



5-2013

Class is out: mental health professionals' social class identification and classist attitudes toward low-income clients

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CLASS IS OUT:
MENTAL HEALTH PROFESSIONALS' SOCIAL CLASS IDENTIFICATION AND
CLASSIST ATTITUDES TOWARD LOW-INCOME CLIENTS

by

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Bachelor of Science, Grand Valley State University 2008
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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

In Partial Fulfillment of the Requirements

For the degree of

Doctor of Philosophy
In Counseling Psychology

Grand Forks, North Dakota

May
2013
Graduation August 2013

This dissertation, submitted by Kipp R. Pietrantonio, in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.



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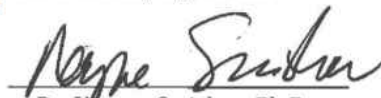


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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate school of the University of North Dakota, and is hereby approved.



Dr. Wayne Swisher, Ph.D.
Dean of the Graduate School

July 15, 2013
Date

Title Class Is Out: Mental Health Professionals' Social Class Identification and Classist Attitudes Toward Low-Income Clients

Department Counseling Psychology and Community Service

Degree Doctor of Philosophy

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Kipp Pietrantonio, M.A.
May 21st, 2013.

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ACKNOWLEDGMENTS

This dissertation is in no way the efforts of a single person. First I would like to thank my committee and more specifically Cindy for her undaunting and unwavering belief in me. You have changed the lives of my family and the generations to come. I would also like to thank Kara Wettersten, Ph.D for being a “dream crusher” (lol) and making sure that I used scientific design to dig deeper and into the research. It is because of you that I found the M-EBS scale which I have shared with countless others in the SES research community. I would like to thank Tamba-Kui Bailey, Ph.D. for allowing me to run my dissertation protocol study in his class. This allowed me to fine tune my survey and greatly helped me with preparation for the final product. I would also like to thank Tamba-Kui for his commitment to social justice and skill in helping me learn that sometimes even the most passionate supervisors/teachers have to know their limits. I would like to thank Alan King, Ph.D. for our Archives advising sessions and for making me memorize the DSM-IV-TR. The knowledge I learned in B-Path has aided me so many times throughout practicum and internship. Finally, I would like to thank Clifford Staples, Ph.D. for our early advising sessions. You helped me figure out what I was studying vs. what I needed to be studying. I don’t think another single conversation I had about this project had nearly as much influence as that one. Also thank you for helping me make sure my study was falsifiable during the proposal!

I also have several friends to thank as well. I first have to thank Zack Kujala whose support and friendship have kept me afloat so many times. I want to thank María Patiño, M.A. for her love and patience with me. I also want to thank Rachel Phillips. Without her attention to detail and commitment to proofreading I wouldn’t have a chance. Although our paths may have divided, I still know this project would have been impossible without you. I would also like to thank my Mom, Dad, Sister, Bre and Rob Langsford for their continued emotional support. Their willingness to be patient while I was gone for the last decade is a gift that can never be repaid.

ABSTRACT

Social class as a variable of culturally competent psychology remains a misunderstood and understudied phenomenon. This study was designed to explore how mental health providers' social class of origin and classist attitudes impact their beliefs and treatment of clients from different economic backgrounds. This was accomplished by exploring five domains across two vignettes that varied in SES indicators (Low-Income vs. Middle Class Vignette). The domains of study included classist beliefs, GAF scores with or without treatment over time, positive and negative stereotype endorsement, perceptions of the therapeutic relationship, and potential treatment modalities. Clinicians did not rate the vignettes differently in terms of stereotypes but rated the low-income client as having a lower GAF score both with and without treatment over time. Clinicians also endorsed the belief that they would like to work with the low-income client more and believed the low-income client would benefit more from therapy. Clinicians from upper class backgrounds tended to endorse more positive stereotypes about the low-income client and believed that said client would decompensate less without therapy. Finally, clinicians from lower class backgrounds tended to be more pessimistic about the middle class client in terms of GAF scores with treatment.

CHAPTER I

Introduction

Social economic inequality and the effects of classism are often overlooked by psychologists and researchers as a potential variable of mental health. Although counselors and psychologists do receive training in multicultural competence, Social Economic Status (SES) is a multicultural factor that does not receive the appropriate amount of attention in social science research. Even today, in an era of multicultural integration, SES continues to be excluded from mainstream multicultural considerations. Lott (2002) states that there is a lack of mention of SES at American Psychological Association (APA) conventions and multicultural conferences, while other aspects of diversity such as race, ethnicity, gender, sexual orientation, and ability receive considerable amounts of focus, attention, and calls for research. As a result, there are rarely presentations or calls for research, and awareness continues to be lacking by the mainstream psychological community. Although theorists such as Bernice Lott, Heather Bullock, William Liu, Matt Diemer, and a few select others have made great strides in bringing attention to this issue, there has not yet been a paradigm shift in the way the field perceives this component of people's lives. As the recent economic downturn has furthered inequality, clients enter the counseling office and are met with techniques and theories that are targeted toward middle class individuals.

The lack of attention paid to socioeconomic issues is reflected in the very lack of precision in language used in psychological literature. Often the terms SES and social class are used interchangeably (Lott and Bullock, 2007). However, the political affiliation of the term “social class” implies a relation of power between classes, which is why some psychologists view the terms as distinct from one another (Lott and Bullock, 2007). In order to clearly articulate the population being discussed, class distinctions (upper, middle, lower, working) were made to clearly define a group with privilege as opposed to assigning value to one group over the other.

The goal of this study was to explore how classism impacts the therapeutic relationship. As in most multicultural interactions, it is important to evaluate both the clinician’s cultural background as well as the clients when exploring discrimination. This study specifically looks at how a clinician’s social economic background impacts their evaluation of clients of different SES groups. The study was predicated on the assumption that classism is a factor in the therapeutic relationship and impacts the clinicians evaluation of clients. Specifically, this study looked at how clinician’s social class of origin and classist beliefs impact their initial and long term evaluation of a client, belief in stereotypes about the client, and treatment options pursued for the client. It was the hope of the researchers that this study would inform multicultural competencies for clinical training programs as well as explore whether classism impacts the therapeutic relationship.

In support of these goals, a review of the literature establishes some general principles around the constructs of SES and classism. The first portion of the review

is dedicated toward framing the problem of social economic inequality. This will be accomplished by exploring four main areas including the lack of research on economic inequality, the history of rising inequality, the middle class mythology, and the difference between advocating socialism and facing economic realities. The review will then shift toward some philosophical lenses which can be utilized in studying social class and classism. This will include a brief history of Critical Philosophy and a description of the strengths and weaknesses of understanding social class using objective and subjective methodology. The third section of the literature review will focus on operationalizing classism using four different definitions: Lott's Cognitive and Behavioral Definition, Liu's Subjective Definition, Wilson's Social Isolation Definition, and the Sympathetic View of Classism. The focus of the review will then change to concentrate on specific effects of classism in several domains. These include vocational effects, health effects, effects on achievement, effects of privilege, internalized classist attitudes in mental illness, classist attitudes toward women, the neurological basis for classism, and how wealth effects ethical decision making. In the final section, the review will concentrate specifically on classism in professional psychology. Four main areas of focus will be included in this section. These include the effect of psychologists who transcend poverty, classism in psychotherapy, classism in psychological research, and finally some examples of class sensitive forms of psychotherapy will be given. This will provide a comprehensive view of the literature that will inform the outcomes of this study.

There were two main hypotheses within the study. The first was that clinicians would evaluate a client from a low-income background more negatively than a middle class client across four domains: positive and negative stereotype endorsement, GAF scores with or without treatment over time, perceptions of the therapeutic relationship, and potential treatment modalities. The second hypothesis examined the same areas, but also took into account clinicians' social class or origin and classist beliefs.

Literature Review

There is a surprisingly small amount of research dedicated to the subject of SES, classism, and psychological health, and there are very few experts in the area of SES (APA, 2008) (Lott and Bullock, 2007). The American Psychological Association (APA) (2001) took an important step in the year 2000 toward addressing this issue when they adopted the Resolution on Poverty and Socioeconomic Status. In 2010, the APA reinstated the resolution to incorporate more research that was developed as a result of the 2000 call for attention.

This resolution identifies populations that may be at risk of poverty including racial and ethnic minorities, refugees, immigrants, elderly individuals, veterans, persons with disabilities, those affected by mental illness, individuals who identify as LGBTIQ, single mothers, youth, foster children, and families. Women and marginalized individuals are specifically cited to be at risk of subprime loans, lower incomes, lower salaries, and higher unemployment. It has also been shown that during economic downturns, these populations are more likely to fall into homelessness and lose their households (APA, 2010).

According to the APA report (2010), individuals from these populations are also at greater risk of not being able to afford housing, have a lack of support, and have a general lack of access to community services. They may also attend lower quality schools, have an inability to gain vocational success, are limited in career training programs, have an inability to access quality daycare, are more vulnerable to layoffs, are not able to afford increasing food costs, and have limited access to transportation. Each of these limitations in turn may affect the psychological well-being of these individuals. The APA states, “Psychologists aspire to enhance the physical, emotional, and behavioral well-being of all persons, especially those who are marginalized and most vulnerable (p. 1)”. For psychologists committed to social justice, this translates to advocacy efforts around prevention of homelessness, studying individual differences between impoverished individuals, providing training and education around poverty-related mental health issues, and advocating for strength based perspective when working with these individuals.

Although this resolution is a step in the right direction, there is still a lack of research dedicated specifically to those with low SES and the effect this can have on the mental health of individuals. Many studies incorporate ideas of SES, but few studies have concentrated directly on SES and even fewer have focused on how classism may impact the daily lives of these individuals. It will be important in the future that the items outlined in this resolution are fully explored, with the ultimate goal of enhancing the quality of lives for all people as a long-term destination.

Rising inequality

In order to provide a context in which classism can be studied, it is first important to understand the economic and social transformation that has occurred over the past forty years, and more specifically the dramatic changes that occurred in the last five years. As indicated by the Center on Budget and Policy Priorities, from 1979 to 2002 the after-tax income of the top 1% of the population in the US more than doubled (increase of 111%). During this same time period, the middle fifth of the population's income only increased 15% and the bottom fifth a mere 5%. As a result of this widening deficit, the U.S. now has the largest inequality between rich and poor of any westernized nation (Lott and Bullock, 2007). In light of the economic recession that has permeated the United States over the last five years, there have been substantial changes in the economic structure of the United States at both the macro and micro levels. From 2007 to 2009, 6,162,836 jobs were lost with the majority occurring in the Midwest and East Coast of the United States. Some states, including Michigan and Nevada, have reached a staggering 14-15% unemployment rate as industry has come to halt in these areas (Bureau of Labor Statistics, 2010). To clarify, that number translates to roughly 1.5 million people out of work in Michigan alone. This type of change has had a major effect on the social makeup of the United States, with many individuals having to adjust to a variety of lifestyle and behavioral changes.

In addition, social class is generally a topic that is not given appropriate attention in government policy or legislation. This may stem from a lack of representation of working class individuals in all three branches of the US

government. Lioz and Cassady (2003) found that 42% of senators, and 23% of representatives are millionaires, compared to a mere 1% of individuals in the general population. Over the past thirty years there have been reductions in many public policies that have contributed to furthering inequality in the United States. These include reductions to welfare programs, education cuts, greater difficulty for poor families to file for bankruptcy (including public humiliation of having it posted in newspapers), reduction in restrictions on corporate outsourcing of working class jobs (Lott and Bullock, 2007). As previously stated, this has resulted in greater inequality, but in addition, this has also further perpetuated the idea of the American principle, "pulling yourself up by your bootstraps." These types of policy changes have politicized the problem of poverty. Instead of focusing on how to help those who are impoverished and create social change, political parties now argue on whom to place the blame for poverty. Poverty is now a topic of philosophy and political responsibility, as opposed to an epidemic with practical solutions. Instead of focusing on solving the problem, politicians debate the underlying philosophical meaning of giving aid to the poor. All the while the poor and working class continue to fall farther into poverty with fewer resources.

Impoverished and lower class individuals face day-to-day problems that remain invisible to the majority of middle class society. These include a lack of access to daily resources, health care visits, higher education, lack of access to the internet and cell phones, and poor living conditions (Smith and Romero, 2010). It should also be noted that these concerns are more widespread than often recognized. Rank and Hirschl (2001, 2002) state that 51% of the United States

population will live in poverty for at least a year, and over 60% will receive some sort of public assistance. Lott and Bullock (2007) believe that the reason daily struggles of many American families are not discussed is because of the long-standing stigma around being poor. Even among poor individuals, it is generally not accepted to discuss financial problems (Bullock, 1995). This indicates a certain level of cognitive distancing which underlies a classist's ideology in the United States (Lott, 2001). As a result many of these issues are unexamined and remain invisible to the public eye.

The middle class myth and economic realities.

Throughout the United States, most individuals identify as middle class despite a wide range of variability in income, occupation, education, and family size, and incredible economic variation over the past fifty years. In a public opinion poll, the vast majority of Americans identified as middle class despite vast intergroup differences. For example, individuals who made \$35,000 or less as well as those that made more than \$150,000 each identified as being middle class (Miller, 1995). This indicates that there is some type of social preference for being viewed in the middle as opposed to either end of the economic spectrum. This migration toward the middle emphasizes a false shadow of equality that continues to misinform the American public.

The fact remains that most individuals are no longer "middle class" in the sense of the type of jobs they perform. The Department of Labor (2001) reported that around 65% of Americans could be identified as doing "working class" jobs as defined as skilled or unskilled labor. Interestingly enough, if individuals are given

the categorical choice of “working class” in addition to lower, middle, and upper class, 50% of individuals will choose the working class option. This may indicate that public perception equates the working class with the middle class (Miller, 1995). This equivocation makes economic differences even more invisible as individuals of dramatically different incomes, occupational prestige, and education levels will identify with the same group, despite having very different quality of lives. Regardless of the reality of what defines each class, it is apparent that the definitions are in flux and ultimately defined by social comparison with a preference toward the middle class. This preference for the middle class hides inequality and gives working class and low-income people the false belief that they are on an equal playing field with those from higher social class backgrounds.

