Recognizing Social Class in the Psychotherapy Relationship: A Grounded Theory Exploration of Low-Income Clients

Mindi N. Thompson, Odessa D. Cole, and Rachel S. Nitzarim
University of Wisconsin—Madison

The process of psychotherapy among 16 low-income clients was explored using grounded theory (Charmaz, 2006; Glaser & Strauss, 1967) in order to understand and identify their unique experiences and needs. Semistructured interviews were conducted with 12 women and 4 men who had attended at least 6 sessions of psychotherapy within 6 months of the interview. Our grounded theory that evolved depicted a tapestry of the dynamic process by which low-income clients experience social class within psychotherapy. Specific therapist behaviors that contribute to more and less positive experiences emerged from the data and pointed to the importance of acknowledging social class within the therapy room. The significance of therapists enhancing the 50-min hour via advocacy and meaningful moments within and outside of the therapy room was highlighted among all participants. Implications for practice with low-income clients and directions for future research are provided.

Keywords: low income, socioeconomic status, social class, psychotherapy

Income and wealth disparities are increasingly prevalent within the United States such that social class affects individuals from all racial, ethnic, gender, and religious backgrounds (American Psychological Association, 2007). Social class and socioeconomic status (SES) have important implications for physical and mental health (e.g., Adler et al., 1994). Research has demonstrated that low levels of social class, income, and education are related to increased anxiety, depression, stress, and substance dependence (e.g., Diala, Muntaner, & Walrath, 2004; Lynch, Kaplan, & Salonen, 1997; Poulton et al., 2002). Yet, low-income individuals are less likely to seek or attain mental health services, are more likely to receive a lower quality of care, and are underrepresented in psychotherapy research (e.g., Goodman, Smyth, & Banyard, 2010; Isaacs & Schroeder, 2004; Levy & O’Hara, 2010; Pope & Arthur, 2009).

Aside from a few notable exceptions (i.e., Balfourth, 2009; Chalifoux, 1996; Cohen et al., 2006; Falconnier, 2009; Falconnier & Elkin, 2008; Ware, Tugenberg, & Dickey, 2004), social class has been relatively ignored within psychotherapy research. In their examination of social class within the mental health treatment literature, Pope and Arthur (2009) concluded that relatively little is known about the subjective experiences of low-income clients in therapy or the factors that contribute to positive outcomes. As such, we used grounded theory methodology to explore the psychotherapy experiences of a sample of low-income clients.

Client and Counselor Variables Within Psychotherapy

Clients’ perceptions of their counselor are formed as early as the first session and have impacts on willingness to continue in counseling, the formation of the working alliance, and subsequent perceptions of therapeutic effectiveness (e.g., Paulson, Truscott, & Stuart, 1999; Wade & Bernstein, 1991). In particular, the development of a strong working relationship has been highlighted as critical to facilitating positive psychotherapy experiences (e.g., Bordin, 1994; Knox, 2008) and is a central component of a common factors approach to treatment (Wampold, 2001; Warwar & Greenberg, 2000).

Client and therapist characteristics also have been demonstrated to affect the development of the working relationship and alliance. Results from the client–therapist matching literature are mixed with regard to the importance of matching clients and therapists on the basis of specific demographic characteristics. For example, results from a recent meta-analysis on racial/ethnic matching of clients and therapists demonstrated that clients moderately prefer therapists of their own race/ethnicity and perceive therapists of their own race/ethnicity somewhat more positively, yet they received almost no additional increase in beneficial treatment outcome based on matching (Cabral & Smith, 2011). Despite mixed findings, results from the matching literature have highlighted the relevance of therapist and client characteristics to psychotherapy processes (e.g., Atkinson & Lowe, 1995). Characteristics such as race and ethnicity, age, attitudes and values, education, and personality are factors that clients notice and perceive to have an impact on therapy. For example, clients’ perceptions of their counselors influence their willingness to self-disclose in session (Qureshi, 2007; Ward, 2005) and the perceived ability of counselors to meet their needs (Pope-Davis et al., 2002). Several authors...
(e.g., Lott, 2002; Smith, Mao, Perkins, & Ampuero, 2011; Sue & Lam, 2002) have argued that clients’ and therapists’ social class experiences and perceptions may similarly affect the formation of the working relationship and subsequent alliance.

Transference and countertransference within the therapeutic relationship also are important to the development of the working relationship (e.g., Comas-Díaz & Jacobsen, 1991; Gelso & Mohr, 2001; Holmes, 2006; Ward, 2005). Attending to transference and developing open communication regarding identity and status differences between the therapist and the client contribute to the working alliance and facilitate further session depth (e.g., Haglend et al., 2011; Marmarosh et al., 2009; Qureshi, 2007). Not surprisingly, research has indicated that clients’ perceptions of—and transference onto—their counselor influence perceived satisfaction with therapy (e.g., Reis & Brown, 1999). In 2001, Gelso and Mohr theorized that race/ethnicity and sexual orientation affect the transference/countertransference relationship and subsequent working alliance. These authors introduced the concepts of “cultural transference and countertransference” (p. 59) and argued that within-therapist and within-patient factors influence the effect of these demographic characteristics. Social class may represent one such within-person factor. Although this literature has not yet explicitly centralized social class as a contextual variable related to transference and countertransference, Kim and Cardemil (2012) recently suggested the importance of attending to status differences and projections related to social class in session.

Social Class and Psychotherapy

Social class and SES are included as cultural variables relevant to multicultural counseling competence (e.g., American Psychological Association, 2007; Sue & Lam, 2002; Sue & Sue, 1999) and are presumed to affect the working alliance and clients’ therapy experiences (e.g., Carter, 1991). Yet social class and SES have been mostly ignored within the psychotherapy literature, and little is known about social class differences or similarities between clients and their counselors (e.g., Levy & O’Hara, 2010; Lott, 2002; Liu, 2002; Sue & Lam, 2002). Indeed, some authors (e.g., Smith, 2005) have lamented that the most solidified finding with regard to this population is that low-income clients have higher attrition rates than do middle- to upper income clients.

More recent studies have illustrated that clients from lower SES backgrounds have decreased improvement rates in therapy compared with clients from higher SES backgrounds (Cohen et al., 2006; Falconnier, 2009). The reasons for these decreased outcomes, however, remain unclear. Some scholars have proposed that poorer outcomes are a result of psychotherapists’ biases and stereotypes toward individuals who are not middle- to upper middle class (e.g., Ballinger & Wright, 2007; Smith, Mao, Perkins, & Ampuero, 2011; Sue & Lam, 2002). These attitudes were prevalent within the psychotherapy literature of the 1970s, in which low income clients were described as “extrospective rather than introspective, . . . relatively unimaginative and less given to fantasy” (Gould, 1967, p. 79), and as having “lower estimated intelligence” than their middle- to upper income counterparts (Brill & Storrow, 1960, p. 343). Recent empirical findings (Smith et al., 2011) have demonstrated that counselors in training had less favorable impressions regarding future work with a hypothetical client who was portrayed as working class than with a hypothetical client portrayed as middle class or wealthy.

