bill paid, then how are you going to take care

of your mental health? There's not a traditional mental health strategy for that" (p. 286).   Other participants reflected similar sentiments that implied mixed perceptions about clinicians' attunement to social class differences and challenges. Significantly, Goodman et al.'s (2007) study maintains strong authenticity validity, as it is one of the few studies to date that centers working class clients' voices in the findings.

Summary

To date, the relevant literature indicates that classism is a pervasive form of individual and systemic oppression that impacts working class and poor individuals both in larger societal structures (Lott & Saxon, 2002; Smith & Redington, 2010; Toporek & Pope-Davis, 2005) and in the context of psychotherapy (Appio, 2013; Chalifoux, 1996; Goodman et al., 2007; Smith, 2013). Overwhelmingly, the current literature suggests that psychotherapists not only lack an adequate understanding of class dynamics in clinical practice (Appio, 2013; Chalifoux, 1996; Cook, 2015; Liu et al., 2007; Smith, 2005; Thompson et al., 2012), but working class clients consistently report negative therapeutic experiences resulting from clinicians' failures to effectively address class differences in the therapeutic dyad (Appio, 2013; Smith, 2005; Thompson et al., 2012). Currently, systematic reviews indicate that working class clients have lower retention rates in therapy and are more likely to end therapy prematurely than are middle class clients, and this finding has been attributed to the lack of class-consciousness that permeates the psychotherapeutic professions (Lott, 2002; Ryan, 2006; Sue & Sue, 2013). Thus, in order to address the gaps in class-conscious research, education, and clinical practice, the current study explores the impact of classism on the therapeutic alliance from the perspective of clinicians who identify with working class backgrounds.

Notably, the literature reviewed includes both explicit and implicit elements of classism, racism, and heterosexism, thus precipitating the presence of additional gaps in the literature. Firstly, a number of articles reviewed are arguably classist even in their explanations of classism; for example, only four of the studies reviewed actually included voices from working class or low-income individuals. The rest of the empirical studies to date have relied on clinicians—who, by default, have at least a degree of earned class privilege and who, according to the literature reviewed, often identify with middle and upper class backgrounds—to convey the social class experiences of working class and poor clients. Moreover, only one of the researchers who relied on clinicians' perceptions of classism explicitly named the limitations of centering privileged voices in their narrative, thus suggesting that other researchers may operate from implicit class biases even while conducting research on classism. Consequently, most of the literature lacks authenticity validity when describing working class or low-income clients. Thus, the current study increases the literature's degree of authenticity validity by focusing on clinicians who both explicitly identify with working class backgrounds and who engaged in psychotherapy as a self-identified, working class client in the past.

In addition, some of the studies included were relatively lacking in racial and ethnic diversity; in fact, the study by Thompson et al. (2012) was considered relatively heterogeneous, even though 11 of the 16 interviewees identified as "White." Relatedly, very few of the studies acknowledged sexual orientation at all when describing the demographics of research participants. In other words, another significant gap in the literature to date lies in its lack of attunement to intersectionality theory and the ways that intersecting sociocultural identity factors contribute to clients' experiences of classism in therapy. As Appio (2013) asserted in her research on working class clients' experiences in psychotherapy, future studies would be

strengthened if conducted with an intersectionality theory lens. Therefore, the current study addresses the intersectional gaps in the literature by explicitly asking for clinicians' experiences of classism from an intersectional lens.

Finally, considering the need for greater class-consciousness in clinical social work (Liu et al., 2007) and considering the gaps in the current literature from a class-conscious and intersectional lens, the implications for clinical practice cannot be understated. Significantly, the current study addresses the need for more class-conscious research by putting clinicians from working class backgrounds at the center of the narrative (rather than relying exclusively on the interpretations of clinicians who hold class privilege themselves). Certainly, there are a number of questions that remain if clinicians hope to better connect with the needs of working class clients in psychotherapy. The current study will expand the body of class conscious literature, address current gaps, and provide a more authentic representation of how classism operates in working class clients' therapeutic experiences by answering one of those questions: *How do perceptions of classism impact experiences of the therapeutic alliance for clinicians who both self-identify with a working class background and who have engaged in psychotherapy as a clinician and client?* The following chapter presents the methodology for the current study that examines this question.

CHAPTER III

Methodology

This qualitative study is an exploration of the following research question: *How do perceptions of classism impact experiences of the therapeutic alliance for clinicians who both self-identify with a working class background and who have engaged in psychotherapy as a clinician and client?* In this study, the term *working class* refers to a social class status in which basic financial needs are met, but there is still a poverty of class privilege; in this case, *class privilege* refers to the tangible and intangible unearned advantages—such as personal contacts with employers, adequate healthcare, assets, educational capital, etc.—that are granted to the middle-class, upper-class, and owning classes (Ladd & Yeskel, 2004). The term *classism* includes 1) the differential treatment based on social class or perceived social class and 2) the systemic assignment of characteristics of worth and ability based on social class (Ladd & Yeskel, 2004). Finally, the term *therapeutic alliance* refers to the felt bond between therapist and client, as perceived by the client and clinician in the dyad.

The purposes of this study were to 1) explore working class clinicians' and clients' experiences of classism in the therapeutic alliance, with attention to intersectionality (i.e., the study of overlapping or intersecting social identities and related systems of oppression); 2) raise awareness of classism as a salient form of oppression that may or may not be replicated in the therapeutic alliance; 3) expand authenticity validity of the literature by centering working class experiences and voices in the study sample and narrative; 4) use findings to identify potential strategies to help clinicians better address class differences in the therapeutic alliance.

Research Design

To carry out the study, the qualitative research design relied on semi-structured, intensive interviewing of human participants, a design that is best used when there is a need to, "explore new issues, investigate hard-to-study groups, or determine the meaning people give to their lives and actions" (Engel & Schutt, 2013, p. 272).

In order to carry out the study, the qualitative methods used exploratory research questions with a commitment to inductive reasoning (Engel & Schutt, 2013). Within that broader methodology, the study relied on semi-structured individual interviews. Justifying this methodology, Engel and Schutt (2013) assert that qualitative methods are most appropriate when 1) research is focusing on processes related to subjective experiences of participants; and 2) there is a need to "explore new issues, investigate hard-to-study groups, or determine the meaning people give to their lives and actions" (p. 272). In this case, I chose to study a topic (i.e., classism) that is still relatively new in social work and sociological research; likewise, the subjective experiences of participants from working class backgrounds have been mostly absent from research narratives to date. Thus, a qualitative approach was the ideal methodology for my topic.

Moreover, my reasons for using semi-structured, intensive interviews for the research design were three-fold. First, the exploratory nature of the research called for an open and flexible research design that relies on inductive reasoning and in-depth responses from participants as the foundation for the findings (Engel & Schutt, 2013). Second, the personal and vulnerable nature of the topic to be explored precipitated the need for intentionality in my research design, particularly to allow participants adequate time and space to reflect on their responses and to feel that their authentic and subjective experiences were heard. Thus, using

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intensive, semi-structured personal interviews, lasting 30-60 minutes, allows participants more adequate time and space to participate fully and authentically. Third, some literature indicates that individuals with less identified class privilege may be less likely than their middle or upper class peers to speak vulnerably in group settings (Liu, Pickett, & Ivey, 2007). Since this study aimed to center clinicians with a working class background in the data collected, semi-structured individual interviews seemed more likely to produce authentic responses from participants than a focus group design.

While there were a number of strengths of using semi-structure and intensive interviews as my qualitative research design, there were limitations that must also be acknowledged. Although the goal of qualitative research is authenticity rather than generalizability, the lack of cross-sample generalizability is still an inherent limitation of qualitative methods that must be noted (Engel & Schutt, 2013). In addition, the use of a more flexible design of intensive interviewing may be limited by a greater likelihood for interviewer biases (Engel & Schutt). Finally, my time constraints and reliance on a non-random sample group (via convenience and snowball sampling) may have posed limitations to authenticity validity (Engel & Schutt, 2013).

Sample

Participants in this study were 12 Masters level clinicians who self-identified as coming from a working class background and who had been involved in therapy as both a therapist and a client. Originally, I had considered studying a sample of working class clients from my community; however, I decided that studying clinicians from a working class background would be a more feasible option given the inherent time and resource constraints in the thesis project.

Ultimately, I decided to focus on a sample of clinicians in order to increase feasibility, yet I crafted my criteria a manner that would preserve the authenticity validity I sought in centering working class voices in my narrative.

To that end, in order to be included in my study, participants needed to meet a list of specific criteria to insure authenticity. To be considered, participants needed to:

1. Be adults (i.e., age 18+)

2. Be a Masters level mental health clinician (i.e., must have a Masters degree; licensure not required)

3. Self-identify as coming from a "working class" background based on some (not necessarily all) objective measures such as:

    a. Lower socioeconomic status (for ex., household income was lower than the U.S. median growing up),

    b. Educational and professional characteristics that reflect a lack of social class power and privilege (such as growing up with caretakers/family who lacked educational capital and/or who worked in professions that are considered low in prestige), and/or

    c. Other sociocultural characteristics understood to reflect a working class identity and a lack of class privilege.

4. Have experience engaging as both a clinician and as a client in psychotherapy.

5. Have voluntarily attended a minimum of 6 psychotherapy sessions as a client.

Data Collection

Recruitment. Prior to recruitment of participants for this research, approval for the study and all safeguards to ensure ethical stands were obtained from the Smith College School for

Social Work Human Subjects Review (HSR) Committee (Appendix A). Upon receiving HSR

Committee approval, my study relied primarily on snowball sampling methods. According to

Rubin and Babbie (2013), snowball sampling is commonly used in qualitative research and is

particularly appropriate when attempting to recruit participants who may otherwise be difficult to

locate (such as special, minority, and oppressed populations).

Recruitment began through outreach on social media (i.e., Facebook). I shared both a

letter and a flyer to friends and relevant Smith SSW groups (i.e., Smith cohort groups and "Smith

Speakeasy") via Facebook (Appendix B). The letter requested both participants and referrals for

participants. I then used networking and snowballing to access participants, such as by

contacting specific colleagues and acquaintances who worked in the mental health field to ask

them to distribute my study information. My direct friends, acquaintances, and colleagues were

not eligible for recruitment, but they were asked to share the letter with others in order to access

participants.

If social media contacts knew potential participants, I requested that they share my flyer

with others and give potential participants my contact information (i.e., phone number and Smith

SSW email). Upon contact with potential participants, I described the study, along with the

potential benefits and risks of participation. Potential participants were informed of their right to

discontinue participation within the time frame and will be given additional information about

engaging in an individual interview (including time-frames, duration, etc.). If participants

wished to participate in an individual interview, a time and place was scheduled where the

consent form could be signed prior to the interview.

 Participants were given the option of doing an interview in person, over the phone, or via

Facetime or Skype. All participants in this study ultimately chose to do their interviews via

Skype or Facetime; thus, for each participant, I explained that I needed a signed consent form

(Appendix C) sent to me electronically before conducting the interview. Finally, the first couple

of minutes of the interview included a review of the informed consent agreement, including

purposes of the study, risks and benefits, and participants' rights. Participants were informed

that they could refuse to answer any question and/or withdraw from participation at any time

before May 1, 2017. Two consent forms were provided to the participant, one for the participant

to keep and one for my research records.

  Data collection instrument. This qualitative study used individual interviews for data

collection and analysis. I drafted a semi-structured interview guide with a set of specific

questions I wanted to cover with each participant (Appendix D). My interview guide was

grounded in the literature overviewed in Chapter II. Additionally, I wrote down probe questions

to solicit more complete answers to use as needed (Engel & Schutt, 2013). Prior to collecting

data from participants, I used my interview guide to complete one pilot interview; the pilot

interview was not included in my data, but was used to evaluate the usefulness and clarity of my

interview guide. I used my pilot interview to receive feedback and to minimize risks for

misinterpretation by adjusting my interview guide based on feedback from the pilot interview.

  After completing and incorporating feedback from my pilot interview, each participant

was involved in a semi-structured interview where they shared their experiences as a clinician

and client who identified with a working class background. I used my interview guide to ask

participants questions about their experiences, but allowed for some deviations from the

interview guide, so that participants could provide authentic representations of their experiences.

Each interview took approximately 45-75 minutes and followed a consistent protocol. To begin,

I attempted to build rapport with participants by engaging in a few minutes of small talk, by explaining what to expect from the interview process, and by reviewing the informed consent and asking for a signature. After allocating 5-10 minutes to initial engagement and informed consent, I explained to participants that I would be asked a set of open-ended questions and would actively listen while they responded. At the end of the interview, I saved a few minutes to thank participants and to complete the interview process.

The interviews were each audio recorded, transcribed, and then coded for themes using constant comparative analysis. All interviews occurred via Skype/Facetime and were audio recorded via a basic hand-held recording device. Audio recordings were then encrypted and saved on a computer. Each interview was transcribed by this researcher throughout the process of data analysis.

Data Analysis

Following my data collection process, semi-structure individual interviews were transcribed and then coded for themes using a general inductive approach known as constant comparative analysis. As a novice researcher, I was partial to a relatively accessible approach for analyzing my qualitative data and resonated with Vaismoradi, Turunen, and Bondas' (2013) assertion that thematic analysis "provides core skills to researchers for conducting many other forms of data analysis" (p. 400). Vaismoradi et al. (2013) urge all qualitative researchers to become familiar with thematic analysis due to its reliable and accessible qualitative approach. Moreover, identifying patterns and themes through constant comparative analysis has been deemed a "flexible and useful research tool" (p. 400) that provides a particularly rich, nuanced, and complex account of the qualitative data. Since one of my purposes for this study was to

provide more nuance and authenticity to the literature on classism in psychotherapy, constant comparative analysis was allowed me to honor working class voices with detail and complexity.

Similarly, I was drawn to a general inductive approach because it is convenient, efficient, "easily used" (Thomas, 2003, p. 237), and "produces reliable and valid findings" (p. 237). Using Thomas' (2003) model, I used detailed readings of my data to arrive at themes through interpretation of the text; reviewing the data, I made inferences based on the literal interpretation of the text, allowing my findings to emerge from the recurring or meaningful themes already inherent in the raw data reviewed (p. 238). Over time, utilizing a general inductive approach allowed me to condense the extensive raw text data into broad categories. Thus, using constant comparative analysis allowed me to conceptualize categories into broader themes that weaved throughout the entire set of data.

Finally, I used the software "Atlas.ti: The Qualitative Data Analysis & Research Software" (Atlas) to assist with my data analysis process. I used Atlas to efficiently and accurately organize and code my data. Just as significantly, I used Atlas to substantiate the validity of my analysis through stakeholder checks; specifically, I used Atlas to easily and securely share my coding with my thesis advisor for review, feedback, and enhanced credibility of my findings. Overall, Atlas was utilized to ease my data analysis by providing more efficiency, organization, and validity to my process. A detailed process of my data analysis is described as follows:

1. Interviews were transcribed verbatim and, using Atlas, were consistently organized and formatted. Files were encrypted and backed up on the researcher's computer.

2. Each transcribed interview was read in detail multiple times, until an understanding of categories began to emerge (Thompson, 2003). Categories were created from coding, or labeling, of actual meanings in specific parts of the text.

3. Categories were condensed as meanings were combined due to similarity in theme. Systematic coding and reviewing of the data allowed themes to emerge more clearly. Stakeholder checks were utilized by allowing my thesis advisor to review my coding process, provide relevant feedback, and check for validity in my analysis.

4. My category system was revised based on feedback from stakeholder checks and based on participant quotations that helped to clarify themes.

5. I continued to combine and assimilate categories until I was able to identify a cohesive narrative that incorporated the most common and significant themes. As is intended in inductive analysis, between three and eight categories were highlighted that captured key themes identified in the coding and data analysis process (Thomas, 2003).