One common problem when writing about economics and social class from a social justice perspective is the view that the researcher may be advocating for an economic or political overhaul. Moreover, fears of being cast as a Marxist or socialist if one writes about social class issues may keep scholars fearful of addressing this topic. This type of macro-level change is neither feasible nor gratifying for American families currently suffering from limited access to resources and mental illness related to poverty. This dissertation will not be in support of any type of neo-Marxist political change, but instead reflect on contemporary problems that must be addressed. Lott and Bullock (2007) state, “...we are not so much proposing revolutionary and untried policies and practices as we are building on a recognition of the social reality of our times” (p. 17). The goals of psychology should not be merely to create political change, but to use research, practice, and outreach to

advocate for policies that are reactionary to the truth of our current economic situation. In an era where talk of socialism, redistribution of wealth, universal healthcare, or other forms of aid are viewed as politically charged topics, it is important to make this distinction. The paper does not advocate that psychology, as a profession, call for economic reorganization, but instead bring awareness to how the impact of social economic inequality affects our work with individuals, groups, or students in practice.

Philosophical roots of social class and classism.

Changes in income/employment as well as growing inequality seem to indicate power dynamics at work. In the past when there have been changing social structures, one of the primary ways of creating change academically is through research based out of Critical Ideology. Critical Ideology shares commonalities with positivist, post-positivist, and constructivist philosophies. It is similar to positivism and post-positivism in that Critical Ideology acknowledges the existence of only one truth. However, this truth is related to constructs of power and oppression (Morrow, 2007). Traditional work with social class has been rooted in a Critical Ideology in both qualitative and quantitative studies. The roots of Critical Ideology come from a strong theoretical background in critiquing social class structure. The primary scientific goal of this philosophy is that oppression that is both interpersonal and institutionalized must be brought to light through research. This type of thought was developed during the 1940's when conflict theorists escaping fascism found discrepancies between United States ideals and the actual social structure (Ponterotto, 2005). This paper is grounded in this perspective.

Specifically, it is designed to show how psychotherapy can be a means of perpetuating inequality.

Understanding social class from a Critical Ideology perspective is important, but in order to study the subject matter, it is crucial to understand how social class is conceptualized and the philosophical assumptions that are used to understand both class and classism. Until recently, there has been a strong post-positivist perspective used when considering social class (Duncan, 1961, Hollingshead, 1975). This perspective has been grounded in the belief that social class exists as a construct and must be measured via standardized/operationalized indicators (Income, Occupation, Educational Attainment, etc). These have been measured systematically and objectively through self-report for the most part. The assumption has been that one could be sorted into social class categories (lower class, middle class, working class, etc.) as a function of some combination of these measureable factors.

In more contemporary theories within Counseling Psychology, the objective measure of social class have been challenged by a relatively new perspective based on the subjective perception of one's class. This view comes from a more constructivist lens and incorporates the personal experience of class, classism, and social comparison as an indicator of one's SES. For example, Liu, Soleck, Hopps, Dunston, and Pickett (2004) created The Social Class Worldview Model based on domains such as consciousness, attitudes, salience, referent groups of origin, aspiration, peer/cohort group, behaviors, property relationships, and life style.

These two views create a philosophical divide in the field in which the pros and cons of each view must be addressed before moving forward. In the next section, the two views will be compared and contrasted, which will lead to a better understanding of how to perceive and comprehend the construct of class and classism.

Difficulties in objective definitions of social class and classism.

One of the primary problems offered by critics of the objective view of social class is that there have been over 400 different words that describe social class and closely related constructs (Liu, Soleck, Hopps, Dunston, and Pickett, 2004). Terms like social class, human capital, social capital, and cultural capital have each operated as an individual indicator of class, but together lack a cumulative and accepted definition. Although the lack of an operational definition does not dismiss a modernist perspective by itself, the critics further argue that the concept of a nationally accepted social structure with established classes (middle class, working class, upper class) is also inaccurate (Liu, Soleck, Hopps, Dunston, and Pickett, 2004). Studies by Leonhardt (2001), and Schor, (1998, 2000) state that individuals generally put more emphasis on comparisons with others within their social group as opposed to objective national levels (Liu, Soleck, Hopps, Dunston, and Pickett, 2004).

Another criticism with the objective measure of social class is the reality of the constructs. For example, looking at educational attainment does not necessarily represent the person's ability to utilize this education or their ability to use the resources their education level grants them (Liu, Soleck, Hopps, Dunston, and

Pickett, 2004). Social skills development, middle class interactions, or writing and verbal skills are abilities one develops in higher education, but may not be measured by simply asking someone what their highest level of educational attainment is. In addition, asking one's income may not incorporate all aspects of their assets. For example, it may omit some of the important variables such as potential savings, spending habits, credit, and debt (Liu, Soleck, Hopps, Dunston, and Pickett, 2004).

The most significant deficit with the objective view is the concept that classism occurs at multiple levels that transcend education, income, and occupations. Liu, Soleck, Hopps, Dunston, and Pickett (2004) state that children are subject to classism in many forms whether it is teasing over clothing, dental care, or not participating in school events that cost money such as school pictures, sports programs, or going on field trips. Simply asking parents to identify their indicators of social class can overlook the long-term effects of these types of discrimination. It may not capture the thoughts and feelings that impact future developments and cognitive schemas. This is why advocates for this perspective believe that a more holistic constructivist view must be used in order to understand what SES and classism means to individuals (Liu, Soleck, Hopps, Dunston, and Pickett, 2004).

Issues confounding the subjective view.

Although the subjective view can capture a richer and more in-depth analysis, it rests on the assumption that people are aware of this type of discrimination and are able to first identify as part of an oppressed group (i.e. the lower class). One problem is that individuals generally attempt to distance themselves cognitively from lower class people, regardless of their own class level

(Lott, 2001). This distancing occurs through individuals maintaining their class status by identifying as a “Middle Class Person” who has run into some hard financial times. Bullock (1999) found that women who were currently receiving welfare assistance were quick to distance themselves from others in similar situations. They were more likely to attribute the difficult circumstances of the others to living off the government, being lazy, and unwillingness to get a job. A study by Seccombe, James, and Walters (1998) discovered similar findings. This led them to conclude that respondents evaluate themselves and their own economic circumstances much differently than that of others in the same financial situations. The important concept to address from these studies is that individuals, despite feeling the effects of classism, seem to distance themselves from the oppressed population and distort their view. Although constructionists in favor of this prospective would argue that their perception is an equally valid truth, it would be difficult to perform research in this area if few are willing to claim this identity. This is especially true if low-income people see themselves as outsiders looking in. This criticism becomes even more relevant in post-recession America as many individuals have lost status and class rank, and could adopt this distanced perspective.

It is important to consider both these philosophical views when considering issues of class as both have a strong bearing on the type of science one conducts. If one uses an objective view, they may be missing the crucial individual experience of classism, while if one uses the purely subjective view, they may fall prey to a limited or distorted scope. It seems that a hybrid perspective is the most appropriate as

this encapsulates the experiences of the individual who is facing this form of oppression as well as captures any cognitive distortions they may have created to maintain class status. This is the reason a modified version of the Differential Status Identify Scale will be used in this study (Brown et al, 2002). Traditionally, this is a scale that appraises a more subjective view of social class barriers individuals' face. In order to incorporate an objective perspective of classism, additional information will be asked in the demographics space to encapsulate a more holistic view of the individual's social class position.

Operationalizing social class and classism

As a result of this philosophical divide, there is no clear consensus on a theoretical perspective in which to measure social class, and in turn classism. This is why it is important to cover a wide variety of potential operational definitions and implement strengths from different views into the experimental design. The objective perspective provides a solid and measureable means of examining social class, which is not limited by a potentially flawed self-perception. The subjective lens provides access to one's own understanding of their place within a social hierarchy and captures a richer and more inclusive view of one's experience. The next section provides an overview of the known operational definitions for social class and classism.

The study of class in psychology is a relatively new concept, but has been a cornerstone of sociological research since the introduction of the science.

Due to limited research on SES in psychology, it is important to cross academic lines and include information from sociology. Bourdieu, a contemporary French

sociologist, revolutionized the way we look at social class inequality in modern western society. He conceptualized the idea of class in what he deemed “cultural capital” (Sallaz & Zavisca, 2007). Bourdieu described cultural capital as containing three subparts, which are “an embodied disposition that expresses itself in tastes (an incorporated form), formal certification by educational institutions of skills and knowledge (an institutional form), and possession of esteemed cultural goods (an objectified form)” (Sallaz & Zavisca, 2007, p .23). This can be broken down into an individual’s taste, social esteem, and material possessions. This is significant as it forms the groundwork of social class as a construct. Bourdieu’s definition established a standard from which classism can be understood and operationalized.

Social class can be defined as an individual’s position within “the economic system of production, distribution, and consumption of goods and services in industrial society” (Rothman, 2002, p. 6). In recent history, SES has been made up of such variables as income, education, occupational prestige, family size, and social capital (Duncan, 1961, Hollingshead, 1975, Sallaz, 2007, Lott and Bullock, 2007). Classism from this perspective is socially constructed barriers, which limit access to income, higher prestige occupations, and educational attainment. Unfortunately, today many studies only consider income or geographic location as a means of assessing SES, despite ample literature stating that other factors such as education and access to resources have shown to be increasingly important. This is unfortunate as many individuals have been stigmatized as representing various social class categories, despite considerable differences in access to resources.

Lott's cognitive and behavioral definition of classism

The term classism is unique as a form of prejudice as it is less transparent to both the oppressor and the oppressed than some other forms of discrimination (Lott, 2001). Lott (2001) defines classism as “cognitive and behavioral distancing in interpersonal interactions, education, housing, health care, legal assistance, politics, and public policy” (p. 1). There is evidence to validate the existence of this type of discrimination. True to any form of discrimination, stereotypes have been created and reinforced, and are perpetuated throughout American society. Lott states “The poor are perceived as failing to seize opportunities because they lack diligence and initiative” and “poor people and welfare recipients are typically characterized as dishonest, dependent, lazy, uninterested in education, and promiscuous” (Lott, 2001 p. 125).

In support of this statement, Cozzarelli, Wilkinson, and Tagler, (2001) compared beliefs of middle class people to beliefs of lower class people around perceptions of individuals in poverty. It was found that descriptors like unpleasant, unmotivated, immoral, angry, lazy, stupid, dirty, criminal, alcoholic, abusive, uneducated, and violent were endorsed as beliefs about individuals in poverty. These terms were endorsed by middle class people at a higher rate than those of lower class. This study indicates the presence of inherent bias towards individuals from lower SES, as they are associated with many negative characteristics. It also further presents evidence for Lott's definition of classism, as individuals who had more exposure to poverty (therefore less cognitive distance between themselves and those in poverty) were less likely to endorse classist stereotypes.

Liu's subjective definition of classism.

Liu, Soleck, Hopps, Dunston, and Pickett (2004) state that one of the great flaws in classism research is that SES is viewed as a demographic instead of a cultural variable. For example, many intake forms may ask what a client's income, education, and occupation are, but rarely is this ever looked at cumulatively or as part of a subculture. Juntunen (2006) discusses a case where an individual comes into therapy with concerns around depression and fatigue. This client is reported as working in a manufacturing plant that is currently experiencing cut backs while she is simultaneously asked to work more weekend and night shifts. Juntunen states that despite these clear occupational and economic concerns, rarely would therapists attribute her fatigue and depression to work and oppression, as opposed to other more traditional etiologies. Another critique of traditional measures of classism is that we rarely take social class into account during interpersonal relationships or as a confounding variable in other forms of oppression. A woman who was raised in a lower class neighborhood may be having difficulty with her boss at work, yet rarely is it considered that the interaction may be symbolic of class conflict or value differences that were learned when she was raised.

In order to understand classism from the perspective of Liu (2010), it is first important to understand his subjective definition of what social class is and how the social hierarchy may affect the individual. Liu defines class as:

“An economic group within which an individual belongs, and the individual perceived material (i.e., types of belongings, neighborhood) and non-material (i.e., educational level) boundaries. The individual may observe other

“classes” which are perceived to be, in subjective hierarchy, higher, lower, and at the same place (i.e., lateral) as the individual’s own class” (p. 19).

Further, Liu argues that in order to understand classism, one must also understand barriers to social mobility between one’s perceived social classes. Class mobility is something that can happen, but will only occur if individuals are able to understand and work within different social class norms, values, and culture. Therefore when an individual is not indoctrinated into or has a greater physical, emotional, or geographical distance from the social class they wish to move to, the greater difficulty they will face rising out of poverty. Therefore classism can be defined as “an employed behavior and attitude, and an expected consequence as the individual attempts to navigate within and between classes” (p. 19). This definition has strong theoretical support and also seems to parallel the Lott (2001) definition of cognitive distancing mentioned earlier.

One other unique component of this model is that Liu, Soleck, Hopps, Dunston, and Pickett (2004) view classism as a form of oppression that cannot be viewed outside of racism and sexism. These theorists believe that classism is interdependent with racism and sexism and that together they form a cumulative oppression that should not be viewed as independent components. In attempting to weed out classism from other forms of oppression we are inherently ignoring interaction effects, which may have a profound impact on individuals in distress.

As mentioned earlier, most subjective measures of SES and classism have some limitations and Liu’s model is no exception. One concern is that social class divides are not always transparent and sometimes individuals in similar social

situations will deny that they face the same social barriers that other impoverished people face. No research has been done to this researcher's knowledge that has directly looked at whether or not an individual's objective definition of social class is similar to their subjective experience of social class, but preliminary research by Bullock (1999) does seem to indicate that there would be a discrepancy. This is important to consider when utilizing Liu's conceptualization.

Wilson's social isolation as classism.

William Julius Wilson (1993) uses the term underclass when discussing those of lower socioeconomic status. His theory states that the underclass face joblessness that is reinforced by social isolationism and poor communities. The underclass further suffers from low SES, a lack of education, less societal support, and less community safeguards. Once these norms are set in place for individuals, they create a vicious cycle, which fosters isolation and makes it increasingly difficult to escape poverty. Wilson states:

“The key theoretical concept, therefore, is not a culture of poverty but social isolation. Culture of poverty implies that basic values and attitudes of the ghetto subculture have been internalized and thereby influence behavior. Social isolation implies that contact between groups of different class and/or racial backgrounds is either lacking or has become increasingly intermittent but that the nature of this contact enhances the effects of living in a highly concentrated poverty area. To emphasize the concept social isolation does not mean that cultural traits are irrelevant in understanding behavior rather,

it highlights the fact that culture is a response to social structural constraints and opportunities" (p. 4).