Others have argued that the grounding of traditional psychotherapy in “White middle-class” conceptualizations of mental health has contributed to its limited ability to meet the needs of clients who are not middle- to upper class (Sue, 1990; Sue & Sue, 1999). Practitioners and scholars have suggested that traditional forms of psychotherapy may not be relevant or useful to low-income, poor, or working-class clients (Chalifoux, 1996; Dumont, 1992; Hillerbrand, 1988; McCarthy, Reese, Schueneman, & Reese, 1991; Parnell & Vanderkloot, 1994). In their recent introduction to a special section about low-income women in Journal of Orthopsychiatry, Goodman et al. (2010) asserted that traditional mental health interventions do not sufficiently address the complex needs of low-income women due to the prevalence of specific poverty-related characteristics (i.e., social isolation, stress, and powerlessness) in their lives.

Although this renewed attention to low-income clients’ psychotherapy experiences is to be commended, we still know relatively little about their subjective treatment experiences (Ballinger & Wright, 2007; Chalifoux, 1996; Levy & O’Hara, 2010; Spong & Hollanders, 2003). A few qualitative investigations represent notable exceptions. First, Ware et al. (2004) examined a range of psychiatric service experiences (psychiatrists, case managers, and psychologists) for 51 low-income individuals with schizophrenia. Results illustrated the benefits that patients received from “non-clinical interactions” (p. 557), which included receiving something in therapy that the client perceived as “extra” such as a cup of coffee, a joke, or a small piece of personal information about the therapist.

Chalifoux (1996) interviewed six White working-class women regarding their experiences of social class identity within psychotherapy. Participants expressed a sense of unease regarding discussion of their values and lifestyle with their therapist because the therapist was not comfortable discussing these matters, which was perceived to impede their ability to connect with the therapist. Relatedly, Balmforth (2009) interviewed seven White British counselors or counseling trainees living in England who identified as working class and reported previous attendance in counseling with a middle-class counselor (one participant identified as middle class and had a working-class counselor). Findings revealed a belief among the participants that their therapists were unable to adequately identify and empathize with them because of the evident differences in social class. The participants lamented that a stronger therapeutic relationship could not have been developed.

Statement of Purpose

The purpose of our study was to explore psychotherapy experiences among a diverse group of clients who self-identified as low income or poor. We aimed to extend the work of previous authors (e.g., Balmforth, 2009; Chalifoux, 1996; Falconnier, 2009; Ware et al., 2004) by examining the subjective psychotherapy experiences in an effort to increase our understanding of what it is like to be a low-income person in counseling. Given what we know of the high attrition rates among low-income clients (Organista, Muñoz, & González, 1994; Wierzbicki & Pekarik, 1993), we intentionally restricted our sample to clients who reported that they have attended psychotherapy for at least six sessions in order to learn
from clients who had more extensive experiences that would allow for a more nuanced reflection. A grounded theory (GT; Fassinger, 2005; Glaser & Strauss, 1967; Strauss & Corbin, 1990) approach using a constructivist lens (Charmaz, 2000) was selected in order to facilitate the development of a broader knowledge base, given GT’s potential to capture the complexities of subjective experiences for diverse and underresearched populations (e.g., Atkinson & Wampold, 1993; Helms, 1989; Hoshmand, 1989; Sue, 1999).

Method

Rationale for a Grounded Theory Method

Grounded theory offers a format for examining the lived experiences of participants, including their values, beliefs, feelings, assumptions, and ideologies (Charmaz, 2006; Creswell, 2007; Fassinger, 2005; Glaser & Strauss, 1967; Ponterotto, 2002; Strauss & Corbin, 1998). This approach also allows participants to take the story where they believe is important through the use of open-ended interviews. The flexibility within this data collection process thereby gives the participant command of the research. Through this process, new concepts and beliefs about psychotherapy with low-income individuals were uncovered.

Participants

Sixteen self-identified low-income individuals who reported that they had attended at least six sessions of individual outpatient psychotherapy within the past 6 months participated in this study. Most participants attended therapy either weekly or biweekly for 3 months or more (sometimes treatment occurred over many years, often with some pauses), and most participants had seen at least two therapists over the course of their treatment. Respondents most often paid for therapy through their Social Security Disability Insurance (SSDI); however, a handful of participants paid out of pocket at reduced-fee clinics. One participant worked with a therapist who had transitioned to private practice during treatment at a significantly reduced fee.

Twelve of the 16 participants were women, and four were men; participants ranged in age from 31 to 60 years. Eleven participants self-identified as White, one as Latina, two as African American, one as Black, and one as White and Native American. Four participants reported current annual household incomes of less than $30,000, eight reported less than $20,000, and four reported less than $10,000. Participants used the following labels to describe their social class category: “lower middle class” (5), “middle class” (1), “lower class” (6), “working poor” (1), “working class” (1), “poor” (1), and “working” (1). Two participants reported working full time, and three reported working part time. Two participants identified as divorced, eight as single, five as partnered or married, and one as widowed. One participant identified as a gay man, one as a lesbian woman, three as bisexual, and 10 as straight. Nine reported receiving some form of government assistance, and one was in the process of applying for assistance. Pseudonyms are used throughout in order to protect confidentiality.

Researchers

The study was conducted in a collaborative format in which all three researchers were involved in each component of the project. Given the focus within GT of researchers as instruments (Glaser & Strauss, 1967), potential researcher bias was considered. The list of these biases included (a) knowledge of the therapeutic process and a value for the importance of common factors in the therapist–client relationship, (b) cultural assumptions and biases regarding low-income clients, (c) personal SES identity and awareness related to this identity as described below, and (d) criticisms of the psychotherapy literature for ignoring issues related to poverty and social class as a unique cultural identity.

The first author is a 33-year-old assistant professor at a large midwestern university. Growing up in a lower middle-class family situated within a more privileged community, she oscillated between being surrounded at school by those from more privileged backgrounds and at “home” by her extended family members who were primarily lower class. The second researcher is a White 30-year-old, third-year doctoral student who grew up in a low-income urban center with a single mother until adolescence, at which point she moved to a homogeneous middle-class suburb. The third author is a 25-year-old, second-year doctoral student who grew up in a middle-class home. As a child, she attended a private Jewish school where most of her peers were middle-upper to upper class. Her father was often unemployed or between jobs, and thus she experienced feeling different or less privileged than her peers. Throughout data analysis, each researcher was involved in the local political movement related to employee unions and decreased medical and mental health service to low-income individuals in this region.