Rigor and Trustworthiness

Despite criticisms of qualitative research being particularly biased or lacking in rigor, Anderson (2010) argues that qualitative research is incredibly valid, in depth, reliable, and rigorous when the data is properly assessed and supported by convincing evidence. Throughout my data analysis process, I attempted to substantiate the trustworthiness of my findings through techniques of respondent validation, constant comparison, and attunement to disconfirming data and contradictory evidence (Anderson, 2010). In using constant comparative analysis for themes, I dedicated myself to considering each piece of data (i.e., each individual interview) in the context of previous interviews; thus, I was able to more rigorously identify unanticipated

themes. To that end, I shared my data analysis with my thesis advisor in order to get necessary and more objective feedback about emerging themes and interpretations of the data.

It was equally important for me to seek out disconfirming data or contradictory evidence as I completed this study, particularly as a researcher who has a close personal connection to my research question and area of study. In order to account for contradictory evidence, I reviewed my data repeatedly and looked at the data holistically, even as I made my initial list of emerging themes. When seeking feedback from my thesis advisor, I remained transparent about potential personal biases and encouraged her to take a devil's advocate approach in reviewing my findings. I not only sought feedback from my thesis advisor but, when feasible, I sought out respondent validation during interviews in order to insure the trustworthiness, credibility, and authenticity of my interpretations of participants' responses.

Ethical Considerations and Safeguards

As previously stated, a number of ethical safeguards were intact prior to beginning recruitment for this study. Chiefly, an extensive Human Subjects Review application (Appendix A) was completed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC) in order to ensure ethical standards were accounted for and maintained before proceeding with my study recruitment, data collection, and data analysis. To that end, the HSRC approved my informed consent document for participants (Appendix C), my recruitment materials (Appendix B), and my outline of ethical safeguards related to confidentiality, potential risks and benefits of participation in the study, and issues such as reflexivity in qualitative research.

Protection of confidentiality. Although anonymity could not be assured in my study due to the fact that I conducted personal interviews, confidentiality was protected through a number of safeguards. These safeguards included the following steps:

All interviews were conducted in a setting that allowed for adequate privacy to insure participant confidentiality. Participant consent letters were kept separate from notes and transcripts. Each participant was assigned a code number for identification and that number was placed on all of the participant's materials. Once audio-recorded interviews had taken place, the data was stored on a digital recording device and immediately transferred to a device that allowed for password protections; moreover, field notes used confidential identifying information (participant ID numbers) rather than names.

All audio-recorded interviews were stored on a digital recording device and immediately transferred to a device that allowed for password protections. Once transcribed, audio recordings of interviews were deleted and transcriptions were encrypted and password protected. I, the researcher, was the only person who had access to the audio recordings and transcriptions, with the exception of my thesis advisor. All identifying data was stripped from computer documents before being shared with my thesis advisor; specifically, materials were assigned with a code number to further protect participants' confidentiality.

Furthermore, all of my documents—including field notes, participant log, my recording device, informed consent documents, and transcriptions—were kept in a locked filing cabinet when not in use; only I, the researcher, had access to this filing cabinet. All of these will continue to be kept in a locked filing cabinet for three years, as required by Federal regulations, and will thereafter be destroyed after the mandated three years. All recordings were permanently deleted from the recording device. Likewise, my computer documents were encrypted and

password protected; they, too, will continue to be stored securely for three years, and then permanently deleted. Finally, participants were assured that no identifying information would be included in any final report that may be published.

Risks and benefits of participation. The consent form outlined the purpose of the interviews to potential participants, as well as potential risks and benefits. Given the fact that I did not study a vulnerable population and that my interview was not likely to trigger significant emotional distress for the clinicians who participated, the consent form delineated that the risks of participation were unlikely or minimal. The study posed a low risk to participants due to their professional status as mental health clinicians; however, because my interview asked questions about experiences of classist oppression that could bring up painful emotions for participants, participants were made aware prior to the interview of the emotional risks. Moreover, participants were informed prior to interviewing that participation was completely voluntary, that their confidentiality would be protected, and that they had the right to refuse to answer any questions at any time. Similarly, participants were informed that they had the right to withdraw from participation and to have their responses thrown out of the study so long as they communicated their decision prior to May 1st, 2017. Participants were further asked to protect the confidentiality of colleagues and clients referenced in their interview responses.

Reflexivity. In addition to considerations of confidentiality, consent, and risks and participation, ethical qualitative researchers make every effort to remain attuned to reflexivity, a term that refers both to the ways that researchers and participants influence each other in the qualitative encounter (Padgett, 2008) and to the ways that a researcher's biases, assumptions, and social locations may influence data collection and analysis (Padgett, 2008). Qualitative researchers who hope to produce valid and authentic research have an ethical responsibility to

account for reflexivity, particularly so that the researcher's own subjectivities can be considered in the analysis and interpretations of the findings. Just as importantly, researchers must remain attuned to reflexivity if they hope to authentically honor their participants' lived experiences as well as the relational influences that were encountered by both participants and the researcher in the data collection process.

In this study, it was particularly important for me, as the researcher, to center reflexivity throughout my data collection and analysis. Like my participants, I am a clinician who identifies with a working class background and it was my own lived experiences of classist microaggressions that ultimately led me to my thesis topic. Needless to say, reflexivity played a significant role in my study from the moment I drafted my research question. From a personal perspective, the study of classism in the therapeutic alliance was important from a professional, client-centered, and personal lens and, because of this topic's importance to my own personal subjectivities, it was imperative to recognize the potential for greater personal biases in my study due to my sense of identification with participants' social class locations.

In order to mediate the risks of neglecting reflexivity in my data collection and analysis, I wrote a personal narrative to my thesis advisor outlining my interest in my topic and the ways that my own sociocultural subjectivity may influence my study; I periodically asked my advisor to review my data throughout my study and was open to her feedback about potential biases and any disconfirming data. Additionally, I wrote personal reflections and reactions in my field notes to remain aware of my assumptions and the ways they could influence my work. In Chapter V, I will elaborate on the ways that reflexivity influenced my work and shaped both my research analysis and my personal understanding of myself as a clinician who identifies with a working class background. The following chapter presents the findings of this study.

CHAPTER IV

Findings

As previously stated, this study sought to explore the question, *How do perceptions of classism impact experiences of the therapeutic alliance for clinicians who both self-identify with a working class background and who have engaged in psychotherapy as a clinician and client?* In order to construct an authentic of the findings from both intersectional and systemic power/oppression lenses, 12 semi-structured interviews were transcribed and coded for themes using constant comparative analysis. After completing the initial transcription and coding process, 90 total codes were identified in participants' responses; from there, codes were merged and then condensed into five main groups or themes. The five themes were identified as being particularly relevant to both exploring the research question and to giving authentic voice to each participants' experiences and narratives as a clinicians and clients from working class backgrounds. The five basic findings were participants experiencing their social class identity as salient to their overall identities and experiences as students, clients, and clinicians; identifying intersectional identity factors; experiencing structural/systemic classism and its impacts on clinical practice; experiencing classism as clients in therapy; and addressing classism as clinicians in order to foster a strong therapeutic alliance. These themes will be discussed after a brief discussion of the demographic information regarding the participants.

Demographic Information

There were 12 clinicians interviewed for this study, all of whom were at least masters-level clinicians and all of whom self-identified as coming from a working class or "poor" background. Relevantly, 11 out of 12 participants were social workers, while one participant was a clinician who had studied counseling psychology. Nine participants had graduated with their Masters degrees within the last five years; seven participants graduated within the last two years; one participant graduated in the late-1990s; and one participant graduated in the late-1970s. All participants had at least 3-5 years of clinical experience, although the two oldest participants had been working in the field for over 20 years.

Participants' professional specializations varied and participants described working in a variety of settings, including adult or family outpatient settings, working with the department of social services, engaging in private practice, working in the foster care system, and working with offenders in the justice system. Most participants were geographically located on the east coast, with two participants located on the west coast and three located in Colorado. Significantly, all but two participants described attending an "elite" or prestigious institution for their graduate clinical education; all but three participants stated that they attended a private institution for graduate school.

Among the 12 participants interviewed, 8 identified as White, 1 identified as biracial (White/Latina), 2 identified as Latina, and 1 identified as Chicana. All participants were female identifying and cisgendered. Out of the 12 participants, 1 participant identified as queer, 2 participants identified as lesbian, and the rest identified as heterosexual. Nine participants were aged 35 or younger, two participants were between the ages of 40-50 years old, and one

participant was in her 60s. Additionally, three participants identified as being impacted by ableism, and four participants specifically identified class-based trauma as a relevant intersecting experience. One participant identified her Jewish background as another piece of relevant demographic information since her mother was a Holocaust survivor.

Theme 1: Salience of Social Class Identities

Unanimously, participants in this study reported that their marginalized social class identities and working class backgrounds were salient to their overall sociocultural contexts, intersectional identities, and daily experiences navigating professional, educational, and personal environments. For example, Participant 9 described her social class identity as "incredibly salient" Participant 8 as "extremely salient" while Participant 5 stated, "I'm keenly aware of it, and almost in ways I wish I wasn't." Similarly, Participant 12 assessed her social class identity as "the most salient part of my identity, along with my racial identity as a working class Latina."

Class as culture. Not only was social class identity salient to participants' intersectional contexts, but all participants were able to describe clear differences between different social classes. Tangentially, most participants gave voice to cultural social class differences as well as factors of socioeconomic status, including various ways that social class identity molds one's beliefs, experiences of daily life, and overall development. Although some specific nuances between social classes varied among participants in their responses, all participants were able to articulate distinguishable parameters of different social classes with little or no hesitation. Most often, participants pointed to differences in SES, as well as nuanced differences in educational capital, cultural capital, and social capital as prime differences between various social classes. Speaking about their nuanced understandings of their social class identities, participants emphasized a need for professionals in the mental health fields to recognize class as culture and

to recognize "all the different ways your life can be impacted" (P6), rather than minimizing its impact on one's "development and sense of self" (P7). Furthermore, many participants described the daily, implicit class biases that cause others—including, in their experience, other clinicians—to assume middle-class or upper-class cultural norms, without realizing that "it's a *completely* different culture" (P9).

Undoubtedly, for many participants, their working class culture served as a lens that influenced *all* aspects of their sense of self and daily realities; consequently, participants stressed the challenges of stepping into more privileged spaces as clinicians. For example, Participants 2 and 12 both stated that being in more class privileged spaces is like "speaking a different language," while Participant 11 was one of many interviewees who stated that different levels of class privilege mean "living completely different realities." Some additional nuances of class culture and participants' experiences of classism included different cultural norms around spending and money management (P7, P2), psychological and emotional impacts (P2, P3, P6, P7, P8, P9, P12), hobbies and past-times (P1, P2, P3), and ideas around self-care (P2, P4, P11).

Still, one of the most salient and oppressive aspects of social class culture identified by every participant was the use of language. Significantly, all participants saw use of language as both a social class cue and as a tool for enacting and maintaining classist oppression. To clarify, all participants named use of language as a form of class culture—and, in the middle and upper classes, a form of class privilege—that is "deliberately inaccessible" (P7) to the lower classes and that led all participants to name feelings of "alienation" (P1, P2, P7, P8, P11), "shame" (P1, P2, P7, P9, P10, P12), and "isolation" (P1, P6), particularly when entering graduate training and when navigating more privileged spaces. Furthermore, almost every participant reported experiences of classist microaggressions that were perpetrated based on the use of privileged

language, intellectual jargon, or vocabulary, often resulting in participants receiving explicit and/or implicit messages that they were "stupid" (P2), "anti-intellectual" (P9), "invisible" (P1, P2) or otherwise unworthy and inferior to their middle-to-upper-class peers and colleagues. Participant 7 represented the nuances around privileged language and class culture when she related her experiences of moving from elite academic spaces to her working class home: It felt like a real big identity crisis. Because on the one hand I was saying I was so different from everyone, but at the same time, I'm at the same school, and I'm getting the same education, and I'm accessing this privilege… And I was also being indoctrinated by that institution, which then also alienated me from my community. And I'm from Hawaii originally and I spoke a *very* different language. Like I remember that first time going home and just using words that like… You know, my family "got" it— it's not like they weren't smart, it was just a different type of language—a really elite, privileged language that is deliberately effusive, deliberately inaccessible, and verbose, frankly. And so, because that's the soup I was in, I go home and suddenly I'm speaking in this different and privileged way, and that was another layer of alienation. Because it was like, "Now I'm different from even where I'm *from*." And… This was the goal, and yet also, I'm still different from the privileged soup that I'm in.

Ultimately, many participants described use of language as one particularly salient example of class culture that was not fully accessible to them as individuals with working class or poor backgrounds and that led to feelings of inferiority, shame, and self-doubt.

Upward mobility and experiencing "survivor's guilt." Certainly, while participants clearly emphasized the impact of their working class cultures on their sociocultural identity development—including on their perceptions of other social classes—they almost universally acknowledged that as clinicians with Masters degrees, they currently hold the educational and

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professional capital to assume a middle-class identity. Still, most participants expressed

complicated feelings regarding their upward mobility—including challenges reconciling their

working-class identity and their new middle-class context— and still did not fully identify with

middle class culture. In fact, all participants stressed that they still found their working class

backgrounds incredibly salient and, in some cases, "even more salient now that I've had some

kind of 'upward mobility'" (P9).

Similarly, every participant who acknowledged a newer middle-class presentation

emphasized that professional, educational, and socioeconomic experiences of upward class

mobility had not eradicated their working class culture, nor had those experiences allowed them

to truly gain acceptance and belonging in middle and upper class spaces.   Instead, participants

continued to reflect that just as class identity is cultural (rather than only based on SES factors),

participants' cultural identities did not change significantly even as their socioeconomic status

increased.   Poignantly, Participant 7 referred to her ongoing professional experiences in the field

as "doing professional drag" (P7), while Participant 4 disclosed the emotional discomfort of "not

being working class anymore" and of chronically feeling like "there is an artificial barrier

between myself and my clients" when it comes to her social class.

Similarly, Participant 11 stated that she "still feels like a minority because of both my

class and my race." Participant 12 further voiced that, "just because I'm more middle-class and

blessed to be more stable, I also can't imagine ever being fully accepted or 'at home' in

middleclass white spaces." Participant 10 similarly reflected, "I will always feel like that person

I was when I was younger; I think I will always feel anxious about what to do with money, what

it means, the anxiety that comes with it, and the differences in identity around it."

Relatedly, Participant 9 gave voice to her "imposter syndrome" of being "in class limbo." She clarified, "Not only am I not a part of the working poor or the working class—I'm no longer in that group—but also, I don't really fit into the middle-class, either. And I feel like a fraud all the time." Indeed, all participants in this study noted some degree of intrapsychic conflict around their upward mobility and around their attempts to reconcile the parts of themselves that "still relates more to the working or underclass" (P6) with the reality that they have now acquired some middle-class privileges.

Most poignantly, the majority of participants in this study specifically named experiences of "survivor's guilt" due to their upward mobility and the fact that their families and loved ones had not been granted the privileges participants themselves were able to access. Participant 10, for example, disclosed that she "felt like a class traitor" when she was finally able to afford a used car that was relatively new. Participant 12 named her struggles with "being around my poor Latinx parents who gave everything for me" and feeling "both blessed and ashamed that even though I wanted it, I feel I've lost some parts of myself and them." Participant 11 discussed some nuances of her own survivor's guilt by stating, "I have 'made it' just enough to feel guilty and super alienated from my community, but not enough to be able to help them like I want to." Overall, participants described both feelings of gratitude and a sense of "loss" (P9) as they tried to integrate their newer forms of class capital with their internal sense of social class identity.