In contrast to other perspectives on classism, Wilson believes it is not internalized values, but the social isolation, which keeps individuals from rising out of poverty. This goes against the more dominant discourse that individuals in poverty tend to "choose" behaviors, which keep them impoverished, and instead states that these individuals have never had exposure to behaviors that would help them rise out of poverty. Classism from this perspective would be similar to Lott's definition in that through the process of distancing, poor communities continue to get isolated. As a result, impoverished people whom have never had exposure to middle class behaviors and value systems are not adequately prepared for success as defined by a white middle class society.

Sympathetic view of classism.

Henry, Reyna, and Weiner (2004) view the American population's perspective of the poor as more complex. They characterize the view of the poor as a paradox because most Americans sympathize with hard-working blue collar Americans, but simultaneously have adverse reactions to individuals who are on welfare programs. In this view of low SES, individuals are willing to show sympathy towards those of low SES, but at the same time believe in the American ideology that they should "pull themselves up by their bootstraps", despite significant social barriers. Although this view deviates from the definition offered by Lott (2002) and Liu (2010), the Henry, Reyna, and Weiner's (2004) study was based on a relatively small sample size in a highly localized area, which may not provide the statistical

power necessary to adjust contemporary understanding of classism. This is an area that should be examined more closely in the future, especially in the context of sympathy and empathy with greater exposure and less cognitive distancing. This approach does seem to offer some face validity as well. Many American stories, values, and principles have come from the poor and there seems to be a collective American pride in working through poverty.

Sociopolitical development as classism.

Classism affects many areas of low-income individuals' lives, but one area that is of particular interest within Counseling Psychology is the way it impacts the world of work. As work encompasses two of the primary components of SES (i.e. income and occupational prestige), it is natural that vocational development is intertwined into one's identity with SES, and beliefs in classism. One model in particular, is the Sociopolitical Development model posed by Diemer and Blustein. Diemer and Blustein (2006) state that limits to resources, education, vocational opportunities, finances, and other social barriers may inhibit the ability to connect to the world of work. It may also have an effect on work salience and the ability to develop vocational expectations for the self. Diemer and Blustein describe the process of interacting with oppression as a form of sociopolitical development with the world around them. Sociopolitical development can be defined as how oppressed individuals formulate a critical analysis of structural oppression and perceived capacity to change inequalities within their sociopolitical environments. This construct can be broken down into social dominance and sociopolitical control, each of which will be defined below.

Sociopolitical dominance can be described as “the value that people place on non-egalitarian and hierarchically structured relationships among social groups...which expresses general support for the domination of certain socially constructed groups over other socially constructed groups (Sidanius and Pratto, 1999, p. 61). Individuals who score high on sociopolitical dominance also tend to support economic inequality in various areas including beliefs in a just world, survival of fittest, and endorse racist beliefs (Pratto et al, 2000). In addition to racism, these beliefs also have classist implications. For example, if an individual believes that some are born superior or more deserving to others, this may manifest as a belief system that can justify economic inequality. These types of beliefs also may imply that individuals are poor because they are inferior in some way, as opposed to macro-level economics, uneven distribution of resources, or physical or mental health issues.

Sociopolitical control “refers to beliefs that actions in the social and political system can lead to desired outcomes” (Zimmerman, Ramirez-Valles, and Maton, 1999, p. 736). This idea is similar to self-efficacy in that it is concerned not with what one can do in a sociopolitical environment, but instead is concerned with what an individual believes they can do. It has been found that individuals who are able to display high levels of sociopolitical control have greater success when encountered with inequality, suggesting this may be a valuable coping skill in the case of class oppression. This further suggests that there may be an inverse relationship between sociopolitical control and social dominance attitudes (Diemer and Blustein, 2006).

Overall, it is apparent that individual's sociopolitical environment shapes their understanding of their self and their relationship to others.

Effects of classism.

In order to understand why a lack of attention to social class and classism is such a concern, it is first important to examine the psychological effects socioeconomic status has on people, attitudes toward people of various SES, and the implications for psychotherapy. The effects of SES range far and wide and include implications for access to financial information, physical health deficits, and limited access to resources such as healthcare, daycare, higher education, healthy food, appropriate clothing, as well as limited ability to afford many institutional and private sector fees and dues (car insurance, tax fees, union dues, etc) (Lott and Bullock, 2007). The following section will look at several domains where classism has been shown to impact growth and development.

Vocational classism.

As previously stated, vocational development is intertwined with SES and classist beliefs. This is crucial to understand as low-income children rarely rise out of poverty, and in some studies, social class of origin has proven to be the best predictor of educational attainment and occupational success (Jones, 2003). This means that poverty is transferred and maintained across generations. This is why vocational and educational interventions in psychology are important in the fight against poverty. Further, Diemer and Blustein (2007) found that racial, ethnic, and socioeconomic barriers generally hinder individuals' vocational development.

Blustein et al (2002) completed a qualitative study with twenty individuals (10 males, 10 females) concentrating on how social economic status may affect school to work transitions. Each individual was interviewed and the data from interviews was analyzed using the Consensual Qualitative Research (CQR) methodology established by Hill, Thompson and Williams (1997). These interviews established that lower class individuals view work as a way of making ends meet, surviving, getting necessities, or paying bills, while middle and upper class individuals tend to see work as a means of identity, life satisfaction, and upward mobility. This also provides evidence for what Diemer and Ali (2009) call social class “work subcultures”. This is described as different social classes in different areas allocated varying value systems around what work means and how vocational development happens. The significance of this study is that work is viewed differently depending on what social class individuals come from. It also provides evidence that work for lower class people is much more of an externalized process, as opposed to a natural and expected part of internal development.

Several other factors may have a profound impact on the way that poverty self-perpetuates across generations. Diemer and Ali (2009) in their review of the relationship between social class and career development indicate a number of barriers that lower income individuals face. They state that individuals from the middle and upper class are better prepared for the world of work and high education, yet this is often attributed to their innate ability as opposed to a component of privilege. Further, individuals from the middle and upper class generally have access to higher status “social actors” (p. 257) which has a greater

ability to influence the world around them. For example, middle and upper class people may be able to contact friends already in college, guidance counselors who are used to working with college acceptance committees, people who have greater access to career assessments, parents who understand the college process, greater funds to print and design better resumes/CVs, etc. Diemer and Ali (2009) argue further that individuals from lower classes have less access to resources, less work experience, have an internalized sense of classism, and have limited career choices.

Ali, McWhirter, and Chronister (2005) studied 114 ninth-grade students (47 males, 66 females) in the Pacific Northwest. Students' social class was measured using parental information in addition to the childrens' vocational self-efficacy, parental support, sibling support, friend support, and perceptions of educational barriers. It was found that individuals from lower social class generally had less self-efficacy when it comes to vocational aspirations. Interestingly, students who reported high parental and friend support seemed to have high vocational self-efficacy and had lower perceptions of barriers. This was even more so for individuals who also reported high support from siblings. It should be noted that the authors do state some limitations to this study. These include the use of a purely objective measure of social class, a relatively small localized sample size, and the use of relatively new measures.

The importance of parental involvement for lower class individuals has also been linked to levels of work salience. Diemer (2007) studied data from over 25,000 students. He looked at various components of support in vocational development including parental and school support, vocational expectations, and work salience.

Work salience was defined as how important vocational success was, and ones beliefs in their ability to find steady work. What was uncovered was that individuals who were identified as poor youth of color generally were in greater need of parental and educational support. What can be concluded from the previous two studies is that individuals from lower social class backgrounds who have higher levels of social support from family and friends seem to have higher levels of self-efficacy and perceive fewer barriers to succeeding at their vocational aspirations.

Diemer, Wang, and Smith, (2009) studied data from 1,575 students from 405 different high schools in 30 different states. The theory of the study was that students who could be identified as lower social economic status generally lack information that allows them to connect current interests to vocational interests through a college major. In simpler terms, poor youth generally have a more difficult time connecting their current interests to future jobs compared to their middle class counterparts. The study explored vocational interests, potential majors, and grade point average. The results indicated that low-income individuals who received career interest assessments were better able to close the gap between current interests and congruent educational experiences and therefore more prepared to select a college major. This study is important for a few different fundamental reasons. The first is that it shows that vocational interventions can help hinder the effects of classism. The second is that it provides evidence against widely accepted notions of social Darwinism. Instead of further confirming the belief that education acts as a natural filter for those that are not successful, this study indicates that a lack of resources may be acting as the barrier instead.

Health effects.

A study by Adler et al, (1994) advocates for the inclusion of health behaviors, psychological factors, perceptions of social ordering, and access to healthcare in considering SES. Their study indicated that people of lower social status groups have the highest morbidity and mortality rates within most populations. This may also be important as currently one of the primary reasons that people file for bankruptcy is due to healthcare cost. In 2001, half of the bankruptcies were due to rising medical bills with the majority of these people reporting having some form of health insurance before becoming ill. In addition, when people become ill it further limits their access to resources, as they are often unable to work, engage in the appropriate mobility, afford doctor visits, etc. (Kramer, 2001). With this in mind, it will be important to consider health and access to healthcare as one of the primary indicators of class privilege in the context of assessing classism.

Lower SES has many impacts on the human body. Adler et al (1994) provides a meta-analysis on the interrelationship among health, social class, and environment. They state that the environment of a person of low social class may expose them to pathogens, carcinogens, and other hazards that others may not experience. This is also true of the work setting of many lower class individuals. This population is also exposed to more aggression and violence while having limited access to resources and forms of support. The authors state that psychological development through experience and lower class environments impact all cognition and mood, as well as health behaviors. The meta-analysis also states that lower class people are more likely to smoke, die younger, be less

physically active, be obese, and consume alcohol. Individuals of higher social class also have greater access to healthcare, high paying jobs, food and nutrition, education, higher quality housing, and greater access to mental health services (Lott and Bullock, 2007).

Effects on achievement.

Concepts of prejudice that have traditionally been applied to minority groups may also have similar negative effects on those of lower SES. An example of this was illustrated by Croizet and Claire (1998), who attempted to extend the idea of stereotype threat (Steele & Aronson, 1995) to lower class people. Stereotype threat can be defined as being at risk of confirming, as self-characteristic, a negative stereotype about one's group. Steele and Aronson describe it as “the self-threat it caused through a variety of mechanisms that may interfere with the intellectual functioning of these students, particularly during standardized tests” (Steele & Aronson, 1995 p. 797). In more general terms, it is the idea that when an individual is somehow reminded of a stereotype about a minority group to which they belong (women having to write their gender on a math test, or African Americans having to write their race on an IQ test), they are more likely to fulfill the stereotype and perform poorly due to increased anxiety. If individuals do not have the stereotype primed, research indicates that subjects will perform on par with their peers.

Croizet and Claire (1998) presented a test to individuals of varied economic status, describing the test as either a test that was designed to examine intellectual ability for solving verbal problems or as a test for the role attention plays in the functioning of lexical memory. Individuals from low SES gave fewer correct answers,

answered fewer questions, and were less accurate in general when the test was presented as an intelligence test. When the test did not have the intelligence presentation, individuals of lower SES performed the same as all others from varied SES. The authors concluded that priming the stereotype that poor people are not intelligent led to the individual not performing well, and hence fulfilling the stereotype. As a result, the authors concluded that individuals from lower SES may fall victim to some of the same forms of institutional discrimination as those of other multicultural populations.

Effects of economic privilege.

Privileged attitudes are also prevalent in American society for middle and upper class individuals. Hunt (1996) did a study in which 2,854 interviews were conducted with individuals around beliefs of poverty, race, and reasons for success or failure. They asked them standard interview questions around components of blame and beliefs around race, ethnicity, and social class, and general background. Those that scored high on income, education, occupational prestige, were white, and had little exposure to impoverished people, were more likely to attribute their economic situation to personal attributes (Hunt 1996). The key concept to take from this study is that individuals with greater exposure and experience to impoverished people were more likely to take an understanding and empathetic approach to why others are in poverty. Those with little exposure were more likely to endorse blaming or concentrating on individual attributes rather than macro level economic change or oppression. It should be noted that the majority of these interviews were conducted via the phone with all individuals being from southern California. As a

result of limited geographical variability, the study's external validity may only be localized to that region of the country.

Internalized classist attitudes in mental illness.

Maher and Kroska (2002) studied the relationship between social class position and the amount of control that those with mental illness believed they had over their mental disorder. It was discovered that individuals from lower social classes have a weaker sense of global control and self-efficacy (Hughes and Demo, 1989) which Maher and Kroska (2002) thought may translate to perceptions of mental illness. They collected data from 1990-1997 for individuals that were diagnosed with severe mental illness (schizophrenia, major depression, bipolar or adjustment disorders) in the Indianapolis region. They found that when social support, marital status, self-esteem, and disorder type were held constant, social class and whether or not individuals accepted public assistance were systematically related to an individual's perception of control over their own mental illness. This was even more significant for African Americans compared to their white counterparts, which further emphasizes the interrelation of race and social class. Some limitations to this study are that data was collected in a small geographical region, and the study focused on a fairly limited population i.e. those with more severe mental illness. This study argues that social position is relevant in one's own perception of mental health in more severe disorders.

Classist attitudes toward women.

Lott and Saxon (2002) gave subjects information about hypothetical women and asked individuals to rate their reactions on a variety of different topics. 1,056

individuals from 36 different geographic regions including Rhode Island, Connecticut, Indiana, Massachusetts, Nebraska, New York, and Virginia. Individuals were given a story in which a mother who was either middle class or lower class was running for vice-president of her local PTO. Four different photographs were included and the women were presented as Jewish, Puerto Rican, or White. All together there were 24 different combinations of ethnicity and social class. The participants were then asked to rate how well they would perform as PTO officer and rate them on a variety of adjectives that could be used to describe them. Regardless of race or ethnicity, it was discovered that the individual's social class as represented by the photograph and the occupation of herself and her husband was the component that had the biggest influence on first impressions. Working class women were rated as less strident, having less perfectionist tendencies, cruder, meeker, less responsible, less emotional, and less suitable for a PTO position.