Procedure

Participants were recruited via flyers that were posted in mental health agencies and offices. According to 2010 census data, approximately 5.8% of families and 15% of the population in this city are considered to live below the poverty line, and 83.96% are European American. Recruitment flyers indicated that the study sought “working class or lower class” individuals who had been in therapy for at least six sessions within the past 6 months. These inclusion criteria were selected on the basis of a desire to recruit a group of participants who had recent and substantive psychotherapy experiences. We purposefully included labels that represent a range of income levels, given the tendency for individuals to lack a clear understanding of their social class category (i.e., the majority of individuals in the United States identify as middle class; Nesbit, 2006). Interested individuals could choose to take a tab from a flyer that contained the first author’s name and contact information. These participants contacted the first author, who conducted a brief (i.e., 10–15 min) telephone screening to determine whether the person met criteria for the study. Participants were asked to describe their self-identified social class category, their monthly household income, and the number of individuals supported by this income. In total, 20 individuals contacted the first author to express interest in the study. All participants except for one who completed the screening interview met criteria for the study (this individual reported that she was upper middle class and lower class in our recruitment poster, we advise future researchers to avoid the use of this term, given its perception as being denigrating to low-income individuals.

1 Although we used the term lower class in our recruitment poster, we
reported a family income of $100,000-plus). Sixteen of the 19 individuals completed an in-person interview in a private room housed on a university campus with one member of the research team. Three of the individuals did not show for their scheduled interviews, and in the effort to reschedule, one stated that he was unable to participate due to time constraints, and two were unable to be reached to reschedule.

At the interview, participants were provided a $25 gift card to a local “big box” store, reviewed the informed consent and demographic questionnaire with the researcher aloud, and completed the semistructured interview. At the conclusion of the interview, participants were offered a handout containing relevant community resources and indicated their willingness to be contacted in the future (all participants agreed). Interviews lasted 60–90 min and were completed between August 2010 and March 2011.

**Interview protocol.** A core set of open-ended questions was developed at the outset of the study to guide data collection and was based on the literature reviewed previously. Consistent with GT (Charmaz, 2006), the interview questions and probes evolved as data emerged, and the need for clarification of new subject matter became relevant after coding was completed following each interview (see Appendix for a final list of all questions). The three authors comprised the interviewers for this study, and each had previously engaged in qualitative research projects, attended trainings, and/or completed classes in qualitative methodology. The first author, a licensed psychologist, supervised all interviews. At the conclusion of each interview, the interviewer completed field notes indicating nonverbal observations during the interview, potential biases that emerged, perceived rapport with the participant, and other significant interview characteristics (Creswell, 2007). Interviews were transcribed verbatim.

**Data analysis.** Data analysis was conducted via the methods described by Glaser and Strauss (1967) and later expanded by Charmaz (2007). The interviews were coded in three phases, which led to the emergence of core themes through an interconnected storyline. The initial phase (open coding) occurred following the completion of each interview and included a low level of abstraction in which all members of the research team named concepts very close to the interviewee’s own words. Interviews were coded using a line-by-line level of analysis in which individual responses were coded into more concise statements. Each author independently completed the open-coding process and then came together to share her codes, reflect upon implicit meanings of the emerging statements, and examine how the units of meaning were similar or different from one another.

In the axial phase, the line-by-line codes were placed into higher order categories (Glaser & Strauss, 1967). Data were grouped and arranged on the basis of parallels and theoretical connections across transcripts. We remained open to new findings as they emerged across all 16 transcripts, avoided forcing data into larger categories (as recommended by Glaser, 1978), and included all opinions rather than debating to consensus. According to GT methodology, the first two phases of coding were completed after the interviews were transcribed so that the line-by-line coding from prior interviews was used to focus the axial coding for subsequent interviews. This process culminated in the construction of 70 distinct codes across the 16 transcripts.

The third phase (selective coding) represents the highest level of data abstraction and involves synthesizing and integrating the axial codes so that they can be incorporated into theory (Glaser & Strauss, 1967). During this phase, we considered the list of codes in its entirety, revisited participants’ incidents within codes, and began extrapolating the main themes that brought together the relationships and connections within the data. This process of selective coding began when it was apparent that new and unique themes within the data were no longer emerging (which coincided with the time when the final three transcripts were being coded). Next, we independently grouped together the 70 codes into themes that captured the essence of the codes and came together to share findings and to identify the emergent theoretical model. Throughout each phase of the coding process, we moved toward higher points of abstraction and nearer to the development of a theory, and analysis shifted between levels of abstraction. This flexibility is especially important when one is considering whether theoretical saturation has been met (Charmaz, 2006; Strauss & Corbin, 1998).

Several data analysis techniques and checks were utilized to maintain quality and rigor. First, we individually coded each interview transcript. The transcripts were then reviewed until the team agreed upon, or added, codes to satisfy all emerging ideas. Second, we met with an expert qualitative researcher, who acted as an auditor, three times during the coding and analysis process. The auditor was used to limit or control for bias, offer “investigator triangulation” (Denzin & Lincoln, 2008, p. 17), and put forward alternative perspectives on the data analysis. Our auditor reviewed transcripts, interview questions, and emerging themes, and presented feedback to us in order to represent an impartial analysis of the data. The auditor affirmed that the emerging themes accurately represented the transcript data. After discussions, revisiting transcripts, and reflection of the emerging findings, there were no issues of discrepancy between the auditor and the researchers. Third, we attempted to use member checks in order to enhance the reliability of data. All participants received a copy of the results and had an opportunity to offer feedback or suggestions to the researchers. No participant contacted the researchers with feedback regarding the results. Finally, the research team maintained a detailed audit trail that included meeting notes and discussions about biases and implications. Field notes were referenced during data analysis to create a trustworthy and authentic theoretical framework (Lincoln & Guba, 1985).

**Results**

The 16 low-income participants represented demographically varied backgrounds and described a range of presenting concerns related to their diagnoses. Despite their different life experiences and identities, all 16 highlighted the salience of social class as a lens through which their counseling experiences have been shaped. The recognition of economic inequity differed among participants, but all shared a sense of being “lower class” compared with their therapist. We draw upon data from participant transcripts to describe the themes that emerged throughout our discussion of the results. These themes are then integrated into the grounded theory that emerged from the data (see Figure 1).

We begin this section with an overview of Matthew’s story because this particular respondent reveals a narrative that explicates the experiences of all participants in some fashion. He shared his account with deep emotion and eloquence, offering substantial
insight into what it means to be a low-income client. Matthew has known poverty throughout his life, and it has acutely affected his experience in the world. He reported living in a “tar-paper shack” and described a childhood and adolescence that were stained with painful difficulties and loss. He cited the complex challenges faced by his family as a risk factor that affected his own mental health: “The death of my brother, my dad being an alcoholic, our social class, you know, just life being the way that it was pretty much [led to] a propensity to drink and lose myself.” Matthew described his mental health struggles (i.e., coping with bipolar disorder and untreated manic episodes that led to drug- and alcohol-related offenses) as experiences that have colored his perception of the world and shaped his identity. Despite these challenges, Matthew holds onto hope that life can be good and that the world includes caring people. He described the critical role that compassionate and dedicated mental health providers have, in part, played in initiating and sustaining this hope. Matthew was tearful as he expressed his appreciation for his experiences in counseling:

I am really grateful that society really does put an importance on what I call lower or poor class people getting some kind of treatment and help whether we the have money to afford it or not . . . Where would we be [without it]? I would be dead, I know that, or committing some horrendous crimes to get drugs or alcohol. Thank God I never had to do that. But it is only because of interventions that I got past that point.