Theme 2: Intersectionality of Social Class and Other Identities

Although the participants of this study unanimously experience their social class as a salient part of their intersectional realities, participants also cited a number of intersectional identity factors that contributed to their approaches to clinical work and that influenced the ways they made sense of their experiences of classism. For example, two participants noted their

genders as females to contribute to their desires to increase accessible care for poor and working class women, women of color, and to avoid reinforcing the "feminization of poverty" (P1, P10). Two other participants discussed intersections of age, social class identity, and sexual orientation as being particularly salient to their intrapsychic, environmental, social, and clinical experiences; specifically, both participants were between the ages of 50-65 and both identified as lesbian and queer, respectively (P3, P5). These participants discussed experiences as professionals and clients navigating issues around coming out and accessing therapy in generations that were less attuned to homophobia.

Similarly, a number of participants described the impact of ableism either on their own experiences of classism or on the experiences of loved ones who have since influenced participants' clinical approaches to their work. One clinician, for example, described being drawn to psychology due to her sibling's mental illness and her struggles with being both stigmatized for her mental illness and barred from accessible and affordable care (P1). Likewise, one participant identified the ways that her single mother's mental health challenges further contributed to the classist trauma and instability experienced by the participant (P7). Finally, all but two participants mentioned race and racism as components particularly relevant to their understanding of their social class identities.

Classism and trauma. A number of participants referenced links between trauma and classism (P2, P6, P7, P8, P9, P11), and five participants discussed the intersections of trauma, ableism, and social class identity in-depth (P2, P6, P7, P8, P9). For example, Participant 7 disclosed how her own intersectional subjectivity informed her dedication to talking about "the intrapsychic realities of class and classism and how it impacts someone emotionally." Similarly,

Participant 9 stressed that "being in a target identity for any type of oppression is just going to be a traumatic experience; you're going to have trauma-related oppressive experiences." Due to her own intersectional experiences and awareness of the relationship between oppression and trauma, Participant 9 further asserted, "If you don't feel comfortable talking to your mental health provider about them, then there's kind of no point in therapy." Finally, Participant 8 reported that her own experiences of trauma and classism are particularly linked in her lenses as both a client and a clinician.

Class and race. Indeed, while participants were open about various aspects of their identities and their intersections on their social class backgrounds, the intersection of social class and race was by far the most cited intersection that impacted participants' experiences and their own perceptions of their marginalization and classist oppression. Strikingly, this finding emerged both for participants of color as well as for white-identifying participants.

Salience of class and race for participants of color. Of the four participants who identified as women of color, all identified both their racial and social class identities to be particularly salient to their subjectivities, lived experiences, and clinical lenses as clients and clinicians in psychotherapy. Moreover, all four participants described their racial and class identities as being particularly intersected and difficult to separate. Participant 12 represented this as she reflected on the "intergenerational components of my family's poverty and racial oppression" (P12). Finally, some participants of color found that while both experiences of racism and classism were salient, they felt that their social class identities were generally "less understood" (P1) in more privileged contexts. Indeed, for all of these participants, conflicts emerged around their lived experiences of both racism and classism, particularly as they navigated academic and professional spaces as clinicians.

Participant 11, for example, stated, "For me, it's really difficult to separate my race from my class." When further reflecting on her educational and professional experiences as "a Chicana from the working class," Participant 11 assessed that her clinical program was "mostly middle-class white women, and some women of color; I honestly cannot think of a single person in my program who I think had a similar class background as I did."

Participant 1, a biracial woman who grew up with her working class and single Latina mother, voiced, "My racial identity is important, and in my case, it's hard to even separate my Latina identity from my working-class identity because they're so intersected in my family." Moreover, Participant 1 stated that there seemed to be "more awareness" around race and racism in her educational and professional experiences, yet stated these perceptions with a recognition that, "I'm biracial, so my experience is still different than someone who has far less racial privilege or who is more impacted by colorism and being darker than I am" (P1).

Still, Participant 12 also disclosed that while both her race and her class were equally salient, she experienced a greater sense of isolation around her social class background when navigating more privileged academic or professional spaces that were both predominantly white and middle or upper class:

> It still was almost harder in internship or in the field now, because you expect better... from people who are relatively "progressive" around ideas of privilege. You expect that they'd be more mindful and they aren't. So that's tough. And that's why I'd say… there is still this need to be more mindful on the impacts on people's lives, particularly around the class piece. Because while I have definitely experienced sexism in the field and racist microaggressions *quite* often, there's usually still some more awareness--like at least one person in the room who can recognize like, "Hey, she's a Latina and that's racist." Like,

at least people think that idea of "examining white privilege" sounds familiar, even if

they still have a hell of a long way to go. But it feels less so with my class identity, and I

feel like even my POC colleagues from class privilege don't always speak up and don't

really honor that I'm not just a Latina, but a Latina *who grew up poor*. So I feel… more

alone in that part of my identity (P12).

In other words, participants of color in this study often described feeling alienated both

from their white-identifying counterparts as well as from their peers of color who came from

middle or upper class backgrounds. Moreover, as Participant 12 emphasizes, the participants of

color interviewed felt uniquely alone in their social class identities, particularly in middle or

upper class spaces where they felt experiences of racism were acknowledged, even if

imperfectly.

 Salience of class and race for white participants. Although the majority of participants

in this study identified as "White," all participants referenced race as it intersects with class.

Additionally, all but one white participant specifically described navigating their lives given their

intersectional identities as white women who benefit from white supremacist structures even as

they are oppressed by classism. When discussed, every participant who named their

intersectional identity of racial privilege and classist oppression disclosed varying degrees of

intrapsychic conflict around reconciling their desires to acknowledge their racial privilege

without invalidating their experiences of injustice and classist oppression.

 To that end, many participants reflected on their white privilege, even as they discussed

their experiences of classist marginalization (P3, P4, P6, P7, P8, P9, P10). For example,

Participant 9 stated an incident in which she felt invalidated due to her social class, yet also

emphasized, "Being a white person and being an American, I definitely… don't have the same experience or the worst experience, by any means of the imagination." At a later point,

Participant 9 disclosed a similar dialectical perspective, disclosing her struggles as a woman with a background of poverty, yet simultaneously recognizing that "as a white woman, I have privilege in being able to have *any* upward mobility and getting paid more than many women of color do."

Participant 10 voiced a similar internal conflict, wanting to recognize her areas of privilege while also giving voice to the areas where classism is not addressed in education and in the social work profession:

> I'm trying to be conscious of my own worries about being dismissive of other types of oppression. Like I don't want to equate my experience with things like racism or ableism or heterosexism. *And* I feel like classism in particular—in the way that it is often also racist and ableist… It can be difficult to speak about an experience as a poor white person without feeling the need to also be like, "But I also understand that race and class are often combined and that it's different experiences for poor people of color." So… Like I found that really difficult to navigate because I often worried about coming across like I was making a "class, not race: argument; I was often really, *really* worried about that. And I'm still worried about bringing up those questions because I don't want to come across that way, because that's not something that I believe in at all. I don't believe in the "class, not race" argument. I was glad that issues around other 'isms' were engaged; it just was also frustrating that classism wasn't given the same kind of space. But yeah… I always struggled with that, as a poor white person.

Ultimately, it seemed that many white participants wanted to emphasize an intersectional awareness of their privilege and oppressed social locations, yet struggled to reconcile their desires to remain both attuned to others' subjectivities while also wishing such attunement was reciprocal when it came to classist oppression.

Theme 3: Identifying Systemic Classism and its Impacts on Clinical Practice

In this study, all 12 participants identified various examples of systemic and structural oppression, particularly as it related to their experiences accessing higher education (i.e., graduate clinical education) and experiences in the professional mental health field. In fact, participants unanimously agreed that both their graduate programs and their professional milieus often neglected to address classism in clinical training and practice. Additionally, all participants emphasized that in addition to neglecting classism in clinical training and education, academic and professional spaces were, in themselves, pinnacles of institutional classist oppression. Most notably, participants all described classist behaviors and implicit class biases demonstrated by colleagues, professors, and peers, yet participants also stated that attempts to call attention to classist microaggressions or implicit class biases were usually "dismissed" (P8) or "not well-received at all" (P10). To that end, all participants made connections between the macro neglect of classism in education with the experiences of class-based oppression perpetrated by colleagues in micro practice.

Assessing educational attention to classism. Overall, not a single participant in this study felt that their clinical education was truly class-conscious and, moreover, no participants felt that their educational institutions adequately addressed classism in its multicultural sensitivity courses or social justice agendas. Instead, participants unanimously described structural and systemic classism when discussing their experiences of graduate school;

specifically, participants identified indicators of structural or systemic classism that manifested as a lack of attention or discussion of classism in the program, a skewed student body composition in which individuals from working class or poor backgrounds were severely underrepresented, and experiences of repeated and unchallenged classist microaggressions in academic spaces.

Neglect of class issues in graduate training. Chiefly, a majority of participants emphasized that conversations around class and classism either never occurred or only rarely occurred throughout their clinical training; thus, many participants felt "frustrated" (P12) by the "lack of acknowledgment of classism, which was yearning to be seen" (P7). Moreover, some participants pointed out that their clinical education's neglect of classism within their multicultural sensitivity agendas was "classist in itself" (P2, P12).

Illustrating these points further, Participant 11 reflected that in her program, "Classism just wasn't really a thing at all, and if so, it was called 'socioeconomic status' and was not viewed as being very important." Just as significantly, Participant 2 assessed, "On a scale of 1-10, with 1 being the least sensitive and attuned to class issues and 10 being the most, I would rate my graduate institution as a 2." Participant 10 similarly asserted that other than a support group that was "finally" started by a fellow student in her final summer of graduate school, "There's no reason for me to say that they were class-conscious at all." Participant 6 responded, "I did not feel that social class or classism was very well-recognized, and when class was discussed, it was very often in the negative." Perhaps most candidly, Participant 3 responded, "Did people talk about class? *Hell, no*."

At best, some participants assessed that class was "occasionally mentioned" (P7) in their graduate programs, but that it was "not talked about enough" (P9) and/or it was referenced

without much awareness, care, or meaning.   For example, Participant 7 assessed, "I think people talked about class, but in this way where everyone felt like, 'We all have debt, so we're all in the same boat,' kind of a thing. That's the way I took it, and it felt *really* dismissive."

Overall, Participant 7 felt "classism just got missed a lot," and that "the nuances of class-- the hardships that come along with being poor—that do things to the intrapsychic and developmental growth of a person—just wasn't discussed." Overall, Participant stated it was her marginalized class identity that was "yearning to be seen and attuned to." Similarly, Participant 4 reflected that in her graduate program, "class was not talked about in any meaningful way," and that, when it was discussed, it was "discussed in a very intellectual way," rather than from a place of true class-consciousness.

While most assessments of graduate school's attention to classism were negative, it is worth nothing that many participants did acknowledge some positive or even reparative experiences.   For example, Participant 7 stated that many of her colleagues "were trying, but they were trying from a very superficial lens." Likewise, Participant 8 assessed that although her graduate program was "mostly not class-conscious," she was "able to find my class-conscious people," like one particular professor who came from a similar class background and who served as a source of support. Similarly, while Participant 4 stated her institution was mostly classist, she did clarify that having one professor as an "ally" to discuss her "alienation" was meaningful. She reflected, "It really mattered to me, that he had a working class background, and I really felt more comfortable with him than with anyone else there" (P4).

Systemic classism and student body class composition. Indeed, the findings suggest that for these participants, classism was both largely unaddressed institutionally and exclusive of working class and poor voices, which were alarmingly underrepresented in participants' student

body demographics. Certainly, participants universally reported perceptions that their graduate clinical programs were almost exclusively composed of middle-to-upper-class white students. Furthermore, participants often expressed that it was a combination of 1) feeling unacknowledged institutionally and 2) feeling socially alone that led participants to experience chronic feelings of isolation and alienation during their graduate school experiences.

For most participants, their identification of structural class privilege and their related experiences of "culture shock" (P2) occurred quickly and painfully. For example, Participant 11 stated her culture shock was "immediate" and that "people's clothes, the jargon I never learned, the intellectual ways they spoke, talking about traveling and how they all went to elite and expensive undergrad programs—even most of the other POC folks—made me keenly aware that none of them were like me" (P11). Likewise, Participant 4 reported a swift awareness that capitalism and classism "would not be discussed in any meaningful way" in her program and that "it was because I went to a school where people had a lot of access to wealth" (P4). Participant 7 noted one of her first experiences of alienation occurring when she realized, "I was the only one who worked, or at least it felt that way."

Participant 9 also referred to strong and painful "culture shock" and stated that, "In some ways, I feel like every aspect of my education has been filtered through that lens of classism" because she went to a private school where "I knew a lot of really wealthy people went. And I really just did not feel like I belonged there at all." Similarly, Participant 10 described her arrival to graduate school as being "a huge blow for me" and "nothing short of awful" due to experiences of isolation and feeling "overwhelmed by the huge differences between myself and other people."

Finally, Participant 5 represented the experience of culture shock when she described relocating to a residence near her graduate school campus:

We moved in March and school didn't start until June, as you know; I figured we should settle in a little, kind of adjust to living together before I started school. So we both picked up little tiny kind of odd jobs, but the undergrads were still in session. And we actually lived on the corner of campus. And there was a big fireworks display right around the time of the undergrad's graduation; it was *elaborate*. And I grew up in a beach town and we had pretty elaborate fireworks, but I remember thinking, "This is *literally people that have money to blow*."

In other words, all participants interviewed quickly noticed that their peers came from backgrounds of class privilege or wealth, leaving participants to experience a sense of culture shock for which there was "no support" (P6). Thus, participants reflected feeling isolated, "othered" (P2, P11) and alienated. Moreover, many participants were able to identify that the social class composition in graduate school—i.e., the overrepresentation of wealthy students combined with an underrepresentation of working class and poor students— "was, in itself, part of systemic classism" (P2).

To that end, Participant 4 linked the structural composition of students and faculty with the neglect of classism in education. Summing up her experience and her recognition of structural classism on educational and professional class-consciousness, she concluded: I just didn't feel like students or faculty really knew what to do with the issue of class and classism. There are just so many people who don't get it because it's not their lived experience… So I don't know… It just sucked. I really just hated it so much. Honestly,

it was really tough… There needs to be more students from working class and poor

backgrounds, especially in social work.

Experiencing classist microaggressions. Relating their observations of systemic

classism with personal experiences, all twelve participants in this study described experiencing

"*a lot* classist microaggressions" (P9) perpetrated by peers and that often went "uncovered and

unchallenged" (P8). In fact, participants described the impacts of classist microaggressions and

implicit class biases as an almost relentless and burdensome source of emotional stress and

psychological damage that influenced their entire experiences of their clinical education.

Participant 2, for example, described that "just stepping onto campus" at her elite social work

program was "painful and exhausting." Participant 10 and Participant 7 both described that even

environmental classist microaggressions—such as being surrounded by wealthy peers, looking at

campus architecture—contributed to feelings of exclusion as they tried to learn in an upper-class

educational culture that "was designed to make you feel as small as possible " (P10). Most

prominently, 11 out of 12 participants described experiencing a microaggressive "silencing

effect" (P2) that occurred both in and out of the classroom. Specifically, this "silencing effect"

included participants' experiences of feeling shut down, dismissed, minimized, and/or otherwise

"silenced" when speaking in middle-to-upper-class spaces (including academic, professional, and

other middle-to-upper-class social spaces).

Chiefly, participants described feeling "silenced," dismissed, "unseen and unheard" (P2),

and "invisible" as they navigated classist educational and clinical environments that denigrated

their social class identities and often invalidated their attempts to bring attention to others'

classist behaviors. Participant 8 described that she often felt "triggered" in her classes due to

others' classist behaviors and comments, yet stopped speaking up due to "being dropped by

professors," who "did not respond to me like they would someone else." Participant 4 similarly

expressed that she became increasingly silent around issues of classism as her graduate

experience progressed, stating that by her third summer of graduate school, "I didn't really talk

about those things at all. Because it was just so emotionally exhausting for me."