In a second study presented by Lott and Saxon (2002), in the same publication, 432 college students were asked to imagine that the brief description and photograph were of the current girlfriend of their older brother or cousin. Working class girlfriends were found to be rated as cruder and more irresponsible. This further provides evidence that a person's social class has an effect on our overall conceptualization and first impression, which may be based on stereotypes as opposed to individual attributes.

Neurological classism.

There is some evidence of neurological indicators of classism and the dehumanization and cognitive distancing from the poor (Fiske, 2007). Participants

were shown photographs of various people of different ages and social backgrounds, while simultaneously having their brains monitored by an fMRI. When a homeless individual was viewed, individuals tended to show a sequence of reactions typically associated with disgust and avoidance. The insula was activated, which usually shows increased activity when non-human objects stimulate people. Similar findings are also found when individuals look at garbage, human waste, or different forms of mutilation. Even Fiske reports surprise at these findings. He reports that it is strange that even a photograph of a low-income person can elicit such a strong response. What this study tells us is that classism may occur automatically and maybe even outside our consciousness.

The wealthy and ethical decision making.

At the APA convention in 2012, Lott (2012) called for greater study of the wealthy and privileged. She noted that we have ample information on how poverty and inequality affect the poor, but very few studies of how economic privilege affects cognition and behavior. One of the challenges with this process is combating social desirability in the experimental design. In a breakout paper, Piff, Stancato, Côté, Mendoza-Denton, & Keltner (2012) completed seven experiments exploring the relationship between SES and engaging in unethical behavior. These seven studies showed both innovation in how we think about studying the privileged class and incredible creativity related to methodology. These studies included real world observation as well as laboratory experiments. One of the ways they reenacted a social class primed interaction was through observations of people's behavior at a stoplight. The first study consisted of 274 drivers and the second had 158 drivers.

Researchers monitored drivers and confederate individuals attempting to cross the street. In these two studies they found that individuals with more expensive cars tended to cut off pedestrians and cars at cross walks at a higher rate compared to those with less expensive cars. This was true even when they controlled for sex and perceived age of the driver. This indicates that individuals who are driving expensive cars are more likely to engage in privileged behaviors compared to those from other social classes.

In another study, 129 individuals were primed to think about their social class via a social comparison task related to income, education, and occupational prestige. They were then asked to engage in some “filler measures” as a distraction. Following this experience, subjects were offered candy and told they could have some, but it was for children in another experiment. They found that those who engaged in downwards comparison and were identified as a higher social class were more likely to take a larger amount of candy compared to their lower class counterparts. The authors concluded that individuals who perceive themselves as from a higher social class and engage in priming exercises are more likely to behave in a privileged way (Piff, Stancato, Côté, Mendoza-Denton, & Keltner, 2012a).

There is also evidence that those who perceive themselves as a higher social class are more likely to engage in cheating behavior. In another study, Piff and colleagues (2012b) gave 192 individuals from various social classes the opportunity to play a dice game in which they had to self-report their results for the chance of a cash prize. Individuals who identified themselves as being from a higher social class were more likely to lie about the results in order to win the cash prize compared to

those from the lower class groups. This study provides evidence that individuals who perceive themselves to have been from higher social class backgrounds are more likely to resort to cheating when chance does not favor them.

There is still little known about how the attitudes, cognitions, and behaviors of people may be impacted by a higher social class, but these studies seem to indicate a sense of entitlement and willingness to break the rules. With this being said, the stakes were relatively low in these studies, so individuals may not have engaged in similar behaviors had the stakes been higher or their behavior would have a greater impact on others. In addition, these studies were all conducted at the University of California at Berkeley with the majority of individuals being university students. This likely limits the external validity of the results. More research that implicitly looks at classist behavior in a national sample could provide some valuable information about the influence social class on behavior.

Classism in professional psychology.

Although there has been considerable attention paid to the existence of classism and its effects in the general population, it is also important to consider the ways classism impacts professional psychology. Specifically, looking at how a psychologists' own social class impacts their sense of identity, their research, and the impact of performing psychotherapy. The next section will focus on how social class has impacted the world of professional psychology. It will also outline the need for studies that focus specifically on how social class impacts the therapeutic relationship and our understanding of psychotherapy.

Lott and Bullock (2007) write specifically on the experience of being a psychologist and the inherent nature of being middle class. Even the rare individuals, who transcend poverty and obtain higher level degrees in the helping professions, are trained to speak and think with middle class values. They suggest that once an individual has risen to benefit from the formally oppressive systems, it is sometimes difficult to then critique them. Training programs often do incorporate theories that take SES into account, but it is usually viewed through a deficit model, as opposed to an aspect of diversity or a piece of cultural identity. This training also seems to focus on the individual effects of poverty instead of the oppressive systems that create this inequality. This results in pathologizing the poor as more trainees are taught to look at individuals through a lens of impairment. Lott and Bullock (2007) give the example of lower-class mothers often receiving interventions that involve skill building. This implies that their cultural difference or the oppressive factors that may have contributed to their place in life are ignored. Only the individual factors are addressed which is inherently disempowering. By only treating a deficit in skills, we are ignoring the larger economic factors that limited their ability to spend the time learning said skills.

Classism in psychotherapy.

Psychotherapy is not immune to classism. Garfield, Weiss, and Pollack, (1973) conducted a study in which counselors were given written scenarios of children with behavioral problems. In the control group, the fictitious child was middle class, while in the experimental group the child had low SES. Each scenario was given to a counselor and they were asked what interventions they were willing

to use in order to help the individual. The therapist was then asked to identify the perceived potential outcome of the student (dropping out, increased behavioral problems, etc). The authors found that if therapists were given the low SES vignette, they were less likely to use more significant intervention such as in-home visits. They also projected that the adolescents who were identified as low SES would be more likely to drop out of school or become a juvenile delinquent. The important component to pull from this study is that even counselors can hold unconscious and conscious classist views that impact client outcomes (Garfield, Weiss, and Pollack, 1973).

Although this study seemed to provide some evidence for social class discrimination, there were some limitations to the design and methodology. The first is that the researchers did not provide empirically validated measures of classism. They also limited the counselors prognosis of the child to a choice of either delinquent, drop out, or satisfying school adjustment. As two of these choices seem to involve negative connotations, the weight of their measure seemed to indicate a negative resolution of the situation. In addition, the researchers associated certain interventions with “more involvement” without necessarily any reliability or validity to make this claim outside of face validity of proximity of distance near the client during any given intervention.

In another similar study, Sutton and Kessler (1986) also performed a vignette-based study that looked at psychologist professional judgments when working with individuals from varied social class. The authors collected data from 242 APA Division 12 members. Psychologists were then given one of three vignettes

that were made to represent various classes from the Hollingshead (1957) measure of class position. Each subject received one of the three vignettes, a letter of instructions, and given an additional nine measures that included 7-point Likert Scale measures of prognosis, client's motivation to change, client's self-concept, severity of disorder, the psychologists personal interest in working with the client, how likely respondents would be to use individual therapy as the primary intervention, and likelihood of referring to a physician for medication. Psychologists were also asked about their own social class, experience, general demographics, and finally their family of origin's social class.

Sutton and Kessler (1986) found that individuals from the lowest class generally received the least optimistic scores. Significant differences were produced for prognosis $F(2, 241) = 3.84, p < .03$; personal interest in treating, $F(2, 238) = 3.30, p < .04$; and client's self-concept, $F(2, 241) = 8.20, p < .004$. Prognosis, personal interest in working with the client, and perspective of the client's self-concept for the lower class vignette was shown to be significantly lower than both the middle and upper class, while there were no significant difference between prognosis of middle and upper class individuals. There were also no differences in classist beliefs for responders from different areas of the country or types of mental health professionals.

Sutton and Kessler (1986) used much more precise and empirically supported methodology than Garfield et al (1973), but there are still some limitations. The first is that they concluded raters' social class from an objective perspective of only parents' occupation and education level, which did not include important variables

such as family size, income, or perceptions of social class barriers individuals may face. In addition, their sample consisted only of APA Division 12 members, which represents a generally middle-class sample with potentially very similar personality and political affiliations. No actual measure of classist beliefs was included, but instead inferred based on a variety of hypothetical treatment variables. This is not necessarily a large flaw because of the lack of an empirically supported measure of classism during the time, but still a limitation to be aware of.

Smith, Mao, Perkins, and Ampuero (2011) did a study focusing on client's social class, therapeutic impressions, and beliefs in a just world (BJW). They presented one of four vignettes to 193 graduate students in psychology. The students were asked to read one of four vignettes about a male client. The vignette's contained similar information, except the client either came from a low-income background, working class background, middle class background, or wealthy background. Each scenario also included a class "appropriate" occupation and living conditions. The participants were then asked to assign a Global Assessment of Functioning (GAF) Score, fill out a clinical features scale, a BJW scale, and a scale that measured the perception of how the student would perceive an upcoming session with the client. The results indicated very little difference in evaluation across the four domains. The only significant finding was that students were less optimistic of outcomes for the working class client.

This study has several significant issues that can be addressed in future research. Their sample consisted primarily of counseling students. The authors' acknowledge that students lack the clinical skills or multicultural competence to

properly evaluate the clinical vignettes. This makes it difficult to properly evaluate the GAF scores. Another area of concern is that the vignettes did a poor job of isolating social class as the main component of study. In the vignette, the individual recently finished an internship with a local television station and was looking for future employment. His presenting concerns also included rumors being spread by other employees that were potentially sabotaging his job search. Both these issues are significant distracters and make it difficult to isolate the construct of classism. The subjects may have been more focused on his ability within interpersonal relationships when providing diagnostic impressions. The Presence of an internship with a television station also indicates a higher level of education and a relatively prestigious career trajectory. It would be wise for future studies to eliminate as many distracting issues as possible and have the primary focus be on stress and anxiety that can be directly linked to the individual's level of income, family size, occupational prestige, or education level.

Classism in research.

Although the previous studies occurred in 1973 and 1986, psychology has not really made strides in classism, at least from a research perspective. Buboltz, Miller, and Williams found that in the *Journal of Counseling Psychology* from 1973-1998, 56% of participants in studies came from college level age participants. Liu, Soleck, Hopps, Dunston, and Pickett (2004) further describe how this represents only 25.1% of the entire United States population and is based on those that are both educated and financially capable of attending colleges and universities. The ramifications of this are startling as this indicates that almost 30 years of research

are derived from middle-upper class value systems. Sue and Sue (1999) further this argument stating that most forms of therapy are dedicated toward educated middle class individuals. In order to better serve low-income clients we must have empirical and theoretical support that is normed on that population. This is a major problem that has occurred in Counseling Psychology and something that will need to be remedied following the continuing economic shift in the United States.

Appio, Chambers, and Mao (2013) did a qualitative analysis documenting stories of the lived experience of the working poor in therapy. One important aspect of the analysis is the documentation of the experience of working class people upon entering therapy. One individual notes the experience of walking into the therapists office, “She had a nice office . . . well, she has a Ph.D., so even though we connected and could communicate, I noticed that, looking at the books she had in office, there was some stuff that was way over my head” (p. 154). Another individual comments on her experience of looking at the clinician’s wardrobe, “Oh, the way they [clinicians] dressed. Definitely the way they dressed, jewelry . . . their mannerisms were, everything was so, oh, how can I say? It was just, everything was talking, it’s like they didn’t fit for the people they were treating” (p. 155). Both these experiences speak to the semi-conscious ways in which we maintain and communicate social hierarchy through a “professional” office and dress. The message that the client is in a power down social situation is communicated before a single word is spoken. Qualitative analysis like this is important because it speaks to the immeasurable way that classism is embedded into the therapeutic relationship.

A high-class environment conveys the message that these individuals do not belong, and can only be empowered through accessing a higher social class group.

Class sensitive forms of psychotherapy.

Smith and Romero (2010) state, “When mental health practitioners work with poor clients, they are working with people whose psychological distress—as well as any interventions offered to them—must be understood within the context of their experiences of oppression” (p. 12). They also argue that it is difficult for therapists to work in the context of financial oppression without addressing the oppression itself. Psychologists and counselors who perform therapy without addressing class oppression are therefore offering help that is inherently ridden with top-down power dynamics between the middle class counselor and impoverished individual.

Although limited in numbers, there are some contemporary forms of psychotherapy which are being touted as more class-oriented in their approach. Smyth, Goodman, and Glenn (2006) have created a “Full Frame Approach” form of therapy for working with low-income women. In this approach, individual components of poor communities and contextual components directly inform the psychological interventions used. Smith, Chambers, and Bratini (2009) have also used a similar style of community-driven therapy that also incorporates creative interventions, such as the use of art therapy, photography, poetry writing, hip-hop, performing therapy while walking through client’s neighborhoods, and reading from books about oppression such as *Pedagogy of the Oppressed* (Smith, Chambers, and Bratini, Freire, 1970). In their work with poor individuals, they actively fought

against the ideas of distance and neutrality. When taking this into consideration with Lott (2001) and Liu's (2010) definition of classism (behavioral and cognitive distancing from the poor) it seems to follow suit that therapy that actively goes against distancing would be successful.

Another example is the Reaching Out About Depression (ROAD) Program, which was collaborative project between law school students and mental health counselors. In this program alternative forms of interventions were developed for working with lower class women around issues such as economic inequality, domestic violence, and parenting. The ROAD program's mission includes setting up a network of support in low income communities, offering strategies that are empowering, providing community resources, creating leadership programs for poor women, and educating mental health and service providers (Goodman et al, 2007).

Psychotherapy programs such as these show the groundwork for culturally competent care. It will be important in the future to continue to develop programs such as these and evaluate their effectiveness. Benchmarking research on different programs designed to help the working class are key to the future of class sensitive psychotherapy. If more of these forms of psychotherapy and skill building can be developed from a class sensitive perspective, we as a field will begin to address the marginalization that occurs within mental healthcare.