Our findings include stories like Matthew’s that give voice to low-income individuals who hold little power in our society and who have been rarely heard within psychotherapy research. The results also illuminate examples of therapists who have worked beyond the bounds of traditional psychotherapy to aid clients who have complex and difficult personal histories.

A Grounded Theory Model of Psychotherapy With Low-Income Clients

A grounded theory of the dynamic processes by which social class affects the psychotherapy experiences of low-income clients emerged from our data and is depicted in Figure 1. All participants noted the salience of social class in the therapy room, which was perceived to affect their experiences in psychotherapy. Most participants described positive experiences in psychotherapy (i.e., feelings of safety and trust within the therapeutic relationship, perceived positive therapy outcomes, and connection to their therapist). Therapists’ explicit acknowledgment of social class complexities and the incorporation of social class-related content into treatment contributed to positive experiences. In contrast, social class differences contributed to less positive experiences in psychotherapy for some (i.e., feeling judged by their therapist, perceiving exacerbated power differences between the therapist and the participant, and feeling disconnected from the therapist). Specific therapist behaviors were perceived to contribute to these less positive experiences, such as failures on the part of the therapist to acknowledge social class differences, to communicate an understanding of the complexities related to being low income, and to integrate social class into treatment. All participants described an appreciation for their therapist’s willingness to enhance the traditional 50-min therapy hour. Meaningful moments and acts of advocacy by the therapist were perceived to facilitate positive experiences in therapy regardless of specific therapist behaviors. In the following sections, we describe this grounded theory using participant examples.

Social Class Is in the Therapy Room

All 16 participants described their lives in the context of being poor and highlighted their struggles to exist within a society that is stratified on the basis of income. Not surprisingly, the individual narratives varied and included examples related to their families, the neighborhoods in which they grew up, and their difficulty with classifying themselves as low income, working class, or poor. Most described “markers” of their social class status, which seemed to offer them a clearer and more concrete way of describing their social class. These markers included instability in housing and homelessness; debt, unemployment, SSDI payments, and con-
cerns about meeting basic needs; mental illness; divorce or death in the family; early and unplanned pregnancy; and limited ability to own a home, take vacations, and have pets.

Participants described the impact of their social class and life experiences on their ability to access mental health treatment and their subsequent experiences in psychotherapy. They spoke in great detail about the ways that these markers of social class and related struggles were perceived to be in stark contrast to those of their therapists and acknowledged making some assumptions about their therapist’s social class status as being higher than their own. These assumptions stemmed from a range of indicators, including the therapist’s self-disclosures about his or her family (e.g., therapist’s partner, including knowing the partner’s occupation) and knowledge of the therapist’s neighborhood, work schedule, billing, and lifestyle. In describing his therapist, Miles, an African American college student from a single-parent family who works two jobs in addition to attending school full time, noted: “It’s not like [my therapist] is hurting. [pause] Honestly I don’t know. She might not have money. But she got a job, she got a relationship, she owns a house, and I feel like she made it.”

One of the more concrete and universal observations of social class cues involved material items and perceptions of wealth based on appearance. Many participants noted their therapist’s physical appearance or levels of physical attractiveness (e.g., clothes, jewelry, hairstyle, hair coloring, exuding confidence/beauty) as well as the décor that a therapist chooses to display in her or his office (e.g., vacation photos, art, sculptures, golf clubs, photos of yachts, pets). Betty, a lesbian woman whose only source of income is SSDI for her self-described “mental problems” explained that she “fell into poverty” after the end of a 17.5-year relationship in which she and her partner worked full time and lived a “middle- to upper middle-class lifestyle.” She reported that she has been unable to maintain employment following the dissolution of this relationship. Her experience of a downward social class shift contributes to her keen awareness of distinctions between middle-class and low-income lifestyles as revealed in statements about her therapist such as “I started getting statements from Medicare showing what was billed, how much she billed for a session, and I about choked.”

Feelings of “jealousy” surfaced as a common theme in reaction to these noted social class differences between participants and their therapist. Olivia, a single White woman who lives on the $10,000 a year she receives from SSDI as a result of her diagnosis of schizophrenia, said,

[My therapist] is so smart, he’s just so smart. I am a little jealous, I’ll be honest. I know that he makes good money. They deserve it. They work hard. To know and learn about each client that comes in. And he’s got mega clients. There is some envy there. [pause] He’ll go on vacation, and I love to travel. I haven’t been on vacation for about eight years.

Betty expressed similar feelings in this later description of her therapist: “It’s hard in terms of knowing that she has stuff that I can never have, that she can do things that I can never do. And that’s just petty jealousy, but it’s there for me, it’s real for me. . . .”

Although feelings of “jealousy” and an awareness of markers of social class were repeatedly noted among participants, they did not necessarily detract from overall psychotherapy experiences. Instead, the impact depended upon therapists’ willingness to address the differences and to acknowledge social class in the therapy room. For example, both Betty and Olivia went on to report positive experiences with their therapists and noted that their feelings of jealousy did not ultimately negatively impact the therapeutic relationship. This illustrates the complex and dynamic process in which there may be more or less informed and aware social class-related moments in therapy. It also highlights the possibility that one positive or negative occurrence does not necessarily define the therapeutic relationship.

**Positive Client Experiences**

Most participants described positive experiences in psychotherapy. These positive experiences were attributed to their therapist’s behaviors in session that communicated that the therapist understood and cared for them despite evident differences in social class. In turn, a safe and trusting relationship was developed, feelings of connection with their therapist were highlighted, and positive outcomes ensued.

Several participants described their discomfort related to social class disparity as being lessened by their therapist’s behaviors. For some, this was represented by a sense that their therapist made genuine efforts to learn the participants’ unique story and worked to create an egalitarian relationship. Matthew described past therapists in this way: “All of them tried to be on the equal level with me. I never felt anybody using his or her position or power to try to manipulate me. I never felt inferior.” For many, an explicit acknowledgment of social class by their therapist contributed to a sense that their therapist understood the complexities related to being a low-income person.

Throughout the interviews, participants discussed basic characteristics that demonstrated that their therapist was “caring,” “compassionate,” “empathic,” “genuine,” “knowledgeable,” “relatable,” and “supportive.” Although these seemingly fit within a general common factors approach to treatment, participants cited them as evidence that their therapist understood and accepted them as a low-income individual. Indeed, several expressed appreciation for therapists who were perceived to make an “extra effort” to get to know them and to show that they care (as Natalie put it, to “know my name”). These simple behaviors were interpreted as indicative of their therapists’ sensitivity to their needs.