 Participant 9's experiences particularly represent experiences of the silencing effect that was

communicated almost universally by participants:

> When there is a classist microaggression is happening, I'm usually too upset to really say
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> anything about it. I'm just like, paralyzed or dissociating—like I said, I'll dissociate and
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> just kind of check out of the conversation to keep myself calm, because… Okay, so
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> calling people out. When you're a poor person calling out somebody who has class
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> privilege, you are made to feel like you are perpetuating all of the classist stereotypes—
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> like you're being a "bad poor person." So the few times that I did come out in class to
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> say something, it was almost *always* dismissed by whoever I was talking to—either the
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> professor or my peers. And I felt like also, I was responded to with the stereotype of
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> being "stupid"—like that I was clearly not "getting" what they're trying to teach me.
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> Like I am a "dummy" for pointing it out. Like I am just not "getting" what they're
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> saying. And that it must be my own stupidity— that that must be why I'm saying what
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> I'm saying. That it's not because I'm right, it's because I'm too "dumb" to understand.

In addition to feeling dismissed and silenced around their social class identities,

participants described a number of other manifestations of implicit class biases in their graduate

training, particularly around the ways that working class and poor people were discussed both in

and outside of the classroom. Participant 6 observed, "I feel like when we were talking about

class stuff, it was very often in the negative. Like, from a deficit perspective. I didn't see too

much talk about the resilience of people in the lower classes." Participant 6 further reflected personally painful experiences in which classist marginalization was discussed "as though it was happening 'out there somewhere,' like something just abstract and intellectual, rather than something so painful. And I'm thinking, 'This is *still happening in my life*.'"

Taking Participant 6's point further, Participant 7 stated that "single-parents and poor families got *trashed* on—just *trashed* on" in her child development class. Participant 7 further stated that the experience was "*so* exhausting" and was "my least favorite class, just because of how clueless it was to the reality of family structures that aren't wealthy." She went on, "And how it's just not *true*. And that there's not a lot of research about how really wealthy families, how fucked up *they are.*"

Some participants, such as Participant 6, further described feeling "unseen" as a result of others' negative biases or assumptions about class. Specifically, she described an incident in which a professor stated his "shock" that she had come from a poor background because her "responses in class were so thoughtful" and because he thought her to "be a really good writer." When asked she experienced that interaction, Participant 6 disclosed it felt "both validating and invalidating" as well as "microaggressive—as if people from my background can't write well or be smart and thoughtful."

Finally, Participant 10 described a number of classist microaggressions enacted by both professors and peers in the classroom when she attended her elite clinical social work program. In one notable example, Participant 10 described a professor who led an exercise in which students were given a hypothetical budget of a family and were put into small groups so they could discuss how they would budget in that family:

Basically, the exercise was to prove that being a working class family is difficult. And I remember getting the paper and getting into my group and looking at the amount of money that the people made, and it was something like a family of four making $70 grand. So I was like, "Uhhh… It seems like this is going to be really easy? (P10 laughs). And afterwards, we were all giving feedback about our experience. And I remember one person in my group saying in this pitying, patronizing way, "You know, it's just really difficult to notice that this family that we have doesn't have the money to go on vacation, and all they would be able to do is go camping once a year." And I was like, *so angry* about that. Because I was like, "My family did the same thing." Like what's so *bad* about that? Like what is so wrong about going camping? And like, they had seriously never considered that not everyone could go on a vacation? I was *so* angry.

Ultimately, as a result of experiencing chronic systemic classism and classist microaggressions in their clinical training, all participants described an impact on their psychological and emotional well being. Most often, participants noted feelings of internalized anger, resentment, shame, self-doubt, and "symptoms of class-based trauma" (P2). Participant 4 and Participant 11 both referenced the pain of navigating institutions that "were not built for people like me," and many participants stated that their awareness of the "all-encompassing classism in the field" (P2) continued to inform their own lenses as clinicians and clients. As Participant 12 verbalized it, "I just thought there would be more people like me—or at least more people who are more aware of people like me—in a social work school, of all places. But I was wrong. And I worry about what impact that has for clients in the field."

Impact of systemic classism on clinical practice. Considering the impact that systemic classism would have for clients in the field, participants universally agreed—based either on their

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personal perceptions and/or direct observations—that a lack of attention to classism in education would and/or does impact the level of class-consciousness of participants' middle and upper class counterparts. Likewise, many participants linked their perceived lack of classconsciousness among some professionals in the field with their earlier experiences of observing the neglect or underrepresentation of classism in higher education. Just as significantly, participants reflected overarching perceptions that, because of their own classist experiences, they have felt more attuned and better equipped to address classism in the therapeutic alliance with working class and poor clients.

Indeed, Participant 9 noted that she experiences her work "very differently" than her more privileged colleagues and that a neglect of classism in clinical training, "*Absolutely* makes a difference." Most participants had similar responses, such as Participant 6, who stated, "I can only assume that a clinician who has not had this personal experience with class struggle and who has not been asked to reflect on it in their education, is going to have a very different way of working with the client because of a lack of really a deep sense of awareness of all the impacts." Participant 5 agreed, "I think people *do* respond to people's class differently. And for some people, I think that trips them up."

Taking those responses a step further, Participant 7 voiced that she often observes that "clinicians who do not have a nuanced view of class and who did not grow up poor respond with pity" to working class or poor clients, which hinders the therapeutic alliance. She clarified, "They project their own sorrows onto those of other people and what they do is… they miss the reality of their experience and they miss the opportunity for accurate empathy. And that hinders the treatment in a negative way."

Additionally, many participants' responses included their own reflections of the strengths they bring to their clients because of their working class backgrounds. Participant 9, for example, stated that she is "in a better position to suss out what's actually going on and take into account classism within the family, whereas somebody with wealth privilege might make a lot of implicit assumptions that lead them down the wrong path."

Likewise, Participant 8 said that because of her working class background, she is "*so aware* of power dynamics and shaming and condescension and belittling, that clinically, if anything, I try *really* hard not to do that." Participant 11 reflected that in spite of dealing with oppression in more than one way, she thinks being a "Latina therapist with a working class background" means she accurately empathizes with and understand her clients' experiences "way more than many of my colleagues do." She explained, "Because if they had training experiences like mine, where there were class privileged people who weren't asked to examine it, then how could they really 'get' it if they haven't been taught and haven't lived it?"

Assessing class-consciousness of clinical fields. Although the nuances of responses varied by individual, all 12 participants in this study felt that the clinical social work and counseling fields generally lacked class-consciousness, as informed by participants' own perceptions and observations of classism on structural and micro levels. That said, many participants also contributed a balanced and nuanced perspective when giving these perceptions, usually summarizing that although there is generally work to be done in the field regarding classism, there has often been at least some degree of class-consciousness, depending on the individual agency and professional. For example, Participant 4, who works at a hospital, responded, "I feel like I don't see [classism] as much as I thought that I would have," yet acknowledged that the way it manifests "occurs when the doctor leaves the room and the patient

is left sitting with me and they're like, 'That doctor doesn't get it at all. They don't know how difficult this is.'" Participant 11 similarly observed, "I've heard colleagues--like even colleagues who are friends-- say classist things to me or about clients in meetings, and I don't think they even recognize that it's classist at all. But it's never across the board." Participant 10, who works in the foster care system, described implicit class biases showing up in the ways clinicians from more privileged backgrounds responded to poor versus wealthy clients, describing poorer clients as being labeled "spoiled" for getting a pair of shoes, "as though they shouldn't have had access to shoes in the first place."

As a clinician who has been in the social work field since the 1970s, Participant 3 had a number of experiences suggesting that, "Many, many, many clinicians—particularly the older ones—just have no idea [about social class]. The whole concept is just foreign to them." To represent this assessment, Participant 3 shared the ways that colleagues' classist biases have shown up both clinically and institutionally. Clinically, she clarified, "It's how they talk—often in mean ways—about clients, saying things like, 'trailer park trash' or about how clients smell." She further observed that such classist biases often leads to "distancing reactions" on the part of more privileged clinicians.

Participant 1 perceived that the mental health field has a "somewhat good understanding of the theories of privilege and oppression… but there's still this lack of awareness or mindfulness on the concrete implications in people's lives, and how it actually shows up for people."

Theme 4: Experiencing Classism as Clients in Psychotherapy

The majority of participants interviewed for this study cited both positive and negative experiences as working class or poor clients in therapy. To that end, three relevant points

emerged from the data: 1) participants all reported attunement to social class cues or "markers" from their therapists that informed participants' perceptions as clients; 2) participants who worked with clinicians from similar working class or poor backgrounds described universally positive experiences (P4, P8, P11, P12); and 3) all participants had worked with clinicians whom they either knew or believed to be from higher social class backgrounds than they were, and most participants described both positive and negative experiences related to their working class backgrounds when working with those clinicians. Chiefly, the majority of participants reported classist therapeutic enactments that ruptured the therapeutic alliance when working with clinicians who appeared to come from middle-to-upper-class contexts. That said, notable exceptions to this theme were present within the data and will be explored further below.

Noticing social class markers. When asked what participants first noticed as working class clients in therapy, all participants articulated being "highly observant" (P2) and even "hyper-vigilant" (P8) of the class cues in their environment. Unsurprisingly, participants' observations extended to the therapeutic encounter when assessing their clinicians' potential class-consciousness. In this study, I referred to social class cues as "social class markers." Such social class markers included the location and decor of therapist's offices, clothing and jewelry worn by therapists, therapist's cars, race/gender, books on office shelves, language used in the encounter, and social class cues related to educational, social, and cultural capital, including both the number of degrees/credentials and the universities attended.

In all cases, participants viewed social class markers not in isolation, but as a mosaic within which they could intuit (often with seeming accuracy) the social class context and backgrounds of their clinicians. Moreover, while no participants suggested that middle or upper-class markers alone led them to assume a lack of class-consciousness on the part of the clinician, such markers did often cause clients to feel less comfortable and more skeptical about

discussing their social class or their experiences of classism. In other words, without any cues to suggest potential understanding and attunement on the part of the clinician, participants were more likely to feel a sense of distance from the therapist in question, even when the clinician was otherwise relational and skillful with the clients in sessions.

Experiencing a strong therapeutic alliance. As previously stated, one relevant finding is that although there were not many participants who either knew or perceived that they had worked with a clinician who did not come from a background of class privilege, all four participants who had encountered that therapeutic experience reported universally positive experiences and strong therapeutic working alliances. For example, Participant 2 stated that after one of her therapists disclosed the he also grew up working class, she "felt that I could trust him more" and "it's made me feel more heard in therapy." Participant 8 stated that her current therapist is also from a working class background and also attended the same elite graduate institution as Participant 8. After being with her therapist for about five years, Participant 8 shared:

> We've really talked about all that, and she's really helped me through this process. The
> way she relates to me, gives her feedback, validation, and reflections… It's almost like a
> mirroring. She takes my past seriously and how it impacts me.

While these are powerful examples of the attunement demonstrated by participants when they encountered therapists with similar experiences of classist marginalization, there were a few examples given by participants who experienced strong alliances and high levels of attunement even when working with more privileged clinicians. One positive experience accessing class-conscious care was described by Participant 7, who found a private therapist that knew how to file with insurance and get reimbursed. Participant 7 characterized that class-conscious attunement as "lifesaving," "a gift," and "the ideal situation."

Similarly, Participant 9 described that although she perceives both her therapists to date came from higher class backgrounds than her own, she has initiated conversations in therapy with them about classism "nearly immediately" and both "are very open to talking about this stuff, which made it a lot easier." In other words, although Participant 9 also admitted there have been a couple of incidences in which she felt that these therapists treated her with "a pitying response," she reflected that her experiences have largely been positive because 1) she was direct and forthright as a client and 2) because both therapists were open to feedback and able to disrupt the power-oppression dynamic almost immediately.

Experiencing classism and ruptures in the therapeutic alliance. While the above experiences reflect that some experiences were positive and attuned, all but two participants reported *negative* experiences as working class clients in therapy when they were working with therapists who they either knew or believed were from higher social class backgrounds than themselves. Moreover, all participants who reported such negative experiences attributed the therapeutic ruptures to their therapist's neglect of social class issues in the therapeutic alliance, perceptions of the therapist's lack of class consciousness or attunement, and/or due to specific incidences in which therapists enacted classist dynamics against the participants (including imposing implicit class biases or perpetrating classist microaggressions on their clients).

The impacts of these ruptures varied for participants--ranging from successful repair attempts made by the clinician, to participants terminating the relationship due to the clinicians' classist behaviors and/or neglect of social class dynamics. In a couple scenarios, therapists were open to hearing participants' feedback and/or they initiated relational repairs, thus preserving or ultimately strengthening the therapeutic alliance (P3, P4, P7); in one case, Participant 4 even described a "reparative class experience." More often, however, ruptures were not repaired, were

often enacted more than once in the relationship, and ultimately led participants to terminate with their more privileged therapists.

In fact, the only exceptions to these themes occurred when two participants described therapists who responded with humility to their classist empathic failures and/or who were particularly dedicated to initiating repair attempts with the client and learning from their missteps in the therapeutic relationship. For instance, in one exceptional case, Participant 4 identified her strongest therapeutic experience as a client occurred with a therapist who came from significant class privilege. She clarified that the therapist in question did initially enact classist microaggression and perpetuated implicit class biases, such as by responding "defensively" (P4) to class issues brought up by the client or by making self-care recommendations that were out of tune with P4's underprivileged context. Still, while P4 described notable ruptures in the therapeutic alliance that occurred from the therapist's initially unexamined privilege and lack of attunement to classism, she stated it was her therapist's response to those ruptures that preserved the therapeutic alliance over time. Namely, Participant 4 described that therapist as powerfully relentless, authentic, humble, and aware of her mistakes as they occurred, thus allowing her the self-awareness to initiate repair attempts with Participant 4 that ultimately led to both a "reparative class experience" and a uniquely strong and long-term therapeutic alliance.

Unfortunately, most participants who did describe classism perpetrated by their therapists did not experience the clinicians to be aware of their own biases and, thus, such emotionally reparative experiences did not occur. More often, participants described only negative impacts on the therapeutic alliance when engaged with therapists who both appeared to come from class privilege and who did not attend to social class identity issues in the encounter. Specifically, participants most often cited challenges related to lack of accessibility to therapeutic care; implicit class biases that led therapists to assume middle-to-upper class norms that were pushed

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onto the client; lack of attunement to classism, as evidenced by social class identity markers in the encounter; and/or specific classist therapeutic behaviors that led participants to feel misunderstood, shamed, pitied, and alienated as clients.

Accessing care. Almost every participant who described class-based ruptures in the therapeutic alliance described at least one empathic failure or rupture around accessing care. Often, these ruptures occurred around participants disclosing their income to request sliding scale fee options or around disclosures of other class-based limitations. Participant 3, for example, identified her biggest issue with therapists "was always finding people who I could afford" and feeling like therapists often have not understood the "reality of how hard this money is to come up with." In one case, she described getting into "a fight" with a therapist who recommended she do two sessions per week and who reportedly did not "hear" the participant when she said she could not afford it. Ultimately, Participant 3 stated this clinician, "was not a bad therapist, but this is an example of how this stuff comes up."

Imposing implicit biases or middle-to-upper class norms on working class clients. In addition to challenges in accessing affordable therapy, many participants described ruptures resulting from clinicians imposing implicit class biases or assuming that middle-to-upper norms were feasible and desired by the participants. Most often, participants described clinicians imposing classist recommendations on clients that were not in any way accessible given their social class location (P1, P2, P3, P4, P5, P6, P11, P12). Participant 2 represented this finding when she described seeing a therapist who she believed to come from a wealthy background, as based on observed social class markers in their therapy:

> He would do things like suggest that I attend more yoga classes, because I had said that I enjoy yoga. And attending yoga classes is expensive, and I did *not* feel like that was

heard when I named that as part of my subjectivity. I feel like he looked at that as me

making an excuse to not take care of myself, and that I was personally doing something

wrong because I'm not taking care of myself in the way he suggested. And… I never

talked about my class again. Needless to say, I didn't continue therapy with him.