Purpose of the Study

Classism is something that is rarely isolated and studied. The APA's resolution (2010) is a clear indicator that more research on the subject is needed.

The recent downturn in the U.S. economy has made the subject of SES even more relevant. The purpose of this study is to examine the potential prejudice mental health providers may hold toward individuals based on socioeconomic status. It has been established that both the general population and those involved in the helping professions hold preconceived notions related to social class and social status. These preconceived notions should manifest in cognitive and behavioral interpersonal distancing from these individuals; i.e. classism (Lott, 2002). Considering the large economic changes in the United States and advancement in psychometrics and technology, it is appropriate to replicate and extend previous vignette based studies. The study was designed to increase attention to this issue and encourage greater awareness around the issue of social class as a component of bias that counselors and psychologists must self-monitor to a greater degree. Currently we do have some data on classist behaviors from mental health professionals, but this has not ever been studied with an in-depth look at the mental health professionals' own social class. In past studies, there has not been a sufficiently reliable measure of classism as now exists, which can serve to further validate results in a manner not previously possible.

Hypothesis

This study pursues two hypotheses. The first hypothesis was focused on comparing therapist reactions to one of two vignettes (middle class vs. lower class). The second hypothesis was focused on how a clinicians' social class of origin impacts their evaluation of each vignette and their classist beliefs. The second hypothesis was used to explicitly examine between-group differences within each

vignette. In addition, a series of preliminary analyses were performed using the variables of sex, education level/occupational prestige, current income level, and perceived current social class level of each therapist.

1. Lower Class Vignette vs. Middle Class Vignette

- a. Clinicians who receive the lower class vignette would endorse lower GAF scores than those who receive the middle class vignette.
- b. Clinicians who receive the lower class vignette would endorse more negative stereotypes (High negative stereotype/low positive stereotype scores) than those who receive the middle class vignette.
- c. Clinicians who receive the lower class vignette would endorse less personal forms of treatment than those who receive the middle class vignette.
- d. Clinicians who receive the lower class vignette would have less optimistic expectations for the therapeutic relationship than those who receive the middle class vignette.

2. Clinician High M-DSIS Score vs. Low M-DSIS Score

- a. Clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) would endorse more classist views (High M-EBS) than those who have faced this type of oppression (Low M-DSIS scores)
- b. Clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores), who receive the low-income vignette, would endorse more negative stereotypes (High

negative stereotype/low positive stereotype scores) than those who have faced more oppression (Low M-DSIS scores).

- c. Clinicians who report their family of origin as facing less social economic oppression (High DSIS Scores), and receive the low-income vignette, would endorse lower GAF scores than those who have faced more oppression (low M-DSIS scores).
- d. Clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) and receive the low-income vignette, would have less optimistic expectations for the therapeutic relationship than those who have faced more oppression (low M-DSIS scores).
- e. Clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) and receive the low-income vignette, would endorse less personal forms of treatment (Referral) than those who have faced more oppression (low M-DSIS scores).

CHAPTER II

METHODS

Participants

The participants included 149 clinicians (24.8% Male, 72.5% Female, 2.7% Gender Queer/Transgender) from across the United States. Individuals were recruited for the survey using a variety of sampling methods. Some individuals were invited to participate in person through a paper pencil survey at professional conferences. Some were mailed the surveys and asked to mail them back completed. Others completed them through the UND Qualtrics survey website. The study was advertised on a variety of social media and online forums directed toward clinicians and sent out across professional list serves.

The racial makeup of the subjects was 85.9% White, 6.1% Bi-racial/Multiracial, 4.0% Hispanic, 2.0% Asian, .07% African American, and .07% American Indian. The bulk of the participants came from the West Coast and Midwest portion of the United States. Of the participants, 55.7% were assigned to the experimental low-income vignette group, while 44.3% were in the control middle-income vignette group. The study included counselors, psychologists, nurse practitioners, and social workers that conduct psychotherapy. Only non-student providers were considered eligible because of the difficulties of accounting for various psychotherapy experience and exposure to multicultural training. In

addition, previous research has shown that student ratings can be a poor indicator of social class beliefs (Smith, Mao, Perkins, and Ampuero, 2011) Also, non-student clinicians are more representative of “typical” clinicians due to their experience level and ability to provide an accurate GAF score.

The type of agency clinicians worked in was sorted into six qualitative categories based on frequencies data. These included University or College Counseling Center (30.9%), Private Practice (24.2%), Community Counseling Center (17.4%), Medical/Health Setting (10.7%), Non-Profit Agency (8.1%), or some type of School Setting (4.7%). The mean age of the participants was 40.5 (SD = 12.60) years old. The average individual income claimed was in the 40,000-50,000 range. The perceived SES categories individuals’ identified themselves as included Impoverished = 0.7%, Lower Class = 0.7%, Working Class = 9.4%, Lower Middle Class = 11.4%, Middle Class = 47.0%, Upper Middle Class = 30.9%, and no individuals self-identified as being Upper Class. Clinicians were also sorted by educational attainment. Two groups were created based on highest terminal degree completed. These groups were named Master’s Level Clinicians or “Masters” and Doctoral Level Clinicians or “Doctoral.”

Instruments/Measures

Demographics

Participants were asked for demographic information, but no unique identifying information was collected. Individuals were asked to indicate their age, sex, education level, racial identity, as well as their own view of their social economic status. They were asked to report their current perceived social class via

seven options. These included; Impoverished, Lower class, Working Class, Lower-Middle Class, Middle Class, Upper Middle Class, and Upper Class. Due to low response rates for the lower class, working class and lower-middle class options, this variable was recoded based on frequency data. Impoverished, lower class, working class, and lower-middle class were sorted into one variable called “Lower Class.” The Middle class option was left as a stand-alone category and called “Middle Class”. Upper-middle class and upper class were combined to form a group called “Upper Class”. This decision was also based upon people’s tendency to report themselves as middle class regardless of socioeconomic status. Any deviation either above or below middle class was rounded away from middle class to protect against this.

Individuals were also asked about income levels that they currently earn as well as their family of origin income level. Income levels were coded into five categories determined by frequency data. The categories included Lower (<\$30,000), Lower Middle (\$30,000-\$40,000), Middle (\$40,000-\$60,000), Upper Middle (\$60,000-\$80,000), and Upper (> \$80,000). These categories were determined through consideration of equitability within the sample as well as national statistics on income distribution. Family of origin income was divided into three categories rather than five because of the high number of individuals that endorsed a middle-income option for this question. These categories included Lower-Income (< \$25,000), Middle Income (\$25,000-\$79,999), and Upper Income (> \$80,000).

Vignettes.

The primary method of evaluation was in the form of a vignette that participants read and made decisions about. The style of vignette was modeled after a combination of the Garfield et al (1973) and Sutton & Kessler (1986) studies on counselor reactions to a vignette. The vignette was about a woman experiencing stress and anxiety that are effecting her psychosocial functioning. A female client was chosen because of women's over-representation in the low SES groups. In the middle class group, the vignette included psychosocial information that clearly indicated a middle class status (i.e. the client has a college degree, \$50,000 income, and is a mid-level manager at an office.) In the low-income group, the vignette included psychosocial information that clearly indicates a lower class status (i.e. the client obtained their high school diploma, 18,000 income, and works at a local fast food restaurant as manager). The individual's occupational prestige, income, and education level were chosen to be independent variables because they are the traditional measures of objective social class. Other than these three changes, the vignettes were identical.

The client was also given two adolescent children with no mention of a partner or marriage. This was to prompt potential stereotypes around promiscuity and poor parenting. The client was specifically made a restaurant employee to reinforce classist stereotypes around service work (such as seeing these individuals as dirty or uneducated). As the vignette progresses the symptoms of the potential client warrant a lower GAF score (i.e. a history of substance abuse, losing patients in childcare, leaving work for mental health reasons, etc). Therefore the reader should

feel like the client is decompensating as they progress through the vignette. These symptoms were chosen because they should prime classist stereotypes around substance abuse, poor parenting, and laziness/weakness.

Global Assessment of Functioning (GAF)

The Global Assessment of Functioning (GAF) score is a widely accepted form of clinical assessment that uses a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults. It is featured as a means of a multiaxial diagnosis in the DSM-IV-TR, which is the most predominantly used tool in psychological diagnosis in the United States. Following the vignette, individuals were asked to predict a GAF score for the individual currently and after 1 month, 3 months, and 6 months of treatment. In order to assure familiarity, a copy of the DSM-IV-TR GAF rating description was included in the packet. Low scores tend to show low functioning, mid-level scores show average functioning, and high level scores show superior functioning. GAF scores were combined to form two variables: "GAF With TX" and "GAF Without TX." Each group was comprised of a mean score created by averaging the initial GAF, plus the scores at the 1-month, 3 month, and 6 month marks (with and without therapy). This was done to evaluate clinicians' initial assessment as well as the prognosis for the client overtime. This allowed the researcher to accurately look at the ratio between initial scores and scores after various amounts of treatment.

Positive and negative classist stereotypes (Cozzarelli, Wilkinson and Tagler, 2001) (Appendix 1, p. 118)

Another way of measuring classism in a vignette study is through the endorsement of classist stereotypes. A list of classist stereotypes was developed and used by Cozzarelli, Wilkinson and Tagler in their 2001 article on perceptions of the poor. The original study used 209 college students from a large Midwestern college with adequate representation from liberal and conservative students. The scale asks respondents to rate how applicable a list of positive and negative attributes are to poor people and middle class people. Positive characteristics include attributes such as Hardworking, Healthy, Nice, Intelligent, while negative characteristics include attributes such as Lazy, Dirty, Abusive, Alcoholic, and Angry. Participants are asked to rate on a 5-point Likert Scale (1 = Not at all Characteristic of Poor People, 3= Not Sure, 5 = Extremely Characteristic of Poor People) how much they believed each attribute was applicable to poor people and then to middle class people. Overall reliability was found to be strong for this scale ($\alpha = .87$) with each subscale also performing strongly individually (Positive Stereotypes ($\alpha = .93$), Negative Stereotypes ($\alpha = .86$)). A study was conducted using 209 undergraduate students at a Midwestern college (110 Men, 99 Women). Due to the lack of scales focusing directly on attributes in poor and middle class individuals, there are no significant measures of convergent or discriminate validity for this scale at this time.

In order to get a cumulative look at classism, positive stereotypes were averaged into a category called "Positive Stereotypes." The same was done for all the

negative stereotypes via the category “Negative Stereotypes.” This allowed the endorsement of stereotypes to be examined as a cumulative indicator. In simpler terms, this allowed for the detection of any stereotypes regardless of which individual stereotype was primed for clinicians. When tested for internal reliability within the sample, both of these variables were shown to be strong with positive stereotypes having a Chronbach’s alpha of $\alpha = .84$ while the negative stereotypes were $\alpha = .90$. This is positive as it provides evidence of good internal consistency across the cumulative stereotype constructs.

Modality of care and perceived therapeutic relationship

Another area to detect classism is the clinician’s choice of intervention and perception of a potential therapeutic relationship. The following interventions were given as options within the survey: Weekly Therapy, Bi-Weekly Therapy, Twice a Week Therapy, In-Home Therapy, Family Therapy, Psychoeducation, and a potential referral to Career Counseling, Psychiatry, Social Worker or a Medical Doctor. Interventions were measured by the amount of social distance between the client and the mental health provider. This is based on the Lott (2001) definition of classism as cognitive and behavioral distancing from low-income people. This was done through a ten point Likert scale (1 – Strongly Disagree, 5 – Neutral, 10 – Strongly Agree) with individuals stating how likely they would agree with a statement. An example statement is “I would likely use individual counseling as my primary intervention, if the client requested it.”

In addition, some questions about the perception of the therapeutic relationship were asked. These questions included the likelihood the client would

show up for appointments, how resistant they believed the client would be, overall perceived enjoyment of working with this individual, and their belief the client would benefit from working with them or from therapy in general. These questions were also asked using a ten point Likert scale (1 – Strongly Disagree, 5 – Neutral, 10 – Strongly Agree).

Modified Differential Status Identity Scale (M-DSIS) (Brown et al, 2002).

The DSIS is a survey designed to measure one's perceived social class. It does this by asking a series of questions related to the subjective experience of facing social class barriers. The scale was validated by brown et al in 2002 and then again in 2007 by Thompson and Subich using 454 students. The analysis showed consistency across racial and ethnic groups. The DSIS has four constructs as identified through exploratory factor analysis. These include economic resources - basic needs, economic resources - amenities, social power, and social prestige. The total variance that these four variables accounted for in the original study was 57.76% (Brown et al, 2002). Economic resources—basic needs consists of items that assessed a person's perceived ability to meet basic needs, such as education, exercise, medical care, access to insurance, and personal possessions. Economic resources—amenities consists of items that measure perceived material possessions and leisure activities, such as home, cars, travel, shopping habits, securing a financial future, and connections with powerful people. Social Power consists of items measuring one's perceived legal power and job responsibilities, such as the ability to influence educational or institutional policies, contacting people who can help one get out of legal trouble, controlling the salary of others, and

networking capabilities. Social Prestige comprised items addressing how one perceives oneself as being valued in terms of ethnic/racial group, type of car driven, and physical appearance. These sub-scale scores can be averaged together to create a cumulative score that represents one's perceived social class. As this is the first scale to subjectively look at the experience of class in contemporary psychology, there is limited convergent or divergent validity data available at this time.

The scale uses a measure of -2 to +2 scale with 0 representing the social class of "The average American." For the purposes of this study we modified this to be a 0-+4 scale in order to guard against people feeling detoured by choosing a negative option. Higher DSIS scores are interpreted as denoting a person who has experienced less class oppression while lower M-DSIS scores are interpreted as a person who has experienced more social class oppression. The scale was modified so that participants were asked to fill it out for their family of origin as opposed to their current family. This change involved minor modifications in wording/instructions. This modification was done to assess clinicians' social class of origin as opposed to their current perceived social class.