Participants also cited their therapist’s willingness to incorporate social class-related content into therapy as contributing to the formation of the working relationship and a sense that their therapist understood the complexities of being low income. They described their ability to express concerns related to finances, employment, disability insurance, and housing as relevant to their ability to connect with their therapist and to benefit from psychotherapy. Participants perceived these seemingly simple conversations as evidence that their therapist possessed awareness and understanding of their life experiences and needs.

Stress and anxiety related to finances were prevalent themes that emerged from the interviews and were commonly cited as connected to participants’ presenting concerns. Olivia shared a story of the connection that her therapist made between her low-income status and her self-esteem. In session, her therapist allocated time to explore the ways in which her low-income identity and her limited ability to purchase “nice” clothing affected her overall self-perception and subsequent moods. Olivia described these in-
Interventions as helping her to develop coping strategies to manage her feelings of insecurity connected to the social class stigma that she regularly experiences. Similarly, Emma, who identified her current low-income status to be a result of the cycle of divorce and single motherhood that had pervaded her family for generations, described the importance of her therapist’s willingness to discuss her economic concerns in session. She stated, “We talk about money. . . . You know, ‘How does it make you feel to be burdened by all of this? And on top of that, how do you feel emotionally?’”

Another participant, Natalie, also described the importance of conversations in session related to social class. Natalie is a self-identified White woman with a Native American father and a White mother who currently receives SSDI for her agoraphobia and anxiety diagnoses. She cited her therapist’s use of simple questions such as, “What do you want to talk about today?” or “Is there anything else you want to talk about?” as vital in alleviating her concerns about bringing topics into session that she otherwise perceived to be outside the norm (e.g., housing concerns, the impact of finances on her romantic relationship).

Angela stressed the interconnections between mental health and employment as relevant topics in therapy. She expressed gratitude for the times that her therapist allowed her space in session to discuss difficulties that she had encountered in her daughter’s mental health treatment given its impact on her own mental health and work difficulties. She shared stories of times that her therapist worked with her in session to develop coping strategies to deal with being fired from her job due to her continual need to leave work to manage her daughter’s mental health difficulties and hospitalizations.

Other participants expressed appreciation for their therapist’s willingness to integrate social class-related content into treatment goals and homework assignments. When describing the difficult period in her life during which she lost her relationship and her job, Betty reported the integral role that her therapist played in both supporting her emotionally and in assisting her in her search for low-income housing and application for SSDI. Betty was tearful as she shared,

I tended to deny that I needed to deal with it, and she [therapist] was really good about bringing me back to subject and asking me what kind of progress I’ve made towards [searching for work, the SSDI paperwork], ‘what can we do to work together to get you moving on this or that,’ or a homework assignment for the week.

Taken together, these behaviors were perceived to contribute to feelings of safety and trust within the therapy relationship, feeling connected to the therapist, and perceived positive outcomes from psychotherapy. Participants highlighted the importance of feeling respected by therapists who acknowledged their life circumstances and demonstrated social class awareness, regardless of external status differences between them within and outside of the therapy room.

Less Positive Client Experiences

In contrast, a handful of participants shared disappointing experiences related to social class with current or former therapists. These painful stories were expressed as contributing to less positive experiences in psychotherapy. Specifically, social class was perceived to impact the therapeutic process in less positive ways via particular therapist behaviors that were perceived to be dismissive of social class as a relevant factor within a participant’s life.

One of the most common and disappointing experiences described by participants was a sense that their therapist lacked awareness of social class and accordingly made no effort to acknowledge or thoughtfully address their own social class. For some, this was encapsulated by a perception that their therapist intentionally flaunted her or his wealth. This was most commonly described as therapists who displayed some of the markers of social class described previously (e.g., golf clubs, expensive art, exotic family vacation photos), with little or no effort to explicitly address social class differences or to incorporate social-class related discussions into treatment. Mark, a White bisexual/queer man, explained that his mental health concerns and poverty level increased when his wife (who provided the family’s stable income from her work as a housekeeper) died 4 years ago. Mark, who was currently in the process of applying for SSDI, angrily expressed the presence of “blatant status symbols” displayed by a former therapist that contributed to his experience of the therapist as “condescending.”

Some participants detailed their less positive experiences as stemming from a sense that their therapist was dismissive of the challenges and complexities related to being low income. For example, perceived inflexibility on the part of the therapist to schedule therapy appointments indicated evidence that the therapist did not “get it.” Angela is a single mother who reported a history of employment-related difficulties due to her need to care for her daughter who receives SSDI for her mental illness. She described a situation in which her former therapist reacted to her request to reschedule because of her inflexible work schedule and daughter’s mental health difficulties as, “You can’t make it. We can’t do this.” Angela proceeded to explain that this type of attitude was a hindrance to her ability to trust her therapist and progress in therapy. Another example offered by several participants was a perception that therapists reacted with “indifference” as they expressed feelings of desperation and hopelessness in their first session due to extremely long waiting periods that they had endured when accessing mental health treatment.

These experiences contributed to less positive perceptions of the therapist and a sense that the therapist did not “get it,” or lacked awareness, with regard to social class. This, in turn, created a wedge in participants’ perceived ability to be understood in therapy. Lydia, an African American woman who depicted a childhood that consisted of growing up in the “ghetto” surrounded by drugs, violence, and gangs discussed her belief that most people, including therapists, cannot truly understand the impact that her life experiences have had on her identity, self-esteem, and trauma symptoms. In describing these lasting effects, she stated, “That was rough for us. We weren’t born the way we are. We were raised to survive . . . and I feel like no one understands.”

The experience of these less positive therapist behaviors related to social class contributed to feelings of “judgment” and “disconnection” in the therapeutic relationship. A handful of participants described feeling stigmatized by their therapists in similar ways that they experienced stigma outside of the therapy room. Holly is a married Latina woman with two children whose ancestors were migrant workers. She thoughtfully reflected on how historical poverty is difficult to escape while also conveying a renewed sense of hope given by her new job in administration that she had begun...
at the time of the interview. Holly expressed her anger toward a society that stigmatizes those who are poor and mentally ill:

There is a huge stigma out there . . . “You must be poor for a reason because that’s a punishment for a crime you didn’t even commit.” If you’re down and out, you’re already thinking that the world hates you because for whatever reason you worked hard enough, but you still didn’t make it.

Later in the interview, Holly described the impact of this stigma within counseling in her statement: “It’s not just about money class, it’s about intelligence class. There is some intellectualism where it’s like, ‘I’m fine, and you’re not, and that’s why you’re here.’ There is a lot of judging that goes on in therapy.”