      Classist responses and behaviors. Finally, a number of participants who described

negative and classist experiences as working class clients in therapy responded with specific

incidences which their therapists' specific classist behaviors led them to feel misunderstood or

invalidated and that consequently ruptured the therapeutic alliance—often without the clinician's

awareness (P2, P4, P5, P6, P8, P11, P12). Participant 12 described working with a therapist

several years ago who "was not very attuned to class at all." She clarified, "I felt a lot of

microaggressions that may have been due to my race and my class, but… I just felt he judged my

family when I talked about how I grew up, and he even used terms like 'white trash' in a way

that I found so offensive." Likewise, Participant 5 described two therapists whose lack of

class-consciousness and implicit class biases led her to feel like, "I didn't belong. Like even now

as a therapist, I'm just on the edge of this world."

      Overall, while participants were quick to point out both the positive and negative traits of

therapists whom they believed lacked class-consciousness in the therapeutic alliance, the

disclosed impact of their therapists' lack of attunement to social class identity issues still cannot

be understated. Chiefly, the classist behaviors unknowingly perpetrated by otherwise skilled

clinicians was painful for the participants in this study, who not only reported such behaviors to

be detrimental to the therapeutic alliance, but who often terminated their therapy because of it.

Theme 5: Addressing Classism in the Therapeutic Alliance

Notably, all participants in the study were able to describe specific ways they worked with classism and specifically named interventions they use to disrupt and to help empower poor and working-class clients. Furthermore, all participants described that addressing classism in the relationship helps them to strengthen the therapeutic alliance and increase authentic connection with working class and poor clients. Indeed, while there were a number of interventions and strategies cited in the data, some interventions were stated almost universally amongst the participants and were noted to be particularly significant and clinically effective. These interventions included disrupting classist power and oppression dynamics in the therapeutic relationship; fostering self-determination, empowerment, and agency; and making therapy more accessible for working class and poor clients.

Disrupting classist power and oppression enactments. All 12 participants specifically reported interventions that they use to disrupt classist power and oppression enactments when working with clients. Indeed, most participants were able to reflect these interventions as ways of "giving power back to poor and working class clients" (P1, P5) and of strengthening the therapeutic alliance. Moreover, a majority of participants identified interventions in this category as being one of the findings that they most wanted other clinicians to understand in order to better address classism and serve the needs of working class and poor clients (P1, P2, P5, P7, P8, P11, P12). When describing specific ways that participants disrupted classist power and oppression enactments, they most often described use of self (i.e., appropriate self-disclosure of social class identities, backgrounds, experiences, and relevant intersectional identities in service of the client), explicitly naming clients' perceived or known class differences in the room, communicating egalitarianism in the therapeutic relationship.

Self-disclosure and naming class-based power oppression dynamics. A majority of participants described disrupting classist power dynamics in the therapeutic relationship through self-disclosure of their own identities, experiences, and personal contexts, and by disclosing or naming identity differences directly in the room. Participant 5, for example, acknowledges that "therapy itself is a foreign culture, so I go out of my way to put them at ease—you know, I'm okay with some small-talk, some humor, some self-disclosure, as long as it's balanced with why they're really here to see me." Similarly, Participant 9 stated that even though she has been "called out" by other providers for not being "professional enough," she does not agree with the, "'Don't share anything, be a blank slate idea. I share a lot of myself with my clients. I mean, with boundaries, but I do share my personal experiences and my life experiences when I think it's appropriate."

Like Participant 9, Participant 3 shares that her overall use of self tends to disrupt classist parameters of professionalism in service of better connecting with clients and building a strong and trusting therapeutic alliance:

> I'm really pretty informal, but still professional in many ways… So I do a lot of things that you're not instructed to do in the beginning… Like self-disclosure, for example; that's a real big one. You know, I'm more open with that, I'm more open with sharing my personality, making jokes, because I know I have the other important stuff really internalized within me and therefore, I feel like I'm really able to be *me*. And that *authenticity...* Oh my gosh, I've definitely encountered therapists where… there was just this air put on… But I'm like, "Oh God! Will you just be a *human*?" Just be a *human* and have a *real connection*.

Participant 6 clarified that she does use some "self-disclosure," whether it is explicit or more subtle. She described, "Even without more explicit self-disclosure, I might say something

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really authentically like, 'Yeah, I totally get it, transportation and having to take the buses is challenging.'" Participant 6 was also one of many participants who described the importance of "broaching the subject [of class] early on in the therapeutic alliance, just to name it."

When elaborating on what self-disclosure looks like for therapists navigating social class issues as clinicians, many participants gave examples of strategies or specific interventions they might use when navigating class differences, naming identity differences in the relational matrix, and disrupting classist dynamics to strengthen the therapeutic alliance. Participant 1, who describes her orientation as "very process-oriented and very interpersonal," represented the theme of using self-disclosure to name identity differences and disrupt oppressive enactments with particular nuance:

> I might self-disclose a little bit more than the average therapist does. So a big piece of that is I try to be really transparent. So I tell my clients what reaction I'm having, what's coming up for me as they're disclosing to me… And so if they're saying something that sounds really familiar… Like one client right now, she is biracial-- you know, half-white and half-Latina, in a graduate program, feels marginalized at times-- and sometimes I will relate to her and join with her. And I'll be like, "*Yeah*, that sounds real familiar! You know, that's what's coming up for me…" So I think in some ways that can be really validating for them, and it also just helps build that rapport and that alliance, to make that relationship safe… And I'll even do that with clients who come from more privilege— not in the first session necessarily, but when the relationship is established. I might challenge my clients with some self-disclosure like, "What's coming up for me is that, you know, as a biracial woman who came from a lower class background than you did, I'm really aware of how that's shaped some of the experiences I've had. And it seems

they're a little different from what you're telling me, and I wonder how that is for you to hear that I --sitting across from you—have experienced 'this.'" Or whatever. You know? So… bringing it in the room. Directly."

Finally, a couple of participants described that they use self-disclosure to initiate repair attempts in the therapeutic relationship when they "make mistakes" (P8). Most notably, Participant 8, who works with middle-school clients, described the importance of empathy, authenticity, and humility when falling into an oppressive dynamic. She stated, "If I do make a mistake, I'll talk it through with them and say, 'This is what I did wrong… and that probably did not feel good for you."

Overall, when participants described using self-disclosure as an intervention, they reported that client responses to such interventions were "overwhelmingly positive" (P9) and were "so far, always effective" (P12) in strengthening the therapeutic alliance and authentic connection with working class or poor clients. When asked if her use of both explicit and more subtle self-disclosure with her working class and poor clients is effective, Participant 6 responded, "Is it effective? Yeah, I think it's trust building. Where I feel like, when I indicate that I understand something is class-related, that it's helpful for the therapeutic alliance and for the relationship. It builds trust." Participant 8 concurred, "It really does help when they feel like I see them and hear them, and like I kind of get it."

Communicating egalitarianism to disrupt classist enactments. In addition to more direct use of disclosure or identification of sociocultural contexts, participants described more subtle, yet powerfully effective, interventions that disrupted oppressive power differentials by both naming that the differential exists, yet working intentionally to "give power back to the client" (P5) and to communicate to the client "that the therapeutic relationship is egalitarian, that the client is the expert in their own life, that 'This is a team effort here'" (P1). For example,

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Participant 1 described that she might specifically orient clients to an egalitarian approach in the first meeting to by stating, "'This is collaborative, I don't like the doctor-patient dynamic for therapy; I'm the therapist, so I have mental health expertise, but you're the expert on yourself, and so I never want to be presumptive or assume, or be prescriptive in a way that is telling you what to do…" Likewise, Participant 12 stated that she, too, likes to name differences while also setting up a "therapeutic norm" in which "the client knows they bring an expertise that I will never have, and that I want to give them as much power in their therapy as possible."

Participant 5 emphasized that one of her primary ways of strengthening the alliance for working class and poor clients is to "acknowledge my role and how that may impact my clients, and try to make them feel at ease and give them power back as much as possible." To demonstrate the ways she has intervened to give power back to clients, Participant 5 described more subtle ways of communicating egalitarianism in the alliance:

> If they want to stand, if they want to sit on the floor, if they want to sit on my chair... I don't really care. It doesn't matter to me. Whatever they need to do to feel—you know, it's Maslow's hierarchy of needs—whatever they need to do to physically comfortable and safe, first and foremost. They're not gonna feel safe emotionally if, for whatever reason, they don't even feel comfortable with me there in the therapy room. Like I had a guy just this week say to me, "You want me to sit in the important chair?" Because I actually needed him to do something on the computer… so I said, "Why don't we just do it in my office?" And I've known him for, I don't know, four weeks… and he's stayed there awhile and he says, "You want me to sit in the important chair?" And I gestured to where he usually sits and I said, *"That's* the important chair."

Just as was indicated by participants when using self-disclosure and when naming class differences or dynamics in the relationship, participants who discussed "giving power back" (P4, P12) or "communicating egalitarianism" (P1, P2) in the alliance stated that such interventions were effective and often built a sense of trust, safety, and connection with working class and poor clients.

Fostering client self-determination, empowerment, and agency. Over half of participants described interventions specifically meant to foster a sense of client empowerment, self-determination, and a sense of agency in the context of oppressive alloplastic factors. The primary ways that participants engaged in such interventions were by demonstrating classconscious attunement to clients' contexts, providing psychoeducation, and using a dialectical approach of both validating clients' experiences of oppression while helping to evoke areas of strength and power that are already present.

Demonstrating class-consciousness/attunement to client class contexts. Various participants who described interventions meant to foster self-determination and a sense of agency for their working class or poor clients described their dedication to staying mindful of their clients' class contexts. Often, this meant demonstrating class-consciousness by "validating the experience, the daily concrete realities" (P6), by giving clients the freedom to express their own class culture or use of language without shaming (P10), and by refraining from making class-based assumptions about relevant recommendations or client needs (P11). For example, Participant 10 reported class-conscious clinical practice by recognizing that "language is very linked to class" and by "not policing the language of the kids like other people do." Likewise, Participant 4 said, "Language in general is important. I don't use like, super-academic words, that kind of thing."

Another manifestation of demonstrating class-consciousness was participants demonstrating attunement with "genuine empathy that isn't sympathy or pity, and it never could be (P10) and by refraining from class-based assumptions. For example, Participant 11 reflected interventions around class-conscious attunement by "not assuming my clients want to be psychoanalyzed" and by not "assuming that I know better just because I'm educated… No. I do whatever I can to truly stay where they are and to not make them feel small or 'othered' or ignorant of their own reality or unheard."

Participant 3 took a similar stance, responding that she does not make assumptions that clients are "resistant" to therapy and she does not privilege therapy over other forms of recovery and healing. That is, noting that "sometimes there's an assumption that people need therapy, and there's a lack of acknowledgment about all the other ways that people get better," she emphasizes that being a truly class-conscious clinician also means acknowledging that, "Therapy is therapy: it can be helpful for some people in some circumstances, and maybe not in others."

Providing psychoeducation. Over half of participants emphasized the importance of providing psychoeducation around classism in order to normalize client experiences, to help their working class and poor clients gain language around their identities to help make meaning from their oppressive experiences, and to foster a sense of agency and empowerment (P1, P2, P3, P7, P9, P10, P11). Specifically, participants named that they provided psychoeducation around systemic and structural classism, microaggressions, and related problem-solving skills.

Participant 3, for example, stated, "I'll often be the one to help label that [classism] for clients." Participant 11 similarly emphasized, I also talk really directly about classism in layman's terms, which I think is validating and gives the sense that I have at least some awareness of how the clients might experience things (P11).

Participant 1 described the following interventions around psychoeducaiton and naming systemic oppression:

So another approach for any of my clients who experience marginalization is pointing out the systemic and the societal barriers that they have against them, naming the systemic dynamics, validating how those systemic factors of power, privilege, and oppression play out in clients' lives… And then trying to bring into the room the ways those systems may be reenacted between us. And giving some psychoeducation to help clients feel more seen and make sense of their intersections given the oppressive structures they're living in.

Overall, participants were aware that providing psychoeducation of the very real and valid barriers against working class and poor clients was "validating" (P1) and that they provided psychoeducation "to normalize the impact of poverty and classism on people's lives, to foster a sense of respect, non-judgment, acceptance, and also to help the identities of young people form in less of a context of shame" (P7).

Validating and evoking sources empowerment and strength. Almost every participant described intentional interventions to validate their clients' experiences of classism and the "very real systemic barriers" (P1) both to help clients feel seen and to ultimately evoke the sources of resilience and strength that are already present (P5, P10, P7, P9). Participant 1 described this as incorporating a "dialectical perspective" with her clients, of recognizing that "there are a lot of things out of their control *and* that we can collaborate to explore ways for them to foster some agency, even in the midst of those barriers." Similarly, Participant 10 responded gravitating "towards working with feelings around marginalization and injustice" and "trying to get my kids

to advocate for things that they see injustice around in their own lives, to try to empower them to speak up about those things instead of just letting it happen."

Finally, Participant 8 represented other participants' responses about the strengths and resilience of the working and poor classes when she stressed, "I really try to help them with a sense of self-determination and empowerment. Because I remember what it was like being a kid and feeling really powerless." She continued, "And I mean, man, these kids are *so* resilient, and smart in so many ways, and are wise beyond their years. They just need help seeing what's already there."

Making therapy accessible. Finally, approximately five participants specifically stressed the importance of disrupting systemic classism by making therapy more accessible for their working class or poor clients (P1, P2, P3, P4, P9). Although responses varied and included interventions such as providing case management as therapists, advocating for clients, the most common response from participants was that they actively worked to make their therapy affordable for working or poor clients, either by intentionally choosing to serve poor and working class clients in an agency or by accepting state insurance and focusing on working class and poor clients in private practice.

Participant 3, for example, stated that making clinical services accessible has "been a really important factor in my work through my career… and even in my private practice, it's that way." Specifically, Participant 3 reported that about 75% of her private practice is

Medicaid/MediCal/Medicare, which is "pretty unusual, and I actually love that population."

Just as powerfully, Participant 4 represented this finding when she passionately implored other clinicians to "take state insurance" and emphasized her own own connections between systemic classism, accessible services, and the ethics of social work:

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I think about insurances a lot… You know, being willing to make less money, basically. And you are choosing to make less money, essentially, but if those are… in my opinion, if social work is what you do, then that should be something that you do. I mean, it's a basic thing, but it's… The main barrier, you know? Like if people are online looking for a therapist, they're looking for someone who can take their insurance and that's the long and short of it. But you know, unfortunately the people I see who *do* take state insurance are maybe people who go to state schools or who have different kinds of counseling degrees and that sort of thing—like, not people who go to where I went. And in my opinion, if social work is what you do, then that should be something that you do. So that's something that if therapists really wanted to take that seriously, then taking state insurance would be really great.

Indeed, out of the participants who discussed making therapy more accessible on a structural level for working class and poor clients, many echoed Participant 4's assertions that accessibility is an ethical issue and that clinicians—especially those with backgrounds of class privilege—have a responsibility "to find ways to serve all clients, not just middle and upper class ones" (P2).

Summary

In summary, the five findings uncovered in this chapter represent major themes exploring the research question, "*How do perceptions of classism impact experiences of the therapeutic alliance for clinicians who both self-identify with a working class background and who have engaged in psychotherapy as a clinician and client?*" Notably, the twelve clinicians interviewed for this study presented vast and nuanced narratives around their own social class identities,

experiences of classism, and their experiences as both clients and clinicians navigating the

therapeutic alliance with a working class worldview. Moreover, as the content in this chapter

suggests, a number of findings emerged from the qualitative data that reflected 90 different codes

present in the participants' stories. Indeed, after coding, analyzing, and merging the data

collected, the five overarching findings presented in this chapter were identified, giving voice

and texture to experiences that often held elements of universality among the individual

participants. In conclusion, the findings presented may be significant in providing a more

cohesive narrative that explores the research question posed and provides a number of potential

implications for clinical social work practice. This assertion, as well as other relevant points,

will be further discussed in Chapter V.