The M-DSIS was scored according to protocol. This included the creation of four subtype variables that parallel the subscales: "M-DSIS Basic Needs", "M-DSIS Amenities", "M-DSIS Social Power," and "M-DSIS Social Prestige." Taking the mean of the four subtype variables created the M-DSIS Total score. This allowed the researcher to examine both ones overall perceived social class of origin as well as the four individual components that make up this category separately. In addition, clinician M-DSIS total scores were broken into five categories, representing their

subjective experience of social class. This data was based on frequencies and broken in equal percentiles; Low SES, 20.30%, Lower-Middle SES, 19.60%, Middle SES, 19.60%, Middle-High SES, 20.30%, and High SES, 20.30%. The range of scores represented the full spectrum of the M-DSIS with a minimum score of 1.03 and a maximum score of 4.68. The mean score was a 3.07 (SD = .77).

The M-DSIS was also consistent with previous reports concerning internal reliability, as the total score was shown to be $\alpha = .93$ with the sub-constructs of Economic Basics ($\alpha = .97$), Economic Amenities ($\alpha = .97$), Perceived Social Power ($\alpha = .97$), and Perceived Social Prestige ($\alpha = .92$) following suit. This is significant as this provides evidence that the modification of the timeline within the DSIS did not seem to have a large impact on the reliability. This should be interpreted with caution as the sub-construct alpha scores are high, which may indicate convergence of underlying constructs.

Modified Economic Beliefs Scale (M-EBS) (Stevenson and Medler, 1995, Aosved, Long, and Voller, 2009).

The Modified Economic Beliefs Scale (M-EBS) was used to directly assess classism. The original Economic Beliefs Scale was developed by Stevenson and Medler (1995) as a means of measuring classism as a form of oppression. They used a seven point Likert scale ranging from strongly agree to strongly disagree with neutral as a moderate answer. Internal reliability was found to be high ($\alpha = .77$) when measured across a sample of 155 participants (82 females, 73 males). When Aosved, Long, and Voller revised the scale in 2009, they added seven additional items. After conducting factor analysis, nine items loaded onto the construct of classism and greater internal reliability was established ($\alpha = .85$). The remaining

items included, “People who stay on welfare have no desire to work”, “Welfare keeps the nation in debt”, “People who don’t make much money are generally unmotivated”, “Homeless people should get their acts together and become productive members of society”, “Too many of my tax dollars are spent to take care of those who are unwilling to take care of themselves”, “If every individual would carry his/her own weight, there would be no poverty”, “There are more poor people than wealthy people in prisons because poor people commit more crimes”, “Poor people are lazy”, and “Most poor people are in debt because they can’t manage their money”. Due to the lack of classism scales in psychology, there are no significant measures of convergent or discriminate validity at this time.

A mean score was taken from the M-EBS and named “M-EBS Classism.” This was the established protocol for scoring the M-EBS. The mean score of the scale represents subjects overall political and social beliefs around social economic inequality. This was the primary indicator of classist attitudes in the study. All components of reliability were shown to be strong with internal reliability having an alpha of ($\alpha = .90$). It was important to run further analyses of the M-EBS because it was adapted from a cultural competence subscale and has not been used with seasoned clinicians before. EFA revealed that one factor accounted for 58.94% of the variance (Eigenvalue = 5.31). Initial EFA revealed that all items loaded onto the first factor at .70 or higher. A varimax rotation was attempted, but because only one component was extracted the solution could not be rotated.

Design

The design for this study was a randomized-between-groups quasi-experimental design. The independent variables in the study were the stimulus vignettes and the amount of social economic barriers the clinicians faced as adolescents (M-DSIS Scores). The dependent variables were classist attitudes based on the vignette (as measured by endorsing positive and negative characteristics of the individual in the vignette) and through a scale that measures general classist beliefs (M-EBS). Finally, individuals were asked to assign a current Global Assessment of Functioning (GAF) score to the individual portrayed in the vignette, and a projected GAF score following 1 month, 3 month, and 6 months weeks of therapy. Clinicians were also asked several questions about their prediction for the therapeutic relationship with the client and their choice of primary intervention. In addition, classist attitudes (M-EBS Scores) will also act as an independent variable for predicting reactions to the vignette.

Surveys

The study received a waiver of written informed consent from the University of North Dakota Institutional Review Board, but information about the study was included in the email and at the top of the packet. Individuals filled out the demographics section first. They then read the vignette and reviewed the GAF score standards from the DSM-IV-TR. Individuals were then prompted to assign seven GAF scores (Initial, and then 1 month, 3 month, and 6 month follow up scores) with and without treatment. The individuals were then prompted with a list of positive and negative stereotypes and asked to rate the client on each. The clinicians were

then presented with questions related to the therapeutic relationship and types of treatment options they would pursue. After this, the clinicians were given the Modified Differential Status Identity Scale (M-DSIS). The instructions were bolded so that individuals would not mistakenly fill it out for their current family. Finally, participants were presented with the M-EBS. Upon completion of the survey, participants were prompted with a debriefing form. This was either handed to them directly or appeared as a prompt upon completing the survey. Individuals were then thanked for their participation and given contact information for the Department of Counseling Psychology at the University of North Dakota in case they would like further information.

Analysis

Hypothesis 1 required an independent samples T-test between the clinicians who received the low-income vignette and those that received the middle class vignette. The dependent variables included the GAF with treatment scores/GAF without treatment scores, cumulative positive stereotypes score, cumulative negative stereotypes score, and the perceived primary therapeutic intervention/perceived therapeutic relationship scores. In addition, individual positive and negative stereotypes were examined between the two groups.

Hypothesis 2 required a one-way ANOVA between the five different social class of origin groups. The dependent variables included GAF with treatment scores/GAF without treatment scores, cumulative positive stereotypes score, cumulative negative stereotypes scores, M-EBS classism scores, and the perceived therapeutic intervention/modality of treatment scores. In addition, to the initial two

hypotheses, some other preliminary analysis was performed. T-tests comparing the sex of clinician and level of education were performed across all dependent variables. An ANOVA was performed for self-reported SES (perceived SES), and level of income. Correlational data between variables was also examined. Post hoc analysis utilized the Tukey test because of the conservative nature of the test.

CHAPTER III

RESULTS

Preliminary Analysis

Before beginning the analysis for the two main hypotheses, it is important to explore other independent variables that may interact with social class of origin. For the purposes of this study, sex of clinician, education level, current income level, and perceived social class were examined. Each of these was compared across the entire sample to look for individual demographic differences in evaluation of the vignette and M-EBS classism scores. When these differences were found, they were further examined within each vignette condition to detect specific interactions between the demographic variable and evaluation of the low-income vignette. This step was performed as these interactions would have the most influence on the hypotheses.

Sex

Women provide the bulk of mental health services within the country. Although the cumulative sample is unevenly skewed toward the female gender, this is representative of typical mental health agencies. With this being said, the results should be taken with caution because of the low amount of men represented within the study (24.8%). One interesting finding was that women as a group tended to

endorse significantly lower M-DSIS scores than men ($t(141) = 2.21, p = .03$),

Table 1							
Sex Differences -							
T-Test - N=147							
Sex	Mean	Men	SD	Women	SD	P	Effect Size r
Total Sample							
M-EBS Classism	1.69	1.74	0.66	1.70	0.68	0.71	N/A
Stereotypes							
POS ST	4.13	4.00	0.41	4.15	0.46	0.08	N/A
NEG ST	2.48	2.60	0.52	2.46	0.54	0.18	N/A
Intelligent	4.28	4.03	0.76	4.35**	0.66	0.01	0.22
Nice	4.25	4.06	0.63	4.30*	0.64	0.05	0.18
Uneducated	2.41	2.89	1.31	2.24**	1.12	0.01	0.25
Weak	2.38	2.73	0.77	2.29*	0.97	0.02	0.23
Treatment							
GAF with TX	66.26	66.78	6.92	66.00	7.24	0.57	N/A
GAF without TX	56.04	56.35	6.59	55.76	8.01	0.69	N/A
In Home Visits	4.07	3.03	2.51	4.43**	2.74	0.01	0.26
Family Therapy	6.39	5.68	2.42	6.65*	2.30	0.03	0.20
PsychoEd	5.63	4.84	2.56	5.92*	2.40	0.02	0.21
Psychiatrist	3.85	3.30	1.75	4.11*	2.22	0.05	0.20
Medical Doctor	3.80	2.97	2.06	4.14*	2.26	0.00	0.26
* = Significance <.05							
** = Significance < .01							

This was also true across all subscales with the exception of M-DSIS social prestige.

T-test analysis indicated no significant differences between men and women across cumulative positive stereotypes, cumulative negative stereotypes, or GAF with or without treatment scores. A few individual stereotypes were significant. Women tended to see the client as more intelligent ($t(142) = -2.50, p = .01$), nicer ($t(142) = -2.02, p = .01$), less uneducated ($t(142) = -2.88, p = .01$), and less weak ($t(142) = -2.46, p = .02$). Concerning treatment, women were more likely to endorse performing in-home therapy ($t(142) = -2.74, p = .01$), family therapy ($t(141) = -2.19,$

$p = .03$), using psychoeducation ($t(141) = -2.33, p = .02$), referring to a psychiatrist ($t(141) = -2.02, p = .05$), and referring to a medical doctor ($t(141) = -2.77, p = .01$) as primary interventions.

To determine whether sex needed to be included in the analyses of the hypotheses, a follow-up analysis was conducted. When examining sex differences in the low-income vignette group alone, only two of the variables remained significant; Performing in-home therapy ($t(77) = 2.35, p = .02$) and referral to a medical doctor ($t(76) = -2.43, p = .02$). These findings provide evidence that there may be an interaction effect between sex of clinician and evaluation of the low-income vignette around these therapeutic modalities.

Education level.

Within mental health providers there are two tiers of professionals; Master's Level and Doctoral Level. T-test analysis was conducted to compare differences within the total sample. Examining both groups together yielded no differences in M-EBS classism scores, cumulative positive stereotypes, and cumulative negative stereotypes. When individual stereotypes were examined, master's level clinicians were more likely to see the individual as friendly ($t(146) = 2.48, p = .01$), nice ($t(144) = 3.20, p = .00$), and promiscuous, ($t(145) = 2.11, p = .04$).

Master's level clinicians were also more likely to endorse a referral to a medical doctor ($t(145) = 2.11, p = .04$) and a psychiatrist ($t(145) = 2.90, p = .00$) in the total sample. The one area in which doctoral level clinicians endorsed significant differences was in the GAF without treatment scores, as they tended to be more optimistic ($t(146) = -2.25, p = .03$) of the client's outcome without therapy.

When examining the low-income vignette alone only two variables remained significant; referral to a psychiatrist ($t(79) = 2.16, p = .03$) and referral to a medical doctor ($t(79) = 2.45, p = .02$). These findings provide evidence that there may be an interaction effect between education level of clinician and evaluation of the low-income vignette around these therapeutic modalities.

Table 2							
Education Level- T-Test							
N=149							
Both Groups	Mean	Master	SD	Doctoral	SD	P	Effect
M-EBS Classism	1.69	1.77	0.66	1.62	0.67	0.19	N/A
Stereotypes							
POS ST	4.13	4.16	0.48	4.09	0.44	0.38	N/A
NEG ST	2.48	2.50	0.54	2.45	0.57	0.65	N/A
Friendly	4.15	4.29**	0.80	4.01	0.55	0.01	0.20
Nice	4.25	4.42**	0.67	4.09	0.57	0.00	0.26
Promiscuous	2.58	2.75	0.98	2.41*	0.96	0.04	0.17
Treatment							
GAF with TX	66.26	66.09	7.51	66.42	6.74	0.78	N/A
GAF without TX	56.04	54.59	7.40	57.38*	7.68	0.03	0.18
Psychiatry	3.85	4.37	2.29	3.36**	1.86	0.00	0.23
Medical Doctor	3.80	4.20	2.28	3.42*	2.17	0.04	0.17
* = Significance <.05							
** = Significance < .01							

Current income level.

In addition to subjective measures of social class, it was also important to consider some objective measures as well. An ANOVA was run for the dependent measures and five different ranges of income for the total sample. These ranges included Lower Income, Low-Middle Income, Middle Income, Middle Upper Income, and Upper Income. The Tukey post hoc analysis was performed to examine

individual differences. The Tukey test was chosen as the conservative nature of the test would guard against errors due to a relatively small sample size. There were no differences in overall classism, positive stereotypes, or negative stereotypes.

Table 3 Clinician Income ANOVA N = 149													
Total Sample	Lower		Low-Middle		Middle		Mid Upper		Upper		F	SIG	
	M	SD	M	SD	M	SD	M	SD	M	SD			
M-EBS Classism	1.69	0.65	1.56	0.58	1.89	0.72	1.52	0.63	1.67	0.69	1.57	0.19	
Stereotypes													
POS ST	4.20	0.55	4.16	0.47	4.03	0.43	4.22	0.41	4.08	0.48	1.02	0.40	
NEG ST	2.41	0.46	2.46	0.63	2.64	0.56	2.39	0.51	2.37	0.57	1.40	0.24	
Strong	4.33	0.70	4.17	1.01	3.81*	0.83	4.46*	0.82	4.30	0.91	3.12	0.02	
Weak	2.26	0.86	2.33	0.96	2.83**	0.93	2.14*	0.79	2.07	0.96	4.03	0.00	
Treatment													
GAF with TX	65.42	6.47	67.11	7.79	66.73	7.87	66.26	5.87	65.64	7.49	0.26	0.91	
GAF without TX	54.05	7.90	56.40	7.35	54.92	9.33	56.63	6.44	58.07	5.37	1.20	0.32	
Severe Disorder	3.63	1.86	4.13	2.01	4.71*	1.80	3.43	1.79	3.75	1.86	2.66	0.04	
* = Significance <.05													
** = Significance < .01													

Regardless of vignette, middle upper income clinicians viewed the client as stronger [F (4, 142) = 3.12, p = .02] than middle income individuals. Middle upper and upper income clinicians also viewed the client as less weak [F (4, 140) = 4.03, p = .00] than the middle income clinicians. There were no significant differences related to GAF scores with or without treatment. Middle income clinicians were more likely to endorse that the client had a severe disorder [F (4, 143) = 2.66, p = .04] than the middle upper income individuals. This difference remained significant in the low-income vignette group [F (4, 77) = 3.41, p = .01] suggesting a possible interaction

effect between middle class income and endorsement of a severe disorder for the low-income group.

Perceived social class.