For some participants, the perception that their therapist failed to acknowledge social class and/or to express an understanding of the complexities of being low income contributed to exacerbated power differentials. A few participants expressed an acute awareness of therapists’ ability to misuse power within the context of treatment. This was described as the therapist being able to control the relationship (e.g., “She [therapist] can terminate the therapy sessions anytime she wants.”—Mark) and related to the perception that therapists have the power to make decisions that will negatively impact participants’ lives. For example, Nancy, who is the primary caretaker for her aging mother, was attending mandated counseling for her recent DUI arrest and expressed frustration with the counseling process. Due to messages in session about her legal status, Nancy believed that she must lie to her therapist about any drinking-related concerns in order to keep her license, which is her only means to bring her mother to medical appointments. Relatedly, Holly, who throughout the interview expressed the most negative reactions, described it this way: “You have to cater to them [therapists]. And jump over their hoops, because their analysis can mean taking away your kids, stopping or starting Social Security, and other stuff.”

In combination, these therapist behaviors contributed to feelings of “disconnection,” “separation,” and of being “unheard.” Kara is a White single mother who described herself as living in poverty as a result of her divorce following her pursuit of a master’s degree during which she accrued significant debt but has been unable to secure stable employment. She summed up her description of a disappointing working relationship with a former therapist whom she saw during her downward shift in social class in this way: “I felt like she was completely a class apart from me.”

Enhancing the 50-Min Therapy Hour

Throughout the interviews, participants painted a picture of a mental health treatment system that is complex, difficult to navigate, and ripe with barriers for low-income individuals. Many cited examples that contributed to their sense that the mental health system does not cater to low-income clients and, more painfully, pushes these individuals out of needed care. Examples included high fees and limited insurance coverage for sessions, a lack of low-cost or sliding-scale treatment facilities, long waiting lists, and a history of seeing a variety of therapists (e.g., therapist trainees who leave the agency at the conclusion of their training, therapists who decrease their caseload to assume administrative positions).

Participants described an acute awareness of traditional modes of therapy and were knowledgeable of the concept that there are rules of the profession that guide their therapists’ behaviors and decision-making processes. All participants communicated their respect for therapeutic boundaries (e.g., Martha stated, “We don’t cross the line. I mean, I could tell her anything about me, but I don’t expect her to disclose her life to me.”). Given this understanding and respect, participants were especially conscious of times when their therapist was perceived to go above and beyond his or her more traditional role to enhance treatment. These acts were cited as occurring both within and outside of the 50-min hour and were perceived to be specific to participants’ needs as low-income clients. These were most commonly described as meaningful moments that demonstrated expressions of care and acts of advocacy.

Several participants became tearful as they told stories of meaningful moments in which their therapist shared part of him- or herself. For some, these were described as instances in which their therapist gave them a gift as part of their work together. Martha, who expressed her spiritual values throughout the interview, cited a time when her therapist gave her “grass from the reservation” so that she could “burn it and bring good spirits to [her] home.” We also heard accounts of participants receiving a hug or pat on the back from their therapist and instances in which a therapist’s use of self-disclosure in session strengthened the bond with the client. Several participants expressed gratitude for times when their therapist joined them in their grief related to the loss of a family member or pet. Perhaps the most powerful example shared by a few participants highlighted a time when their therapist “teared up” as the participant described difficulties in session. During these moments of authenticity, participants felt deeply connected to their therapists.

The positive impact of a phone call outside of the 50-min therapy hour was one of the most common expressions of care cited by participants. Some recounted stories in which their therapist called to check in on their status (e.g., when the participant was in crisis, when the participant was waiting to be connected to a resource or agency). Sarah, who identified as a White woman who grew up in a poor family, described a history of coping with childhood verbal, physical, and sexual abuse. She shared her perception that her therapist played an integral role in her treatment and described calling her therapist on her personal home phone to contact her during a crisis. Sarah identified this as particularly relevant to her progress in therapy:

I was so numbened. I cried most of that day. And it was the only time I called her. It was Sunday. I called her house and said I couldn’t deal with it. She talked me through what I was feeling at the time . . . The next morning, she fit me in to talk about it.

Other participants shared stories of times that a phone call was perceived as a personal expression of care or concern. Natalie became tearful as she described the time when her therapist called her on the first anniversary of her father’s death to let her know that he was thinking about her on that day. These instances were appreciated and perceived as evidence of the therapist extending him- or herself beyond the norms and bounds of traditional psychotherapy.

We also heard stories of therapists advocating on a client’s behalf. For example, we learned about the integral role that therapists played in connecting participants and participant’s family members to mental health treatment and social services (e.g.,
community agencies specializing in services for low-income persons or individuals with mental health concerns, financial literacy opportunities, reduced-fee services for medication). For some, this meant that they did not have to “go on a waiting list and go through a whole bunch of hassles” (Matthew). Martha, a Black woman who characterized herself as “coming from a slave line,” put it this way: “Anytime she sees things that she can set me up with, she will always let me know. She’ll tell me about new support groups that I can use. She will do whatever it takes to keep me alive.” Many participants described their therapist as critical in facilitating the coordination of their mental health care (e.g., communicating directly with the client’s medication prescriber, making arrangements to transfer the client to a trusted colleague when the therapist left his or her position).

We repeatedly heard stories of therapists who used time in session and outside of session to support participants in their application processes (e.g., to gain approval to have a pet in their apartment, to be accepted into low-income housing, to earn a scholarship to the “Y” for exercise). Most participants who were receiving SSDI reported that their therapist provided documentation on their behalf, and several credited their therapist for their subsequent approval. Betty put it this way: “I don’t think that I would’ve gotten it [SSDI] if it hadn’t been for her and a description of what a basket case I was at the time.” Relatedly, Natalie, who reported having lost almost 100 pounds after having gastric bypass surgery in 2006, described the role that her therapist and nurse practitioner played in providing documentation that helped her to secure insurance reimbursement approval for the surgery:

> They said it would be due to my mental stability; it would help with all that. So they wrote letters stating that it would help with my mental disability. It would make me more confident, and they believed it would get me back to work. And it did.

At the time of the interview, Natalie reported that she was working part time and completing night classes in computer and clerical skills. She attributes her progress to her positive therapeutic relationships, which allowed her to manage her symptoms of agoraphobia and depression and ultimately facilitated her return to school.

Finally, participants who were paying out of pocket for treatment described their therapists’ flexibility regarding payment as representative of their advocacy related to social class. Sarah, whose low-income family of origin gave considerably to the poor and refused to accept unemployment or other “handouts” due to their religious values, described the difficult process of asking for a reduced fee in therapy. She stated: “There was always this fear that I shouldn’t be asking. And that they probably don’t think I should be asking . . . I have always been uncomfortable, but I have gotten better at it. The therapists I’ve had really handled it well.”

Others similarly discussed critical conversations with their therapist regarding their ability to remain in counseling due to their unstable financial situations. Betty put it this way:

> When I lost insurance, I was really freaked out about how I was going to pay for [therapy], and I clearly needed it. My therapist was very understanding, and was willing to work with me on it, and went to a sliding scale fee. We spent a lot of time in session talking about how stressful it was for me not to have the answers about where I could go and how I was going to deal with this on a long-term basis.

Given the myriad barriers and complexities embedded within the mental health system for low-income clients, participants expressed extreme gratitude as they passionately shared stories of times when they perceived their therapist to have enhanced the traditional 50-min therapy hour. As participants recounted these stories, it was clear that these extra efforts by the therapist evoked intense emotional reactions.