CHAPTER V

Discussion

The objective of this qualitative study was to explore the relationship between perceptions of classism and impacts on the therapeutic alliance for clinicians who self-identified with working class backgrounds. To that end, while some of the findings discussed in Chapter IV reflect those from prior literature, it is equally apparent that the clinicians in this investigation also contradicted earlier findings and enhanced previous literature by providing a more authentic representation of classism as it manifests on both macro and micro levels of clinical practice. This chapter discusses the findings and implications for the clinical social work field in the following order: 1) key findings, focusing on the relationship between the study's results and previous literature; 2) strengths and limitations of the current study, including reflexivity; 3) recommendations for future research; and 4) implications of the findings for social work education, policy, and practice.

Key Findings: Comparison with the Previous Literature

As implied above, the findings of this study supported, expanded upon, and at times contradicted the previous literature. Specifically, all of the participants in this study appeared to give nuanced, complex, and authentic responses about their own experiences as students, clients, and clinicians who self-identified with a working class or lower class backgrounds. Thus, while individual responses inevitably varied as much as the individual clinicians themselves, themes emerged that connected all participants within a tapestry of class-conscious exploration.

Additionally, this study supported efforts to address calls for increased attention to classism in the field (Appio, 2013; Bullock & Lott, 2001; Liu et al., 2007; Smith, 2005). Furthermore, this study contributed data that will begin to close gaps in the literature reviewed, specifically by 1) utilizing an intersectional lens in the analysis; 2) specifically comparing the

work of clinicians from working class backgrounds with the work of more privileged clinicians; and 3) centering working class voices in the narrative. To that end, this study extended the work of the few class-conscious scholars (Appio, 2013; Chalifoux, 1996; Goodman et al., 2009; Thompson, Cole, & Nitzarim, 2012) who previously aimed to ally themselves with poor and working class individuals by centering their voices in their research.

Although this study filled gaps, enhanced, and generally supported prior findings, the utilization of clinicians from working class backgrounds added a unique and nuanced angle to the current findings, particularly since participants in this study were able to describe authentic experiences on both sides of the therapeutic dyad. Consequently, while participants' experiences as clients mirrored prior findings that used samples of working class or poor clients' voices in the sample (Appio, 2013; Chalifoux, 1996; Goodman et al., 2007; Thompson et al., 2012), the current findings simultaneously diverged from the literature that centered clinicians' voices in the data (Cook, 2014; Lott, 2002; Patterson, 2013; Ryan, 2006). This section, discussing those nuances and the results of the study in comparison to the previous literature, is divided into the following sections, based on the findings outlined in Chapter IV: salience of social class identity; identifying intersectional identity factors; identifying structural/systemic classism and potential impacts on clinical practice; experiencing classism as clients in therapy; and addressing classism as clinicians in clinical practice.

Salience of social class identity. The results of this study show that clinicians who self-identify with marginalized social class backgrounds 1) view their social class identities as an incredibly salient aspect of their intersectional subjectivities, and 2) experience their social class identities as being just as nuanced and culturally relevant as other social locations. Indeed, to some degree, participants' descriptions of social class as cultural, rather than simply

socioeconomic, supported prior research that asserted a need for researchers in the mental health field to view social class within a broader context of social inequality (Appio, 2013; Beeghley, 2008; Gilbert, 2008; Krieger et al., 1997; Lott & Bullock, 2007; Smith, 2010; Zweig, 2000). Concurrently, participants contradicted previous studies that highlighted clinicians' feelings of confusion and their lack of understanding around definitions of social class and its manifestations in therapy (Cook, 2014; Liu et al., 2007; Lott, 2002; Ryan, 2006). In fact, while these 12 study participants occasionally expressed uncertainty about the technical definitions of different social class terms, they did not express any confusion about the many nuances of social class identities and universally denoted classism as a system of power, privilege, and oppression. Instead, participants articulated that classism is characterized by widespread and nuanced differential access to resources in a system of class power and privilege (Smith, 2010), and that differential access is often observable (Appio, 2013).

Similarly, previous qualitative studies pointed out a tendency for clinicians to report social class identity factors only in the context of socioeconomic status (SES) (Cook, 2014; Liu et al., 2007). Strikingly, clinicians in prior studies often did not have any sense of social class identity factors at all, let alone a sense of how such factors may influence clinical practice (Cook, 2014; Liu et al., 2007; Lott, 2002; Patterson, 2013; Ryan, 2006; Smith, 2005). For example, in Cook's (2014) findings on clinicians' understandings of social class identities, zero participants indicated that social class is a significant or relevant cultural variable in the field.

In the current study, however, participants emphasized their understanding of their own social class identities as going far beyond SES factors such as income. Instead, all participants presented nuanced reflections about how even seemingly subtle social class cues (i.e., clothing, use of language/vocabulary, architecture, self-care habits) are manifestations of significantly

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different class cultures and lived realities. Furthermore, participants described their own hyper-awareness of such class cues in their environments, as well as the impact of their observations on their own navigation of different social class contexts. In other words, the participants in this study demonstrated an increased understanding of social class dynamics that contradicted findings from earlier studies focusing on clinicians' perspectives (Cook, 2014; Patterson, 2013).

Notably, such a contradiction in the current findings is likely attributable to the fact that prior literature consisted almost exclusively of clinicians who came from class privilege. In fact, one researcher identified their more privileged sample as an explanation for the lack of   class-consciousness in the findings (Patterson, 2013). Indeed, rather than simplifying class culture within the construct of socioeconomic status alone, the participants in the current study— who came from a lack of class privilege themselves—strongly asserted their social class identities as cultural experiences.

Finally, participants' views of working class and poor people were equally nuanced and indicate that individuals with working class or poor backgrounds are able to identify strengths and resources of their social class identities. Unlike samples of middle-class undergraduate and counseling graduate students, who tended to make internal attributions of poverty and view poor people as "lazy" (Cozzarelli et al., 2001, p. 22) and "criminal" in prior studies (Cozzarelli et al., 2001; Cozzarelli et al., 2002; Patterson, 2013; Toporek & Pope-Davis, 2005), participants in this study made external attributions of poverty and described working class and poor people as "hardworking" (P1, P10, P11, P12) and "nonjudgmental" (P2, P5, P8). Again, while prior studies uncovered the implicit class biases of privileged students—including students studying to be counselors—the current study's participants came from a place of classist marginalization and

thus, they emphasized both the challenges and the inherent strengths of working class and poor people.

Identifying intersectional identity factors. One particularly relevant outcome of this study was the theoretical attention to intersectionality when exploring participants' experiences of classism. Chiefly, none of the previous studies reviewed explicitly utilized an intersectional lens in the data collection, although Appio (2013) conducted the first study that included voices of working class men and women of color who spoke about the intersections of classism and racism. Still, Appio (2013) and Thompson et al. (2012) both specifically called for more intentional focus on classism and intersectional identities in their recommendations for future research.

Thus, this study expanded the current body of literature by taking one of the first steps to fill that gap. Although social class and classism remained the focus of the research, the data was analyzed and viewed from an intersectional theoretical lens. To that end, participants were explicitly encouraged to discuss their intersecting identities and experiences of oppression, particularly as they influenced participants' experiences of their social class and the salience of classism in their lives. With this theoretical approach, results of the study mirrored more general understandings of intersectionality; that is, every participant viewed their own classist oppression within their larger intersectional context, conveying "varying amounts of penalty and privilege from multiple systems of oppression which frame everyone's lives" (Crenshaw, 1991, p. 559).

In other words, clinicians in this study did not experience their social class identities in a vacuum. Rather, results were consistent with the contentions of Appio (2013) and Thompson et al. (2012): that working class and poor clients experience classism as operating in relationship to other identities such as race, ability, sexual orientation, and gender. Participants identified their

experiences of classism as operating within associated systems of oppression that influenced their individual experiences of marginalization.

Identifying systemic classism and its impact on clinical practice. The third finding outlined in Chapter IV emphasized that participants universally experienced and understood classism within a broader framework of systemic power, oppression, and privilege. Chiefly, participants identified systemic and structural classism and often connected their observations to their subjective experiences of classist oppression on a micro scale. Overall, clinicians in the current study were able to identify various connections between macro classist systems, structural/institutional manifestations of systemic classism, and the impact for working class and poor people in micro therapeutic contexts.

Firstly, participants universally agreed classism was not adequately addressed in their experiences of clinical education. Moreover, participants described various ways that their program's neglect of classism manifested and hindered their sense of self, their academic growth, and their professional development. These findings supported prior studies focusing on the experiences of working class and poor undergraduate students attending elite colleges (Cozzarelli et al., 2001; Ostrove, 2003; Stewart & Ostrove, 1993; Wentworth & Peterson, 2001). For example, Participant 6's observation that the working class and poor were viewed only from "a deficit perspective" supports Cozzarelli et al.'s (2001) finding that middle class undergraduate students view working class and poor individuals as "uneducated, unmotivated, lazy, and criminal" (p. 225). Likewise, participants' experiences of being made to feel less intelligent and "othered" (P12) throughout their educational pursuits echoed Lott and Saxon's (2002) conclusion that working class professionals are deemed less competent and less intelligent than their middle-class peers, leading to "institutional and interpersonal exclusion" (p. 495) of students from marginalized class backgrounds.

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Additionally, just as Toporek and Pope-Davis (2005) found that counseling psychology masters students held negative class biases against working class and poor individuals, the participants in the current study identified various ways that even well-intentioned colleagues, professors, and peers enacted class-based prejudices that went unchallenged in middle-to-upper-class spaces. Indeed, all participants described various personal experiences of classism as students, trainees, interns, and clinicians, thus mirroring earlier findings that even seasoned therapists are not immune to marginalizing working class and poor clients and peers (Appio, 2013; Ostrove, 2003; Toporek & Pope-Davis, 2005; Wentworth & Peterson, 2001). Since Toporek and Pope-Davis' (2005) study was the only inquiry that focused on graduate school students in the previous literature, the findings enhance the current literature by further providing qualitative nuance around the ways that classism operates in counseling and social work graduate programs.

Perhaps most relevantly, participants in the current study support and enhanced Smith and Redington's (2010) contention that classist microaggressions may be analogous to more widely-researched racial microaggressions and may be just as unconscious, demeaning, and harmful for target social class groups. Consistent with Sue et al.'s (2007) studies on microaggressions, participants described feelings of confusion, self-doubt, anger, shame, silencing, and alienation as a consequence of experiencing chronic classist microaggressions. Since classist microaggressions have received little attention in the psychology and social work literature, the current study may add credibility to the argument that classist microaggressions are as harmful as other microaggressions (Smith & Redington, 2010; Smith, 2010), and that, consequently, they deserve greater attention in research, education, and clinical training (Appio, 2013; Liu et al., 2007; Smith & Redington, 2010; Smith, 2005, 2010).

Ultimately, because of both their ongoing experiences of classism and their universal perceptions that classist oppression was not adequately addressed in their clinical training, participants in the current study felt that they were more class-conscious than many of their middle and upper class colleagues. Additionally, all participants perceived that their more privileged colleagues may be less attuned to classist dynamics in the therapeutic relationship due to a lack of training around classist oppression. Significantly, such perceptions are indeed supported by the literature, which heavily centered the voices of middle and upper-class clinicians and concluded that those clinicians usually did not demonstrate class-consciousness in their practice (Cook, 2014; Liu et al., 2007; Lott, 2002; Patterson, 2013; Ryan, 2006).

Overall, prior literature has tended to focus on one area, either on systemic classism (Liu et al., 2007; Lott & Bullock, 2007) or on classism enacted on a micro clinical scale (Cook, 2014; Chalifoux, 1996; Ryan, 2006). More recently, only a few researchers have asserted the ways that institutional classism gets enacted in relationships via group-based stereotypes and implicit class biases (Appio, 2013; Lott, 2002; Lott & Bullock, 2007; Smith, 2010). The results of this study, however, may help shed a more nuanced light on 1) the ways that macro and micro classism mutually reinforce classist cultural norms in the mental health field; 2) the systemic dynamics that ultimately lead even well-intentioned clinicians and educators to maintain larger class oppressive structures; and 3) the toll of systemic classism on working class and poor students, clinical trainees, clients, and other individuals hoping to access mental health services.

Experiencing classism as clients in psychotherapy. The results of this study both supported and enhanced the previous literature on working class and poor clients' experiences of classism in psychotherapy. Primarily, the results supported previous findings that working class and poor clients often experience various forms of classism that is perpetrated by their clinicians

(Appio, 2013; Chalifoux, 1996; Goodman et al., 2007; Thompson et al. 2012). The results further suggest that these acts of classist oppression or microaggressions often happen outside of the clinician's awareness (Appio, 2013; Chalifoux, 1996; Thompson et al., 2012). Likewise, the findings of this study reinforced earlier conclusions that clinical enactments of classist oppression do, in fact, rupture the therapeutic alliance for poor or working class clients and such ruptures may be beyond repair (Appio, 2013; Chalifoux, 1996; Goodman et al., 2007; Thompson et al., 2012). Finally, this study reinforced that clinicians' unacknowledged class biases in the therapeutic process negatively impacted the therapeutic alliance for participants, including retention rates and overall perceptions of treatment outcomes.

For example, supporting Appio's (2013) findings, participants in the current study reported universally positive experiences when working with therapists who participants believed or knew shared similar class backgrounds with themselves. As clients with therapists who shared similar class-based experiences, participants described feeling more understood and validated. Generally, the findings of this study suggest that shared social class identities between therapist and client can be helpful, but are not necessarily essential for building a strong working alliance for poor and working-class clients.

Comparatively, when working with clinicians who were perceived or known to be from middle-to-upper-class backgrounds, participants reported mixed experiences based on the clinicians' ability to openly address social class identity issues and class-based ruptures in the therapeutic alliance. Consistent with previous research (Chalifoux, 1996; Thompson et al. 2012), participants in this study felt disappointed, misunderstood, and disconnected when therapists appeared to lack the willingness, knowledge, or awareness to appropriately attend to clients' material needs in counseling. It appears that therapists who neglect class issues in therapy may

unwittingly commit classist microaggressions in their relationships with poor and working-class clients (Smith & Redington, 2010). From the perspective of Sue et al.'s (2007) research on microaggressions, therapists who neglect to address class issues in therapy may communicate that clients' material concerns, experiences of classism, and reactions to the class cues they observe in the therapy room are unworthy of discussion. Specifically, therapists who decontextualize clients' presenting concerns (e.g. asking, "Why won't you do two sessions per week?" or suggesting expensive self-care without considering the barriers working class clients may face) may further communicate insulting, silencing, and invalidating messages to clients. Still, the current findings emphasize earlier conclusions: that therapists who are able to recognize these class-based ruptures can take steps to repair the relationship (Appio, 2013; Thompson et al., 2012). Thus, the findings of this study and others (Appio, 2013; Chalifoux, 1996; Thompson et al. 2012; Weintraub & Goodman, 2010) implore clinicians to recognize such class-based ruptures in the therapeutic alliance and to take steps to initiate repair in the relationship by authentically naming the classist experiences that often get silenced in working class and poor clients' lives. Likewise, participants in the current study identified that clinicians from middle-to-upper-class backgrounds can better support the needs of working class or poor clients by 1) remaining aware of classist enactments in the therapeutic alliance, by 2) being willing to engage in self-reflection, and by 3) initiating in authentic repair attempts after class-based ruptures in the alliance occur.