Participants were asked about their current perception of their own social class. These responses were sorted into three categories because of the tendency for individuals to endorse the middle class option. These groups included Lower, Middle, and Upper. When looking at the total sample, positive stereotypes,

Table 4 Perceived Social Class ANOVA N = 149								
	Lower		Middle		Upper		F	SIG
	M	SD	M	SD	M	SD		
M-EBS Classism Stereotypes	1.74	0.72	1.68	0.63	1.68	0.70	0.10	0.90
POS ST	4.19	0.48	4.09	0.43	4.14	0.51	0.48	0.62
NEG ST	2.44	0.50	2.50	0.55	2.45	0.60	0.18	0.83
Friendly	4.42*	0.79	4.05*	0.59	4.09*	0.73	3.50	0.03*
Nice	4.50*	0.62	4.20	0.65	4.16*	0.60	3.20	0.04*
Immoral	1.81*	0.69	2.13	0.80	2.29*	0.89	3.29	0.04*
Treatment								
GAF with TX	64.86	7.61	66.68	6.70	66.60	7.35	0.80	0.45
GAF without TX	54.37	7.99	56.12	6.72	57.09	8.64	1.21	0.30
Benefit in General	8.94*	1.27	8.47	1.13	7.95*	1.88	4.52	0.01**
Twice a Week	6.48*	2.54	5.80	2.42	4.84*	2.82	4.03	0.02*
Career Coun	3.87*	1.96	3.34	2.04	2.77*	1.68	3.19	0.04*
Psychiatrist	4.56*	2.42	3.89	2.02	3.29*	1.97	3.46	0.03*
Medical Doctor	5.10**	2.53	3.53**	2.12	3.29**	1.91	7.58	0.00*
* = Significance <.05								
** = Significance < .01								

negative stereotypes, and GAF scores with and without treatment were not significantly different across SES. Although there were not significant differences in the cumulative variables of positive and negative stereotypes, some individual stereotypes, treatment modalities, and opinions about the therapeutic relationship

were significant. Examining the total sample revealed that those from the lower class group were more likely to see the client as friendly [F (2, 145) = 3.50, p = .03], nice [F (2, 143) = 3.20, p = .04], and less immoral [F (2, 144) = 3.29, p = .04] compared to the upper class group. The middle class group was less likely to see the client as friendly compared to the lower class group [F (2, 145) = 3.50, p = .03]. The lower class clinicians were also more likely to believe the client would benefit from therapy [F(2, 143) = 4.52, p = .01], would be more willing to see the client twice a week if asked [F(2, 144) = 4.03, p = .02], more likely to refer the client to career counseling [F(2, 145) = 3.18, p = .04], more likely to refer to a psychiatrist [F(2, 144) = 3.46, p = .03], and more likely to refer to a medical doctor [F(2, 144) = 7.58, p = .00] compared to the upper class clinicians. The middle class clinicians were also less likely to refer to a psychiatrist compared to the lower class group [F (2, 144) = 3.46, p = .03].

When examining these differences in the low-income condition alone, only referral to a psychiatrist [F (2, 78) = 3.19, p = .05], and medical doctor [F (2, 77) = 5.39, p = .01], remained significant. In addition, GAF scores without treatment were also significant in the low-income condition, despite not being significant in the total group sample [F (2, 79) = 3.38, p = .04]. This suggests a possible interaction effect between GAF without treatment score and present SES as well as referral to a psychiatrist and medical doctor in the low-income vignette.

Preliminary Analysis Summary

A few of the main dependent variables seemed to interact with the preliminary analysis independent variables. In terms of sex, when looking at the

low-income condition, women were significantly more likely to endorse in-home therapy and referral to a medical doctor. This provides some evidence that there is an interaction effect between sex of the clinician and willingness to perform in-home therapy as well as referring to a medical doctor. Secondly, doctoral level clinicians were less likely to refer the low-income client to a medical doctor or psychiatrist compared to masters level clinicians. This provides some evidence that there could be an interaction effect between education level and referral to a medical doctor or psychiatrist as well.

Finally, perceived SES proved to have three potential interaction effects, including one with the main dependent variable GAF without treatment. Clinicians who identified as upper class and middle class reported significantly higher GAF without treatment scores compared to those from low income backgrounds. Those who identified as being from a lower class background were also more likely to refer to a medical doctor and a psychiatrist than those from middle or upper class backgrounds. It was important to consider these potential differences when examining the hypotheses and correlational analysis.

Hypotheses - Results

Overall, the mental health professionals in this study scored at the low end of the M-EBS classism scale. The normal mean score for the M-EBS is 3.00. This sample produced a low mean score ($M=1.69$, $SD = .67$). Categorically, this would place mental health professionals between the strongly disagree and disagree category in regards to their average endorsement of classist statements. The highest score

endorsed (Max = 3.33) is categorically between the neutral and agree categories, and the lowest score was solidly in the strongly disagree category (Min = 1.00).

Concerning positive and negative stereotypes, the average score across the total sample was slightly above the predicted middle score (m = 4.13, SD = .46),

indicating most individuals endorsed at least some positive characteristics for the client in the vignette regardless of which they received. The negative stereotype mean score was slightly below the middle score (m = 2.48, SD = .55) indicating that most individuals were likely to

Table 5					
Description					
Positive Stereotypes					
Positive Stereotypes	N	Min	Max	Mean	SD
Positive Stereotypes	148.00	2.92	5.25	4.13	0.46
Hardworking	148.00	2.00	6.00	4.86	0.76
Healthy	147.00	1.00	6.00	3.63	0.73
Proud	146.00	2.00	6.00	3.86	0.92
Intelligent	148.00	3.00	6.00	4.28	0.70
Family Oriented	147.00	1.00	6.00	4.26	0.85
Happy	148.00	1.00	6.00	2.96	0.90
Strong	148.00	2.00	6.00	4.18	0.88
Friendly	148.00	2.00	6.00	4.15	0.69
Responsible	148.00	3.00	6.00	4.61	0.79
Loving	145.00	3.00	6.00	4.34	0.70
Nice	146.00	3.00	6.00	4.25	0.64
Moral	146.00	2.00	6.00	4.21	0.75

slightly disagree with the majority of the negative statements. The rest of the stereotype descriptives were summarized in Tables 5 & 6.

The average GAF score with treatment was in the “61-70 - Some Mild Symptoms” category (m=66.26, SD = 7.10) of the DSM-IV-TR. This category is defined as “Depressed mood and mild insomnia OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy), but generally functioning pretty well, has some meaningful interpersonal relationships.” (APA, 2000, p. 34).

Table 6					
Description					
Negative Stereotypes					
	N	Min	Max	Mean	SD
Negative Stereotypes Total	147.00	1.15	3.71	2.48	0.55
Lazy	147.00	1.00	4.00	2.07	0.80
Stupid	147.00	1.00	4.00	1.95	0.78
Dirty	147.00	1.00	4.00	1.97	0.82
Uneducated	146.00	1.00	5.00	2.41	1.20
Unpleasant	147.00	1.00	6.00	2.33	0.87
Immoral	147.00	1.00	4.00	2.11	0.82
Angry	147.00	1.00	6.00	3.12	0.99
Weak	146.00	1.00	5.00	2.38	0.94
Violent	147.00	1.00	4.00	2.04	0.82
Mentally Ill	146.00	1.00	6.00	2.79	1.24
Too Many Kids	146.00	1.00	4.00	1.89	0.88
Abusive	146.00	1.00	4.00	2.25	0.87
Alcoholic	147.00	1.00	5.00	3.07	1.03
Criminal	146.00	1.00	4.00	1.89	0.82
Unkind	144.00	1.00	6.00	2.35	0.96
Depressed	146.00	1.00	6.00	4.38	0.94
Physically Ill	143.00	1.00	6.00	3.08	0.85
Promiscuous	147.00	1.00	5.00	2.58	0.98
Unmotivated	146.00	1.00	6.00	2.33	0.96
Drug Abuser	146.00	1.00	6.00	2.51	1.03
Inconsiderate	147.00	1.00	9.00	2.39	1.24

The GAF without treatment mean was in the “51-60 Moderate Symptoms” category ($m = 56.04$, $SD = 7.64$). This category is defined as “Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). Concerning the therapeutic relationship, clinicians generally believed the client would benefit from working with them ($m = 8.09$, $SD=1.14$) and would benefit from therapy in general ($m = 8.42$, $SD=1.46$). Participants generally disagreed that the client had a severe disorder ($m = 3.99$,

SD=1.46). Clinicians tended to slightly agree that the client would miss appointments (m = 5.16, SD=1.66) and slightly disagreed that the client would be resistant in therapy (m = 4.18, SD=1.63). These findings were summarized in greater detail in Table 7.

Table 7 Therapeutic Relationship/ Primary Intervention Descriptions					
	N	Min	Max	Mean	SD
Benefit from Me	148.00	1.00	10.00	8.09	1.14
Benefit in General	146.00	2.00	10.00	8.42	1.46
Severe Disorder	149.00	1.00	8.00	3.99	1.89
Miss Appointments	148.00	1.00	10.00	5.16	1.66
Resistance	147.00	1.00	9.00	4.18	1.63
Weekly Therapy	148.00	1.00	10.00	8.28	1.58
Biweekly Therapy	148.00	1.00	10.00	7.08	2.17
Twice A Week Therapy	147.00	1.00	10.00	5.67	2.63
In-Home Visits	148.00	1.00	10.00	4.07	2.75
Family Therapy	147.00	1.00	10.00	6.39	2.38
Psycho Ed	147.00	1.00	10.00	5.63	2.49
Refer to Career Coun	148.00	1.00	9.00	3.29	1.95
Refer to Psychiatrist	147.00	1.00	10.00	3.85	2.13
Refer to Medical Doctor	147.00	1.00	10.00	3.80	2.25
Refer to Social Worker	147.00	1.00	9.00	3.33	1.97

In terms of intervention choice, clinicians strongly endorsed that they would be willing to provide weekly counseling (m = 8.28, SD=1.58) and bi-weekly counseling (m = 7.08, SD=2.17). They were somewhat less likely to provide counseling twice a week (m = 5.67, SD=2.63), a psychoeducation class (m = 5.63, SD=2.49), and family therapy (m = 6.39, SD=2.38). Clinicians slightly disagreed with

their willingness to perform in-home visits ($m = 4.07, SD=2.75$), their willingness to refer to career counseling ($m = 3.29, SD=1.95$), a psychiatrist ($m = 3.85, SD=2.13$), a medical doctor ($m = 3.80, SD=2.25$), or a social worker ($m = 3.33, SD=1.97$). These findings are summarized in greater detail in Table 7 as well.

Hypothesis I: Lower Class vs. Middle Class Vignette

A T-test was performed comparing the clinicians who received the low-income vignette to those that received the middle class vignette comparing positive and negative stereotypes endorsed. There were no significant differences between the groups concerning cumulative positive stereotypes ($t(146) = -.17, p = .87$), or cumulative negative stereotypes ($t(145) = .06, p = .95$). Although there were no overall significant differences, there were some differences across individual stereotypes. The middle class client was judged to be lazier ($t(145) = -4.15, p = .00$, Effect Size = .32), weaker ($t(144) = -2.08, p = .04$, Effect Size = .17), more intelligent ($t(146) = -4.32, p = .00$, Effect Size = .34), and less uneducated ($t(144) = 8.02, p = .00$, Effect Size = .56).

A T-test was performed comparing the clinicians that received the middle class vignette with those that received the low-income vignette in terms of cumulative GAF scores with and without treatment. GAF scores with and without treatment were both shown to be significantly different between the groups. Clinicians who received the middle class vignette believed that their client would function better with treatment ($t(146) = -2.33, p = .00$, Effect Size = .18). This difference was even more pronounced for the GAF without treatment scores ($t(146) = -3.34, p = .00$, Effect Size = .27). For the low-income vignette, the range of

GAF with treatment was 52 - 80.25 and from 37.75 – 70 without treatment. For the middle class vignette, the range of GAF with treatment scores was from 47.50 – 83.75 and from 40 - 76.75 without treatment.

Table 8 Lower Class vs. Middle Class Vignette T-Test N = 149 (Lower Class N = 83) (Middle Class N = 66)							
Constructs	Mean	Lower Class	SD	Middle Class	SD	P	Effect Size r
Pos Stereotypes	4.13	4.12	0.51	4.13	0.51	0.87	N/A
Neg Stereotypes	2.48	2.47	0.60	2.50	0.54	0.95	N/A
GAF With Tx	66.26	65.05	6.37	67.75	7.69	0.02*	0.18
GAF NO TX	56.04	54.22	7.07	58.30	7.78	0.00**	0.27
Sig. Positive ST							
Intelligent	4.28	4.07	0.68	4.55	0.64	0.00**	0.34
Sig. Negative ST							
Lazy	2.07	1.84	0.77	2.36	0.76	0.00**	0.32
Uneducated	2.41	3.01	1.15	1.68	0.77	0.00**	0.56
Weak	2.38	2.24	0.97	2.56	0.88	0.03*	0.17
Like to Work	8.06	8.24	1.16	7.83	1.37	0.03*	0.16
Benefit from Me	8.09	8.32	1.06	7.80	1.17	0.00**	0.23
Refer Psychiatrist	3.85	3.49	2.18	4.29	2.01	0.00**	0.19
* = Significance <.05							
** = Significance <.01							

For perceived therapeutic relationship and treatment modality, there were only a few differences between groups. Clinicians were more likely to endorse wanting to work with the low-income client ($t(132) = 2.21, p = .03, \text{Effect Size} = .16$) and more likely to believe the low-income client would benefit from working with them ($t(146) = 2.80, p = .01, \text{Effect Size} = .23$). In addition, the clinicians were more likely to refer the middle class client to a psychiatrist compared to her low-income counterpart ($t(131) = -2.75, p = .01, \text{Effect Size} = .23$). This single difference could have also been a result of interaction effects with sex, education level, or perceived current social class as opposed to just classist distancing

Hypothesis II - M-DSIS Scores

M-DSIS Score for the Low-Income Vignette

An ANOVA was run to examine the social class of origin of respondents (Lower vs. Lower Middle vs. Middle vs. Upper Middle vs. Upper) and evaluations of each vignette. Examining the data for clinicians who evaluated the low-income vignette alone provided some interesting results. Positive stereotypes were shown to be significant across social class of origin groups [$F(4, 77) = 3.09, p = .02$]. Those from upper class backgrounds tended to endorse higher rates of positive stereotypes compared to their middle or low-middle class of origin counterparts. Specifically, the positive stereotypes of proud [$F(4, 75) = 03.02, p = .02$] and strong [$F(4, 77) = 2.40, p = .05$] seemed to drive this significance. Tukey test post hoc analysis revealed that respondents from upper class backgrounds were significantly more likely to see the low-income client as proud compared to clinicians from middle class backgrounds. Upper class origin clinicians were also more likely to see the low-income client as strong compared to those from lower-middle and upper middle class backgrounds.