The Dynamic Process by Which Social Class is Experienced Within the Therapy Room

The grounded theory that emerged from our data depicts a dynamic and complex process by which low-income clients may experience more and less positive encounters with their therapist over the course of their treatment based on the therapist’s ability and willingness to manage or acknowledge social class within the room (see Figure 1). For example, some participants who shared less positive experiences in therapy that illustrated a potential lack of awareness about social class (i.e., feeling judged) ultimately described positive experiences in psychotherapy as a result of their therapist’s willingness to enhance the 50-min therapy hour. Likewise, some participants who shared unconstructive or even negative experiences with regard to their therapist’s behaviors (i.e., flaunting her or his social class) later depicted positive experiences in therapy because their therapist eventually addressed social class within the room. Finally, an effort to offer social class supports outside of the 50-min therapy hour was perceived to trump most other experiences as a vital relationship-building device, which led to self-reported improvements in mental health.

Discussion

The findings provide a glimpse into the process of psychotherapy for a population that has been relatively ignored as a specific and identifiable cultural group within the literature. The grounded theory presented above is based on the experiences of 16 low-income individuals who had attended psychotherapy for at least six sessions and elicits the dynamic and fluid effects of social class on psychotherapy processes. Social class was highlighted as a contextual characteristic that is present within the therapy room, impacts the therapeutic process, and contributes to the overall experience of psychotherapy among low-income clients. The emergent theory also emphasizes the benefits that participants ascribed to their perception of their therapist’s willingness to enhance the traditional 50-min therapy hour through meaningful moments and acts of advocacy.

A variety of markers of social class differences between participants and their therapists emerged and elicited a range of emotional reactions. Participants highlighted these differences as affecting their overall experiences in psychotherapy. This finding is consistent with prior research that has demonstrated that clients’ perceptions of their counselors develop early and have an impact on therapy’s effectiveness and the formation of the working alliance (e.g., Gelso & Mohr, 2001; Paulson et al., 1999; Wade & Bernstein, 1991) as well as with scholars who have argued that client and therapist perceptions of social class affect the therapeutic relationship (e.g., Smith et al., 2011; Sue & Lam, 2002).

The extent to which social class differences were perceived to affect experiences was related to the degree to which the partici-
pants perceived their therapist to address social class within the context of treatment. Acknowledgment of social class was described as occurring via a variety of mechanisms, including conversations regarding social class differences between therapists and clients, discussions about the presence of social class in the therapy room, explicit integration of social class-related content and interventions into treatment, and mutual understanding and awareness regarding the complexities faced by low-income clients. As such, our findings reiterate Goodman et al.’s (2010) suggestion that mental health treatment with low-income clients needs to specifically address social class-related complexities in session.

The failure of current or former therapists to acknowledge social class differences, to demonstrate an understanding of the complexities related to being low income, and to incorporate social class into treatment contributed to participants’ less positive experiences within the therapy room. This suggests a potential lack of awareness about social class among the therapists as a factor that has an impact on therapy. Consistent with results from previous research that have demonstrated the importance of addressing status differences and attending to countertransference in session (e.g., Balmforth, 2009; Chalioux, 1996; Gelso & Mohr, 2001; Holgland et al., 2011; Kim & Cardenil, 2012; Marmerosh et al., 2009; Qureshi, 2007), participants uniformly viewed the incorporation of social class-related content into treatment positively.

Our data highlighted the dynamic nature of the process by which participants experience social class in relation to their psychotherapy experiences. Although social class disparities were apparent to all participants, clients and therapists still formed effective working relationships, and participants described positive experiences. Aside from the few stories of therapists who were perceived to intentionally flaunt their social class or entirely ignore the presence of social class in the therapy room, the fact that differences existed did not, in and of itself, contribute to negative outcomes. Indeed, these perceived disparities were not viewed as detrimental even among participants who described intense emotional reactions to the social class differences between themselves and their therapist. Although preliminary, these results seem to suggest that client–therapist matching based specifically on social class may not be absolutely necessary in order to facilitate positive psychotherapy experiences among low-income clients. This is consistent with results from a meta-analysis of 53 studies indicating that racial/ethnic therapist–client matching had almost no effect on client outcomes from therapy (Cabral & Smith, 2011). Our data may also indicate that when there are breaks in communication or discomfort around the topic of social class, repair can ensue through recognition of the issue at a later point in therapy.

Perhaps most important, therapists’ willingness to extend their “traditional” role by enhancing the 50-min hour was repeatedly highlighted for its contribution to positive treatment experiences and outcomes as it illustrated an awareness of the needs of their low-income clients. The need for flexibility, support, and advocacy from their therapist was a theme that surfaced for all participants. Acts of alliance or relationship building have long been considered to be important elements of therapy (e.g., Wampold, 2001), and these acts were perceived to enhance the development of the working relationship. Acts of alliance or advocacy may be particularly critical for low-income clients who may not readily have access to extended social and community networks (e.g., Wolf, 2007).

Acts of advocacy or alliance were cited as key factors that contributed to integrated care. These data suggest that connecting a client with a support group, acting as a liaison in the client’s efforts to obtain important life essentials such as affordable housing or SSDI, and demonstrating a willingness to go above and beyond one’s traditional role in order to express care and concern for clients may contribute to positive treatment experiences and outcomes. Among participants, these acts served as motivating factors for change that significantly affected their perception of improved life experiences. At times, they acted as buffers that mitigated the otherwise deleterious effects of some of the less positive therapist behaviors. Our data, therefore, confirm the suggestions offered by others (e.g., Goodman et al., 2010; Kim & Cardemil, 2012; Ware et al., 2004) that therapists need to treat the whole person within the context of the system within which the client exists rather than to focus exclusively on decreasing mental health symptoms.

**Limitations and Directions for Future Research**

These findings should be considered in light of several limitations. Although we used a thematic analysis shaped by the views of 16 participants, the extent to which these findings can be attributed to all low-income clients is unknown. All participants were recruited from the same midsize midwestern city, which limits our ability to generalize the findings to other geographic regions with a different cultural composition (e.g., racial/ethnic, rural versus urban). In addition, a relatively heterogeneous group (e.g., age, gender identity, sexual orientation, race/ethnicity, disability status) comprised our sample, which points to both a strength and a potential limitation of our findings. Future research is needed in order to tease apart more closely the impact of intersecting cultural identities (e.g., low-income lesbian women or low-income Filipino American men) on psychotherapy experiences.