In summary, the findings of this study enhanced the previous body of literature by supporting the previous findings on working class and poor clients' experiences in psychotherapy (Appio, 2013; Chalifoux, 1996; Goodman et al., 2007; Thompson et al., 2012). Thus, this study helps fill the significant gap in the literature by providing another data set within which previous

authentic experiences were validated. In other words, the findings of this study reinforce that the neglect of classism in the field's social justice agenda has far-reaching and negative consequences for both the clinicians and for the clients who are most marginalized by classist oppression.

Addressing classism as clinicians. While past studies have centered middle-to-upper class clinicians in their samples and found that clinicians demonstrated little attunement to social class issues in the therapeutic alliance (Cook, 2014; Lott, 2002; Patterson, 2013; Ryan, 2006), the current study disrupts the use of privileged clients in the sample and consequently, participants contradicted previous findings. Certainly, one of the most striking and hopeful results of this study was participants' unanimously successful class-conscious, authentic, and accurately empathetic practice with poor and working class clients.

Strikingly, all participants presented clear and reflective answers about how to work to address class issues in the therapeutic alliance, including using psychoeducation, case management, validation, and interventions that disrupt power/oppression dynamics in the therapeutic dyad. Interestingly, many of the interventions utilized by participants echoed the clinical *recommendations* of prior scholars (Appio, 2013; Chalifoux, 1996, Goodman et al., 2007; Thompson et al. 2012), yet embodied the opposite approaches of those taken by some of their more privileged colleagues in the data (Cook, 2014; Lott, 2002; Patterson, 2013; Ryan, 2006). For example, while Lott (2002) highlighted clinicians' tendencies to enact distancing and denigrating responses toward working class and poor clients, participants in the current study discussed disrupting classist enactments and giving power back to their clients by actively broaching discussions of social class identities, differences, and classist experiences. Similarly, while Chalifoux (1996) found that working class and poor clients experienced disconnection with

therapists who failed to give concrete tools and resources given their social class marginalization, current study participants emphasized giving concrete tools, increasing accessibility (by taking state insurance, offering sliding scale fees, etc.) and class-conscious resources.

Relevant to the points above, participants in this study linked their own classist experiences with stronger personal motivations to remain class-conscious as therapists. Many participants specifically channeled their own marginalized class backgrounds to respond with more accurate empathy and attunement to their working class and poor clients in the therapeutic relationship. This finding emerged in stark contrast to prior studies, which featured the perspectives of clinicians from more privileged social class backgrounds and concluded that psychotherapists were lacking in their class-conscious awareness, education, empathy, and practice (Cook, 2014; Lott, 2002; Patterson, 2013; Ryan, 2006).

Indeed, past studies of working class and poor clients found that clients reported less positive treatment outcomes when working with therapists who appeared inauthentic and unaware of class issues within the therapeutic relationship (Appio, 2013; Chalifoux, 1996; Thompson et al., 2012). In the current study, participants most often implored their more privileged colleagues to interrogate their own class privileges, to name classist dynamics in the therapeutic alliance, and to locate their social class identities within a social class power/oppression/privilege framework. Again, these findings clearly outline that therapists can contribute to positive treatment outcomes for poor and working-class clients by attending to class issues within therapy and by engaging with clients authentically.

Ultimately, in voicing their experiences and perceptions across macro and micro contexts, participants mirrored a critical hypothesis posed by Patterson (2013) for further inquiry: that clinicians with working class and poor backgrounds may be more class-conscious and better able

to work with working class and poor clients. Given the prior findings on clinicians' lack of

class-consciousness, the current study's findings regarding participants' strong class-competent

clinical practice—including their specific dissemination of interventions to better address

working class and poor clients' needs—may be the most significant contribution of this study.

Strengths of Study

The primary strengths of this study included authenticity, validity, trustworthiness, and

rigor. First and foremost, this study centered the voices of poor and working class individuals in

the narrative, thus disrupting the neglect of authentic representation of poor and working class

clients and clinicians in the previous literature. To date, the narratives of working class and poor

clinicians and clients remain largely invisible in the field. Therefore, by reflecting the voices of

clinicians with working class backgrounds, the current study enhances the body of authentic

literature on working class and poor clients' experiences.

Similarly, a number of study procedures increased the trustworthiness and credibility of

the findings presented (Charmaz, 2005). First, working with my thesis advisor for consistent

feedback and review of my data analysis helped me maintain objectivity and reminded me to

interrogate my own reactions and potential biases throughout the process. Second, my use of

constant comparative methods further ensured that the theoretical categories and concepts that

emerged were grounded in the data and refined by subsequent data collection. That is,

throughout my data analysis process, I attempted to substantiate the validity and trustworthiness

of my findings through techniques of respondent validation, constant comparison, and

attunement to disconfirming data and contradictory evidence (Anderson, 2010). In using

constant comparative analysis for themes, I dedicated myself to considering each piece of data

(i.e., each individual interview) in the context of previous interviews; thus, I was able to more rigorously identify unanticipated themes.

Additionally, in order to account for contradictory evidence and remain conscious of my own biases, I wrote field notes, reviewed my data repeatedly, and looked at the data holistically, even as I made my initial list of emerging themes. When seeking feedback from my thesis advisor, I remained transparent about my personal biases and encouraged her honest feedback in assuring accuracy of my data analysis and findings. I not only sought feedback from my thesis advisor but I sought out respondent validation during the here-and-now of interviews in order to insure the trustworthiness, credibility, and authenticity of my interpretations of participants' responses.

Finally, I provided enough evidence for readers to "form an independent assessment" (Charmaz, 2005, p. 182) of the study findings, thus adding credibility to my findings. In order to do this, I presented numerous participant quotations to support my claims and presented my findings as a cohesive narrative where each participant could be observed both in an individual context and as a reflection of larger experiences among the group. Indeed, the number of shared experiences reflected by participants further reinforces the reliability of the study, particularly as my sample size was adequate to produce a saturation phase of many findings during data collection.

Theoretically, strengths of this study include its originality, usefulness, and its resonance for the participants interviewed. First, this study began to address a number of gaps in the literature, including a need for more focus on intersectionality during data collection and a need for more studies centering working class and poor voices. Second, this study addressed some specific inquiries posed for additional study in the previous literature, including a need to further

assess whether clinicians from lower class backgrounds are more effective at class-conscious practice than are their more privileged colleagues (Patterson, 2013). Third, this study confirms and extends the findings of past studies of poor and working-class clients' therapeutic experiences, as well as the findings highlighting classism as an important cultural construct in working class and poor individuals' lives. In other words, this study provided additional credibility to prior findings and expanded the depth and breadth of data on the subject of classism in social work and counseling contexts.

Limitations of Study

This study has a number of limitations that warrant consideration. This sample was a self-selected group of clinicians with working class backgrounds who were informed in advance about the topic of the research.   Therefore, individuals who volunteered and consented to participate in this study may be people who experience issues of social class as particularly salient in their lives or who have a special interest in this topic area. In addition, although intersectionality was emphasized in the study's design, methodology, and findings, the preliminary sample still suffers from a lack of diversity across relevant realms of identity. Out of the 12 participants in the sample, only 4 participants identified as clinicians of color. The lack of representation of clinicians of color is a particularly relevant limitation because the four clinicians of color interviewed identified their racial identities as being particularly salient to their experiences of classism. Likewise, all of the participants identified as cisgender females, most were under the age of 35, and most were heterosexual.

Relatedly, the lack of educational diversity in participants' graduate programs is a limitation that warrants specific consideration. Namely, 11 out of 12 participants attended private graduate institutions and 9 out of 12 participants attended the same "elite" graduate

program. One potential strength of such demographics is the potential to gain awareness of the classist oppression these institutions reportedly perpetrate. However, the relatively small size of the sample and the specific educational contexts of these participants limit generalization of the findings of this study. As is the case with most qualitative methods, the findings in this study can only be generalized to the 12 participants who were interviewed.

Similarly, while there were a number of strengths of using semi-structured and intensive interviews as my qualitative research design, there were limitations that must also be acknowledged. Namely, the convenience and snowball sampling techniques utilized in this study may have further limited the diversity of experiences and backgrounds of the individuals in this sample. Although it was not feasible due to time limitations for completion, a more random sampling technique and/or more time for recruitment may have resulted in a more diverse sample of participants (Engle & Schutt, 2013).

Additional limitations of this study are related to the use of a singular data source and some of the specific conditions of data collection and analysis. In qualitative methodologies, scholars emphasize the importance of obtaining information from a variety of sources to enhance the theoretical model and triangulate the data (Vaismoradi et al., 2013). Qualitative researchers further emphasize the use of participant checks (i.e., participant review of transcripts or data analysis) and immersion in the field of study in order to triangulate data and achieve more rigorous analysis and trustworthy findings (Charmaz, 2005). Due to time limitations, I was able only to conduct one interview with each participant and, while I did check for accuracy during the interviews themselves, I was not able to utilize participant checks.

Reflexivity

Another important point to underscore in this discussion is that my own sociocultural subjectivity as a social work student and researcher inevitably influenced this study. As a mixed race social work student who experiences ableism and identifies with a working class background, my research has resonated on both theoretical and personal levels. Not only does a researcher's subjectivity inevitably influence research regardless of methodology, but my method of data collection was particularly relational. That is, by collecting data with semistructured interviews, reflexivity became a consistent area for reflection, mindfulness, and ethical consideration. Often, I identified with participants' experiences and felt a genuine empathic connection with those I interviewed. Thus, in my data analysis, my own salience with participants' statements, my connection to the topic, and my overarching emotions, values, and opinions could have led me to emphasize responses that more strongly reflected and/or conflicted with my own background.

At the same time, some qualitative researchers have voiced the importance of sharing similar sociocultural identities with participants in order to strengthen rapport and the trustworthiness of findings. Specifically, Fassinger (2005) asserts that when possible, it is more ethical and methodologically rigorous to match researchers and interviewers demographically in order to ameliorate the limitations that tend to arise when a researcher is more privileged than their sample. To that end, my strong identification and attunement to the topic and to participants' experiences served as strengths in allowing for more accurate empathy, greater ability to build safety and rapport with participants, and ultimately, increased trustworthiness of the data and findings presented. Often, participants expressed a sense of camaraderie knowing that I, the researcher, shared some of their experiences of classism. On some occasions,

participants even disclosed that I was the first person to whom they had ever disclosed certain experiences, reactions, feelings, and ongoing sources of intrapsychic and interpersonal pain.

Therefore, it is possible that my findings would not have been as resonant, trustworthy, or authentic if my I had not been as personally connected to the material. Certainly, as a researcher, it was touching and deeply rewarding to experience such profound connections and authentic, mutually validating exchanges in participant interviews. Moreover, due to the connections and rapport built with participants in this study, my ongoing reflections, validations, and checks for accuracy throughout each interview, it seemed participants described their experiences vulnerably, authentically, and accurately.

Recommendations for Future Research

In reviewing the study's findings and comparisons with the literature reviewed, there are a number of recommendations for future research that may give further insights on the impact of classism in the fields of counseling, psychology, and social work. While there is still vast research needed in the examination of classism in psychotherapeutic contexts, some directions for future research include more studies centering the voices of working class and poor clients, more studies centering the clinical perspectives of clinicians from working class and poor backgrounds, more studies using an intersectional lens, and quantitative studies exploring various perceptions of classism across diverse educational milieus. Each of these recommendations is summarized below.

To begin, there is still a need for more authentic narratives about working class and poor clients and more studies are needed to reflect the authentic experiences of clinicians and students who come from working class or poor backgrounds. Certainly, there is still a need to focus on the voices of working class and poor clients and making those narratives visible, rather than

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relying on more privileged voices in the data. Likewise, since this was the first study in the literature reviewed to center voices of clinicians who identify with working class or poor backgrounds, additional studies may enhance these findings, provide necessary nuance or disconfirming data, and/or provide additional validity and credibility to this study's claims.

Taking the above points further, there is still a particular need to explore the experiences classist experiences in the field from an intersectional lens. Currently, there is still a significant gap in the literature regarding intersectionality and authentic representation of diverse working class voices and, as this study illustrates, intersectionality matters to working class and poor individuals' experiences as students, budding professionals, and as clients who yearn to feel adequately seen and understood in therapy. Specifically, this study further highlighted a need for more authentic explorations around intersections of classism and racism, with classism as a primary focus. Undoubtedly, continuing to increase explorations of both clients and clinicians' class-based perceptions and experiences may continue to enhance and/or provide nuance to the needs of working class clients, to the needs of clients given their intersectional subjectivities, and to the ways that clinicians either support or hinder those treatment needs and outcomes.

Finally, one exceptionally relevant direction for future research would be to continue studying structural classism as it manifests in social work and counseling training programs. Specifically, it may be most useful to utilize quantitative research methods to collect more data on the perceptions of classism among graduate school students across the country who are enrolled in various types of clinical mental health programs. For example, how might clinicians who identify with working class or poor backgrounds experience graduate school, clinical training, the profession, and their clinical work if they attend public—and potentially, more accessible—institutions? Conducting a large quantitative or mixed-method study would be

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useful in answering such questions, enhancing the current study, and providing more data to inform class-conscious educational and clinical policy decisions in the field.

Implications and Expected Contributions to the Field

There has been little research conducted on the ways classism impacts experiences of psychotherapy, and prior research has almost exclusively centered middle class or wealthy voices in the narrative. Thus, this study aimed both to address a need for more class-conscious research and to add more authenticity to prior narratives by centering working class voices in the narrative. As previously stated, expected contributions to the field include expanding the relatively limited literature on the impact of classism in clinical social work, raising awareness of systemic classism and its implications for professionals in educational and professional contexts, and serving as a tool for clinicians to better recognize and attend to issues of classism in their practice.

Taking those expected contributions further, the findings may begin to provide more nuanced portraits of classism as a "blind spot" (Liu et al., 2007, p. 194) in the field's multicultural sensitivity agenda. Indeed, as individuals who experienced classism as both clinicians and as clients, participants in this study were adamant about the seeming lack of awareness from colleagues,' professors,' and supervisors' about their own implicit class biases. Moreover, the majority of participants emphasized the ways that structural classism—for example, graduate programs' neglect of classism in clinical social work education—may trickle down to micro practice milieus, manifesting as class-based empathic failures, oppressive behaviors, and consequential ruptures in the therapeutic alliances with working class and poor clients.

From an educational policy perspective, for example, it is clear that educational and professional institutions are complicit in maintaining classist oppression not only in micro interactions, but in structural dynamics that limit educational and professional access for working class and poor students, clients, and potential clinicians. Certainly, the current study suggests significant evidence that private, "elite," and supposedly progressive social work and counseling institutions may be setting trainees up to fail when 1) they neglect classism in the curriculum and 2) when they undervalue and/or underrepresent working class and poor students in both the classroom and, ultimately, in the field itself.

Thus, one implication of the study's findings includes the potential for elite institutions to increase their own sense of accountability and awareness around the authentic experiences of their working class and poor students, as well as the ultimate impact of educational classism on working class and poor clients. There are several implications for educators in this regard, particularly given the need to increase the visibility of working class and poor voices in the demographics of programs themselves, in academic curricula, and in professors' facilitations of classroom discussions and group dynamics. For example, these findings indicate elite graduate programs need to better invest in students who are marginalized by classism, including offering more equitable financial aid opportunities and social and academic supports. Likewise, conversations around classism need to occur more often and should be reflected in the curriculum. Within those classroom conversations, use of inaccessible academic language should not be privileged over other types of expression. Finally, educators need to become more aware of classist enactments and classist microaggressions in the classroom and ideally, they could use these findings to more mindfully insure that each student is seen, heard, and valued.

Related to the educational and structural policy implications above, participants in this study were adamant about the need for leaders in the field—including policymakers, supervisors, and individual clinicians—to disrupt classism on a larger scale and increase overall accessibility of mental health services for all working class and poor clients. On a macro scale, social workers and counselors should support political and professional policies that increase access to affordable healthcare and mental health services for poor and working class clients. Likewise, leaders in the field should support initiatives that disrupt larger manifestations of systemic classism, such as living wage laws for all workers. On an individual level, the findings of this study suggest that clinicians—and especially social workers—have an ethical responsibility to take insurance and provide accessible care for working class and poor clients.

Ultimately, the current study suggests that clinicians from working class backgrounds do experience their clinical work differently than their middle-to-upper class counterparts, and in the current study, this was to the benefit of their clients. That said, one implication of this finding is that clinicians may become more aware of the nuances of classism and, as a result, may become more aware of their own implicit biases and the ways those biases may enact classist power dynamics in their relationships with clients. Indeed, one hopeful clinical implication in this study is that privileged clinicians can learn to increase awareness of social class identity and culture, can interrogate their class privilege, and can make changes to improve their clinical practice with working class and poor clients. However, clinicians need to be able to own their social class identity and recognize that working class and poor clients automatically observe social class cues in their environment that will lead to feelings of connection or disconnection with a therapist. Therefore, class differences, dynamics, and enactments need to be openly discussed in the therapeutic alliance.

One final clinical implications of this study includes providing clinicians with successful interventions that may serve as tools to increase class-conscious practice when working with clients who are marginalized by classism. For example, clinicians who read this study may feel more comfortable discussing classism and helping clients put their experiences into accessible words that help them feel validated and empowered. Similarly, clinicians need to become more comfortable working on problem solving, tools, case management, and other concerns related to classism, rather than erroneously focusing exclusively on intrapsychic conflicts or analysis. Since previous studies did not give authentic voice to clinicians who engaged regularly in successful class-conscious clinical practice, the implications of these findings also cannot be understated, as clinicians now may have more concrete, specific examples of how to build strong therapeutic alliances with working class and poor clients.

To summarize, there are a number of implications that can be summarized from the study, its findings, and the discussion points outlined in this chapter. On an educational level, the findings in this study echo prior assertions that classism needs to be addressed more readily and explicitly on a structural level (i.e., by making programs more accessible for poor and working class students), in the curriculum, and in the facilitation of classroom group dynamics (i.e., by asking more privileged students to interrogate their class privilege and disrupting classist microaggressions). On a larger policy level, participants in this study model ways for educators, clinicians, supervisors, and other leaders in the field to practice truly equitable and classconscious care by accepting insurance, attending to clients' concrete needs, and making therapy as accessible as possible. On a clinical level, there are a number of implications for the field and for social work practice in this study, including the acknowledgment that even subtle class cues, classist microaggressions, and an overarching silence around social class concerns can

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all alienate working class and poor clients. Conversely, being attuned to clients' class cultures and contexts, engaging with humility and authenticity, and bringing classism and social class identities explicitly into the conversation all have the power to strengthen the therapeutic alliance and therapeutic outcomes.

Conclusion

As one famous adage by an unknown author contends, "If it's inaccessible to the poor, then it's neither radical nor revolutionary." Poignantly, although clinical social work itself is known for its visions of radical and revolutionary social justice, the literature to date shows that many educators, supervisors, and clinicians continue to exhibit a classist blind spot in their attempts to uphold the ethical ideals of the profession. As many participants of the current study implied, social workers are incomplete in their social justice agendas if classism is neglected, and as these findings clearly illustrate, the consequences of such blind spots are insidious, comprehensive, and far-reaching. More personally, as clinicians from marginalized class backgrounds, the participants of this study vulnerably disclosed their own yearnings to be seen and valued in the midst of classist oppression perpetrated by other clinicians and social workers.

Hopefully, with more data analysis and discussion, the findings of this study may give credence both to the demonstrated clinical strengths of working class clinicians and to previous assertions that the clinical social work field may benefit from increasing classism as a priority in educational and clinical contexts. Indeed, by increasing awareness and attention to issues reflected in the findings of this study, clinicians may become better equipped to build strong therapeutic alliances with working class and poor clients, may better serve their clients' intersectional identity needs, and may see higher retention rates and better therapeutic outcomes

in the process. To that end, the findings in this study may influence professionals' levels of clinical attunement and their awareness of specific class-conscious interventions.

To conclude, the findings of this study may give more insight into systemic manifestations of classism in the clinical social work field and to the micro impacts of those manifestations. That is, by grounding findings in the narratives of poor and working-class clients, and making visible how the therapeutic relationship is embedded within a sociocultural context, this study offers a useful resource by which clinicians can evaluate their work with classoppressed clients. Consequently, the study may encourage clinicians, educators, and researchers to increase the amount of attention and attunement given to classism within clinical and social justice agendas and may inform the interventions utilized by clinicians to serve client needs. While the clinical social work field may not be truly radical or revolutionary yet, hope remains that one day it will be.

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Appendix A: HSR Approval Letter

SMITH COLLEGE

School for Social Work

Smith College

Northampton, Massachusetts 01063

February 3, 2017

Taylor Millard

Dear Taylor,

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,

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

CC: Susanne Bennett, Research Advisor

Appendix B: Recruitment Message

Hello friends,

As some of you may already know, I'm currently working on a research project that will fulfill the thesis requirements to finish my Masters of Social Work (MSW) degree from Smith College SSW. Please spread the word!

My study is a qualitative exploration of how perceptions of classism impact experiences of the therapeutic alliance for clinicians who identify with a working class background and who have engaged in therapy as both clinicians and clients. To date, there has been little research done in this area, and prior research has centered middle class or wealthy individuals in the narrative. As a student who cares deeply about centering marginalized voices in the mental health field, I hope to further clinicians' understandings of classism so they can better serve working class clients in the future.

This is an opportunity for clinicians who identify with a working class background to share their stories.
Qualifications for Participation:
You qualify for participation if…
- You are at least 18 years old
- You are a Masters level mental health clinician (i.e., you have a Masters clinician; licensure not required)

- You self-identify as coming from a working class background.
  - You self-identify as coming from a working class background based on objective measures such as lower than average socioeconomic status (for ex., household income was lower than the U.S. median), educational and professional characteristics reflecting a lack of social class power and privilege (for ex., growing up with caretakers/family who lacked education and/or who worked in professions that are considered low in prestige), and other social or cultural factors that you have understood to reflect a working class identity and lack of class privilege.
- You have engaged in psychotherapy as both a clinician and as a client
- You have voluntarily engaged as a client in psychotherapy for a minimum of 6 individual therapy sessions

Participation in the study includes reading and signing an informed consent agreement and participating in a 45-60 minute interview with myself. Interviews can be done via phone, Skype/Facetime, or in-person, depending on geographical location, convenience, and participant preference. Your participation is voluntary and confidential, and you may remove yourself from participating at any time.

Due to ethical requirements, I am unable to interview anyone for my thesis who I am already closely acquainted with. However, I would be incredibly grateful if you could share this information along and spread the word.

Interested individuals, please contact me, Taylor Millard, at tmillard@smith.edu (preferred contact method) or call/text 303-956-6747 for further information, questions, or participation.

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

Appendix C: Consent Form

SMITH COLLEGE

2016-2017
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

....

Title of Study: Classism in the Therapeutic Alliance: Implications for Clinical Social Work Practice

Investigator(s):

Taylor B. Millard, tmillard@smith.edu

....

Introduction

- You are being asked to be in a research study of the impacts of classism on the therapeutic alliance for working class clinicians and clients.
- You were selected as a possible participant because:
- You are at least 18 years old
- You are a Masters level mental health clinician (i.e., you have a Masters degree; licensure not required)
- You self-identify as coming from a working class background.
- You self-identify as coming from a working class background based on objective measures such as lower than average socioeconomic status (for ex., household income was lower than the U.S. median), educational and professional characteristics reflecting a lack of social class power and privilege (for ex., growing up with caretakers/family who lacked education and/or who worked in professions that are considered low in prestige), and other social or cultural factors that you have understood to reflect a working class identity and lack of class privilege.
- You have engaged in psychotherapy as both a clinician and as a client
- You have voluntarily engaged as a client for a minimum of 6 individual therapy sessions
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose(s) of Study

- The purpose(s) of the study are to 1) explore working class clinicians' and clients' experiences of classism in the therapeutic alliance, with attention to intersectionality (i.e., the study of overlapping or intersecting social identities and related systems of oppression); 2) raise awareness of classism as a salient form of oppression that may or may not be replicated in the therapeutic alliance; 3) expand authenticity validity of the literature by centering working class experiences and voices in the study sample and narrative; 4) use findings to identify potential strategies to help clinicians better address class differences in the therapeutic alliance
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: to participate in one individual interview conducted by the researcher and lasting 45-75 minutes. The interview will focus on your experiences both as a clinician and as a client regarding issues of social class and its intersection with your other identities. The interview will be audio recorded.

Risks/Discomforts of Being in this Study

- The study has little foreseeable (or expected) risk, but I will be asking you to discuss your working class identity and experiences of classism that may be emotionally painful. Feel free to decline to answer any question or, if necessary, to end the interview early and withdraw your participation if the discussion causes too much discomfort. I will provide you a list of follow-up supports to help cope with any emotional discomfort.

Benefits of Being in the Study

- The benefits of participation may include: having the opportunity to share stories about your experiences as both a clinician and client from a working class background. Additional benefits may

include having the opportunity to share the ways your social class background has influenced your experiences in the field and to use your experiences to provide information that will help raise awareness of the impacts of classism in psychotherapy and so that clinicians, supervisors, educators, and researchers can better serve the needs of working class clients in the future.

- The benefits to social work/society are: to provide information for future research, to hopefully expand the current literature's authenticity and validity by centering working class voices, and to identify relevant themes that will hopefully help clinicians better recognize and work with implicit class biases and class differences in therapy.

Confidentiality

- Your participation will be kept confidential. The researcher will be the only person who will know about your participation. The interview will take place either at the researcher's office, at your office, at a quiet public place of your choice that provides privacy, or privately via telephone or Skype/Facetime. I will be the only person who will have access to the audio recording and transcriptions, with the exception of my research advisor and one possible transcriber, who will sign a confidentiality agreement before beginning transcriptions. Your materials will be assigned with a code number to further protect confidentiality. Recordings will be destroyed after the mandated three years. They will be permanently deleted from the recording device. Furthermore, *I will disguise all identifying information that may appear in your interview responses.*

- 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. I 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 answer any question or withdraw from 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. If this is an interview and 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 May 1, 2017. After that date, your information will be part of the thesis, dissertation or final report. You have the right not to answer any single question, as well as to withdraw completely up until the date noted above.

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, Taylor Millard at tmillard@smith.edu or by telephone at (xxx) xxxxxxx. 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. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

....

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix D: Qualitative Interview Guide

Qualitative Interview Guide
Introduction (to be read to every participant prior to beginning the interview):

You are being asked to be in a research study on how perceptions classism impact experiences of the therapeutic alliance for clinicians and clients who identify with a working class background. You were selected as a possible participant because you are an adult, Masters level mental health clinician who identifies as coming from a working class background and who has engaged in psychotherapy as both a clinician and as a client. I'd like to ask you now to read over my written

consent form to make sure you understand the purpose, procedures, risks, benefits, and your rights as a participant before we continue with an interview. I do want to let you know upfront that this interview asks questions about experiences of classist oppression in your own life and therapeutic experiences and may therefore cause emotional discomfort. Please know that you are engaging in this voluntarily and you have the right to refuse any questions and/or to completely withdraw from participation at any time.

Do you have any questions about the consent form?

Once consent form is signed, proceed to interview questions and turn on the tape recorder.

I. Perceptions of Personal Social Class Identity

1. For the sake of this study, certain terms are used to convey therapeutic experiences and social class identity. What are your perceptions of the poor? Working class? Middle class? Upper class?

2. When and how did you first become aware of your social class identity?

Probing Questions:

- How do you perceive that your experience of social class identity has shifted or changed over time?
- How salient would you say your social class background was/is to your overall identity and daily experiences?
- How do you identify your social class location now?

3. How do you feel your working class background (and, as relevant, salient intersecting identities) influenced your experiences of higher education and clinical training?

4. To what extent do you believe that your graduate clinical training was class-conscious? I.e., to what extent do you feel that classism and class identity was addressed in discussion, the curriculum, etc.?

Probing:

- If not class-conscious, what did you notice was lacking in your graduate education regarding class issues in psychotherapy?
- How did you experience your graduate institution to be class-conscious and/or culturally sensitive to social class identity factors?
- To what extent did your graduate program address classism as an aspect of multicultural sensitivity or social justice in clinical work?

II. Social Class Identity as a Clinician

4. What does it mean to you to be a therapist with a working class background?
Probing questions:
   - Growing up, how did you know you were in the working class (i.e., what did you notice varied among yourself and middle or upper class people?)
   - How did your class identity influence your career choice, if at all?
   - How do you perceive that your class background affects your clinical practice?

5. When you reflect on your experiences as a clinician from a working class background, what times stand out when you noticed class differences between yourself and a client(s)?

Probing questions:

   - What did you notice?
   - What did you notice in the transference/countertransference matrix?
   - How did you respond to those differences?
   - How do you think those differences may have impacted your therapeutic working alliance with that/those client(s)?

6. Based on your own experiences, perceptions, and professional observations, what differences, if any, have you noticed in how you work with working class and poor clients as compared to your colleagues and peers who hold titles of class privilege?

Probing:

   - How do you perceive that implicit class biases have impacted the ability of middle class and wealthy clinicians to develop a strong working alliance with poor and working class clients? How so or how not so?

III. How Social Class Impacts Therapeutic Alliance as Clinician

7. When working with working class or poor clients, how have you responded clinically to possible social class identity issues (including power, privilege, and oppression) in the therapeutic alliance?
Probing:
   - How do you think your working class background has impacted your navigation of class differences and dynamics of power and oppression between yourself and your clients?

8. What does the term "therapeutic alliance" mean to you in your work?

9. How have you seen classism impact the development of strong therapeutic working alliances in your work as a clinician?

Probing questions:

- How have you responded clinically to class-based differences and classism in the therapeutic dyad?
- How has your own sociocultural location influenced your clinical judgments and interventions when working with sociocultural difference and sameness?

IV. Influences of Social Class on Experiences As A Client

10.   When you reflect on your experiences as a working class client in therapy, what incidences stand out when you noticed class differences and/or similarities between yourself and your therapist(s)?

Probing:

- When did you first notice social class differences/similarities between yourself and your clinician? What did you notice? What did you think about what you noticed? How did you respond to what you noticed?
- What social class location do you believe your clinician(s) belong/belonged to?

11.   How have your perceptions of your therapist(s)' social class location(s) influenced your perception of the therapist and your working alliance as a client in therapy?

12.   How do you feel classism has impacted the development of a strong therapeutic working alliance in your experiences as a client? How so?

Probing:

- When, if ever, have you felt judged, shamed, discriminated against, or otherwise impacted by classism as perpetrated by your therapist(s)? What happened and what was that experience like?

13.   To what extent has/have your therapist(s) been attuned to and addressed social class and classism in sessions? Probing:
- What did your therapist(s) do or not do to express acknowledgment of and attunement to relevant class issues for you as a client?
- How did those actions or inactions impact your experience of the therapeutic alliance with your clinician(s)? What was helpful? What was unhelpful?

14.   What other perceptions of sociocultural difference (i.e. race, gender, ability, etc.) between yourself and the therapist may have contributed to your response and to your experience?

V. Concluding Questions

15.   Given your experiences as both a client and a clinician, what do you perceive to be markers of a strong therapeutic alliance as it relates to social class, classism, implicit class bias, and other relevant intersecting social identities?

16.   What do you think other clinicians, educators, supervisors, and researchers need to know to better understand classism in therapy and to better serve the needs of working class and poor clients?

Probing:
- What do they need to better understand about working with students or colleagues from working class or poor backgrounds?
- How do you think understanding this may expand the mental health field's degree of class-consciousness in the future?

17.   Is there anything else you'd like to say about this topic that I haven't asked and/or we haven't yet covered?