Our sample was also restricted by recruitment decisions. The fact that all participants highlighted the salience of social class may be a reflection of their being primed by our recruitment flyer or interview questions. Because we were interested in enrolling participants who had recent and robust counseling experiences, we specified that participants must have attended psychotherapy for at least six sessions within the past 6 months. These selection criteria excluded individuals who discontinued therapy before completing six sessions. Previous research has demonstrated that up to 50% of clients drop out of therapy before the eighth session (e.g., Lambert & Ogles, 2004) and that low-income clients are noted to have particularly high dropout rates (e.g., Organista et al., 1994). Given these findings, it seems likely that our recruitment strategies deterred us from gathering data from individuals who had intensely negative experiences in counseling that subsequently resulted in termination prior to a sixth session. It is, however, noteworthy that a handful of clients had terminated with past therapists due to off-putting experiences in the first few sessions. Future research that specifically explores factors that hinder low-income individuals from persisting in psychotherapy and research that assesses the mental health treatment needs of low-income individuals who have not attended psychotherapy are necessary.

Although participants in our study attended therapy at four different treatment centers, most reported that they received ser-
sives at a community mental health center that caters to low-income clients. Because of clinic restrictions, therapist encouragement, and client interest, our sample does not fully represent client experiences in private practices (one private practice-based participant did interview with us) or health insurance-based clinics or hospitals. As such, future research may benefit from the inclusion of individuals who have received treatment in a wider variety of settings. This research may also provide a more nuanced perspective of the role of session fees on psychotherapy access and experiences.

Finally, most participants reported significant mental health concerns—although we did not specifically ask participants to report their diagnosis, we did not restrict our sample on the basis of diagnostic criteria or the severity of mental health symptoms reported by participants. Most described mental health diagnoses such as bipolar disorder, schizophrenia, chronic major depressive disorder, and symptoms of trauma (e.g., persistent paranoia, mental health-related hospitalization, witnessing the murder of a parent, life-threatening cutting or suicide attempts, extensive alcohol and drug addictions). The majority of participants were receiving SSDI on the basis of their mental health diagnosis. There may be a variety of reasons for this finding that point to potential directions for future research. For example, it seems possible that low-income individuals are able to access mental health treatment only if their symptoms are significant enough to warrant SSDI or some other assistance that will cover the costs of their care. Alternatively, low-income individuals who are employed and who have less severe diagnoses may not have participated in our research given the multiple demands on their time (e.g., inflexible work schedules, transportation difficulties, child or other family care responsibilities). Research is needed in order to more fully capture psychotherapy experiences among individuals who are low income or working class and employed as well as to examine the extent to which low-income individuals without significant mental health diagnoses are able to access care.

Implications for Practice

Our findings highlight the need for therapists to be aware of experiences that may be common to low-income clients while also attending to the subjective personal account that each client brings into therapy. Consistent with Fischer, Jome, and Atkinson’s (1998) extension of a common factors approach to psychotherapy as the “skeleton” upon which multicultural awareness and knowledge are the “flesh” (p. 540), we suggest that clinicians consider social class knowledge and awareness as part of the “flesh” relevant to treatment. Because social class is a cultural identity that cuts across diverse phenotypes, gender expressions, sexual orientations, and religions (Aries & Seider, 2007), it is likely that all clinicians will work with a low-income client at some point in their career. We suggest that trainees and professionals attend to social class as a component of multicultural counseling regardless their intended place of employment.

We encourage clinicians to increase knowledge and awareness about social class as a specific cultural identity. For example, our results revealed the power that language can have in communicating with clients from diverse income backgrounds. Participants repeatedly cited the detrimental impacts of societal messages and labels that others (including some therapists) ascribe to low income individuals (e.g., “lazy,” “dumb,” or “responsible for” their income status). We echo the sentiment of others (e.g., Smith, 2009) who have called for therapists and trainees to increase their awareness of their own biases and assumptions toward low-income individuals and challenge practitioners to embrace more empowering language.

Consistent with previous findings (Balmforth, 2009; Chalifoux, 1996), many participants noted that social class differences between themselves and their therapist were, unfortunately, not made explicit within the therapeutic relationship. Social class-related behaviors and cues were instead left up to the interpretation of the client. Clinicians who choose to create a space in their office that is comfortable and inviting by incorporating personal items (e.g., photos of family members or vacations, artwork, golf clubs) are encouraged to also be cognizant of the potential stimulus value of these items for clients. Our data suggest that it is likely that clients will have emotional reactions to social class disparities. We recommend that clinicians consider social class differences as sources of transference and countertransference to be addressed in the room, as suggested by others (e.g., Holmes, 2006; Ward, 2005). Consistent with Gelso and Mohr’s (2001) argument that race, ethnicity, and sexual orientation can act as a “lightning rod for transference” (p. 64), a therapist’s perceived social class may invoke similar reactions.

Finally, the importance of acts of advocacy or meaningful moments that were perceived as indicative of the therapist’s willingness to enhance the 50-min hour was repeatedly emphasized throughout our interviews. We encourage readers to consider avenues by which they might incorporate some of these practices into their own work with low-income clients who may have unique and complex life circumstances and needs that are best met by with an integration of traditional therapy and work that occurs “beyond the 50-min hour” (Goodman et al., 2010, p. 3). Although extra time and financial resources are often not built into clinicians’ work schedules (and in fact require additional juggling of life roles, insurance policies, and agency policies), all participants noted the power of these “extra” acts in the formation of the working relationship, alliance, and subsequent perceived positive psychotherapy outcomes.

Summary

As Matthew was leaving the interview, he said “You know, I’m doing this because I want to help everybody and myself . . . I don’t think it’s fair that one person should have $500 billion and the next person is eating out of the garbage can.” This interview offered him a vehicle to express his gratitude for the many people who helped him struggle through decades of mental illness, addiction, and poverty. In the moment, Matthew may not have realized that not only did he meet his goal of appreciating those mental health providers who helped him, but he also gave voice to a group of individuals who have been relatively silenced within the psychotherapy literature. He, along with all participants, also deeply affected the three researchers who combed through their data, their story. Even through their sometimes-painful accounts, participants moved our understanding of ourselves as psychologists and psychologists in training, and it is our hope that we have been able to share these stories in such a way as to enhance our profession’s...
knowledge, awareness, and effectiveness when working with low-income individuals in psychotherapy.

References


Appendix A

Experience of Social Class in Psychotherapy Final Interview Questions

1. Tell me a little bit about yourself.

2. Tell me about your experience in counseling.

3. What issues were you hoping to address in counseling?

4. In what ways was your experience in counseling beneficial for you?

5. In what ways was your counselor different or similar to you?

6. Was there anything that you needed but could not get from your counselor?

7. Was there anything that you wanted to talk about in counseling that you did not get the chance to talk about?

8. Can you talk about a particular situation/moment/interaction with your therapist that stands out to you? (note: say this in a way that makes it clear it’s not about their particular breakthrough or personal crisis but rather about an experience that the client and therapist share together.)

9. Earlier you identified XXX and XXX being relevant to how you think about social class. Do you have any other thoughts about how social class affects therapy?

10. How did you hear about the study and what made you choose to do it?

Received August 12, 2011
Revision received January 4, 2012
Accepted January 4, 2012

This document is copyrighted by the American Psychological Association or one of its allied publishers. This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.