Negative stereotypes for the low-income client were not shown to be significantly different across any of the social class groups. With that being said, there were still some interesting findings within the individual negative stereotypes of lazy [$F(4, 76) = 3.11, p = .02$], angry, [$F(4, 77) = 3.36, p = .01$], and weak [$F(4, 75) = 3.92, p = .01$]. Those from upper class backgrounds were less likely to see the low-income client as lazy compared to those from middle upper class backgrounds,

angry compared to those from both upper middle class/middle class backgrounds, or weak compared to those from upper middle class backgrounds.

Table 9												
SES of Origin, N = 149												
Sample Size - Lower (N=17), Low-Mid (N=16), Mid (N=19), Upp-Mid (N=15), Upper (N=16)												
Low-Income Vignette	Lower		Low-Middle		Middle		Mid Upper		Upper		F	SIG
<i>Stereotypes</i>	M	SD	M	SD	M	SD	M	SD	M	SD	F	SIG
POS ST	4.15	0.39	4.01*	0.42	3.91*	0.46	4.10	0.47	4.46*	0.63	3.09	0.02*
NEG ST	2.35	0.46	2.53	0.64	2.58	0.64	2.65	0.63	2.27	0.58	1.14	0.34
Proud	4.25	0.93	3.73	0.80	3.36*	1.01	3.53	0.99	4.33*	1.23	3.02	0.02*
Strong	4.24	0.44	4.06*	1.03	4.16	1.07	4.07*	0.88	4.94*	1.12	2.42	0.05*
Lazy	1.69	0.60	2.07	0.80	1.89	0.66	2.20*	0.86	1.38*	0.72	3.11	0.02*
Angry	3.06	1.00	3.13	1.06	3.57*	0.96	3.73*	0.80	2.56*	1.21	3.36	0.01**
Weak	2.00	0.73	2.80*	1.01	2.05	0.71	2.67*	1.11	1.73*	0.96	2.43	0.05*
<i>Treatment</i>												
GAF with TX	64.68	6.54	63.28	4.46	64.88	7.51	66.79	6.91	65.94	6.13	0.65	0.63
GAF without TX	52.32	8.88	50.40*	5.11	55.26	6.96	56.45	5.90	56.86*	6.19	2.68	0.04*
SES of Origin, N = 149												
Sample Size - Lower (N=12), Low-Mid (N=14), Mid (N=10), Upp-Mid (N=15), Upper (N=13)												
Middle Class Vignette	Lower		Low-Middle		Middle		Mid Upper		Upper		F	SIG
<i>Stereotypes</i>	M	SD	M	SD	M	SD	M	SD	M	SD	F	SIG
POS ST	4.24	0.47	4.10	0.43	3.89	0.20	4.24	0.37	4.18	0.42	1.39	0.25
NEG ST	2.37	0.59	2.30	0.51	2.59	0.32	2.53	0.44	2.49	0.51	0.67	0.61
<i>Treatment</i>												
GAF with TX	62.35*	7.62	69.94*	6.94	65.39	4.94	68.76*	8.06	72.12*	6.88	3.70	0.01**
GAF without TX	54.77	7.14	60.65	6.28	57.25	5.97	58.61	8.61	60.97	9.12	1.42	0.24
In-Home Therapy	6.25*	2.83	3.64*	2.41	3.30*	2.71	3.53*	2.59	3.23*	1.74	3.21	0.02*
SES of Origin, N = 149												
Total Sample	Lower		Low-Middle		Middle		Mid Upper		Upper		F	SIG
<i>Classism</i>	M	SD	M	SD	M	SD	M	SD	M	SD	F	SIG
M-EBS Classism	1.46*	0.56	1.96*	0.64	1.71	0.72	0.71	0.13	1.57	0.64	2.54	0.04
* = Significance <.05												
** = Significance <.01												

Concerning treatment predictions, there were no differences across respondent social class concerning GAF scores with treatment [F (4, 77) = .65, p = .63]. There were significant differences for GAF scores without treatment [F (4, 77) = 2.68, p = .04]. Those from upper class backgrounds tended to be more optimistic about the clients GAF score without treatment compared to those from lower-middle class backgrounds. Concerning modality of care and perceived therapeutic

relationship there was no significant differences across the low-income vignette group. It should be noted that there was a potential interaction effect between education level and GAF without treatment which may have partially accounted for this difference as well.

M-DSIS Score for the Middle Class Vignette

None of the positive stereotypes [$F(4, 59) = .83, p = .52$] or negative stereotypes [$F(4, 59) = .66, p = .63$] of the middle-class condition were significant across respondent social class of origin as identified by the M-DSIS. There were also no differences for GAF scores without treatment, [$F(4, 59) = 1.69, p = .16$]. However, significant differences did emerge for GAF scores with treatment; clinicians from lower class backgrounds reporting lower scores than those from lower-middle, middle upper, and upper backgrounds [$F(4, 59) = 4.65, p = .00$]. Another new area of significance was in the clinician's willingness to perform in-home therapy [$F(4, 59) = 3.21, p = .02$]. Those from lower class backgrounds were significantly more likely to do in-home visits compared to all other SES groups. This was likely accounted for by sex differences as mentioned in the preliminary analysis.

Correlations

In order to fully understand the results of the study correlational analysis was also performed. Four correlation tables were created for each condition. This allowed for further examination of the four subtypes of the M-DSIS (four aspects that make up social class of origin) and M-EBS Classism scores in terms of the dependent variables (stereotypes, GAF scores, therapeutic relationship, and treatment modalities).

When examining the low-income vignette alone, several important variables were shown to have relationships. Positive and negative stereotypes had a strong negative correlation ($r = -.56, p = .00$). Positive stereotypes correlated weakly with M-DSIS social power ($r = .24, p = .03$) and had a moderately negative relationship with M-EBS Classism ($r = -.30, p = .01$). Negative stereotypes correlated positively at a moderate level with M-EBS Classism ($r = .37, p = .00$). GAF with TX correlated strongly with GAF without TX ($r = .56, p = .00$). In addition, GAF without TX correlated positively at a moderate level with M-DSIS basic needs ($r = .26, p = .03$), M-DSIS amenities ($r = .28, p = .02$), M-DSIS social power ($r = .29, p = .02$), and M-DSIS Total ($r = .29, p = .02$). GAF without treatment also correlated negatively at a weak level with M-EBS Classism ($r = -.22, p = .05$). Perceived SES level proved to be a potential confounding variable in the preliminary analysis concerning GAF without TX scores. When the analysis was run again while controlling for perceived SES, only M-DSIS social power ($r = .25, p = .03$), M-DSIS total ($r = .23, p = .05$), and M-EBS Classism ($r = -.25, p = .03$) remained significant.

Finally, in regards to primary treatment modality/perception of the therapeutic relationship there were four significant relationships. First there was a weak negative relationship between willingness to perform weekly therapy as a primary intervention and M-DSIS social prestige scores ($r = -.23, p = .04$). There was also a moderate negative correlation between referring to a medical doctor as a primary intervention and M-DSIS amenities ($r = -.30, p = .01$). Finally, there was a weak correlation between referring to a psychiatrist as a primary intervention and M-DSIS Total ($r = -.25, p = .03$). This seems to have been driven by a moderate

negative correlation between referring to a psychiatrist and M-DSIS amenities. Preliminary analysis indicated that sex of the clinician may be a confounding variable for this aspect of the study. Therefore the analysis was run again while controlling for sex. There were no significant differences in terms of treatment modality when sex was controlled for. Finally, none of the indicators of perception of the therapeutic relationship correlated with any component of the M-DSIS or the M-EBS classism scores.

When examining only those that received the middle class vignette, several of the relationships that were significant in the low-income vignette disappeared. For example, positive stereotypes still strongly correlated with negative stereotypes ($r = .28, p = .02$), but to a lesser degree. Positive stereotypes no longer significantly correlated with M-DSIS social power or M-EBS Classism. Negative stereotypes did not correlate with any other variable in the middle class vignette group, despite correlating with M-EBS classism in the low-income vignette group. In the low-income group, GAF without treatment correlated with all aspects of the M-DSIS, but in the middle class vignette group only M-DSIS social power remained significant ($r = .28, p = .02$). Finally, unlike the low-income vignette, M-EBS Classism no longer correlated with GAF without treatment.

Some new relationships emerged in the middle class vignette group. GAF with treatment correlated positively with M-DSIS basic needs at a strong level ($r = .40, p = .00$), M-DSIS amenities at a moderate level ($r = .33, p = .01$), M-DSIS social power ($r = .37, p = .00$) at a moderate level, M-DSIS social prestige ($r = .25, p = .04$) at a weak level, and M-DSIS Total ($r = .38, p = .00$) at a moderate level.

There were no significant relationships in terms of M-DSIS scores and primary intervention/ perceived therapeutic relationships in the low-income vignette group, but several in the middle class vignette group. M-DSIS social power negatively correlated at a strong level with willingness to perform in-home therapy ($r = -.44, p = .00$). M-DSIS basic needs was significant and negatively correlated at a weak level with in-home visits ($r = -.29, p = .02$). M-DSIS social power also correlated negatively at a weak level with willingness to perform family therapy ($r = -.29, p = .01$), and willingness to perform a psychoed class ($r = -.29, p = .02$). A referral to career counseling negatively correlated at a weak level with M-DSIS amenities ($r = -.28, p = .03$) and M-DSIS social prestige ($r = -.23, p = .01$) while correlating at a moderate level with M-DSIS social power ($r = -.36, p = .00$) and M-DSIS total ($r = -.31, p = .01$). M-DSIS social prestige ($r = -.29, p = .02$) and M-DSIS amenities ($r = -.27, p = .02$) correlated negatively at a weak level with referring to a medical doctor. M-DSIS social power ($r = -.33, p = .01$), and M-DSIS total ($r = -.30, p = .02$) correlating negatively at a moderate level with referral to a medical doctor. Finally M-DSIS social power also negatively correlated with referral to a social worker ($r = -.29, p = .01$) at a weak level. When controlling for sex, there was only one significant difference change in the analysis. The correlation between a referral to career counseling and M-DSIS social prestige strengthened from a weak to a moderate level. All other changes when controlling for sex affected any given score by less than + or - .04.

Table 10 Stereotype Correlations									
Low-Income Vignette Group - N=82									
Construct	Pos ST	Neg ST	M-DSIS Basic Needs	M-DSIS Anenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Pos Stereotypes	1.00								0.85
Neg Stereotypes	-0.56**	1.00							0.92
M-DSIS Basic Needs	0.15	-0.04	1.00						0.97
M-DSIS Anenities	0.20	-0.02	0.84**	1.00					0.96
M-DSIS Power	0.24*	0.03	0.72**	0.86**	1.00				0.97
M-DSIS Prestige	0.15	0.02	0.66**	0.75**	0.78**	1.00			0.9
M-DSIS Total	0.20	-0.01	0.90**	0.95**	0.93**	0.86**	1.00		0.91
M-EBS Classism	-0.30**	0.37**	0.20	0.12	0.03	0.14	0.13	1.00	0.87
Middle Class Vignette Group - N=64									
Construct	Pos ST	Neg ST	M-DSIS Basic Needs	M-DSIS Anenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Pos Stereotypes	1.00								0.85
Neg Stereotypes	-0.41	1.00							0.89
M-DSIS Basic Needs	0.01	0.13	1.00						0.96
M-DSIS Anenities	0.09	0.09	0.94**	1.00					0.96
M-DSIS Power	-0.92	0.04	0.82**	0.80**	1.00				0.97
M-DSIS Prestige	0.11	0.11	0.73**	0.73**	0.64**	1.00			0.90
M-DSIS Total	0.02	0.10	0.97**	0.96**	0.90**	0.82**	1.00		0.93
M-EBS Classism	0.05	0.09	-0.06	-0.13	-0.18	-0.21	-0.15	1.00	0.92

* = Significance <.05

** = Significance <.01

Table 11 GAF Correlations										
Low-Income Vignette Group - N=82										
Construct	GAF With TX	GAF W/O TX	M-DSIS Basic Needs	M-DSIS Anenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha	
GAF With TX	1.00								N/A	
GAF W/O TX	0.56**	1.00							N/A	
M-DSIS Basic Needs	0.12	0.23*	1.00						0.97	
M-DSIS Anenities	0.13	0.25*	0.84**	1.00					0.96	
M-DSIS Power	0.12	0.29**	0.72**	0.86**	1.00				0.97	
M-DSIS Prestige	0.06	0.25*	0.66**	0.75**	0.78**	1.00			0.90	
M-DSIS Total	0.12	0.28*	0.90**	0.95**	0.93**	0.86**	1.00		0.91	
M-EBS Classism	0.00	-0.22*	0.20	0.11	0.03	0.14	0.13	1.00	0.87	
Middle Class Vignette Group - N=64										
Construct	GAF With TX	GAF W/O TX	M-DSIS Basic Needs	M-DSIS Anenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha	
GAF With TX	1.00								N/A	
GAF W/O TX	0.70**	1							N/A	
M-DSIS Basic Needs	0.40**	0.22	1.00						0.96	
M-DSIS Anenities	0.33**	0.18	0.94**	1.00					0.96	
M-DSIS Power	0.37**	0.29*	0.82**	0.80**	1.00				0.97	
M-DSIS Prestige	0.25*	0.15	0.73**	0.73**	0.64**	1.00			0.90	
M-DSIS Total	0.38**	0.23	0.97**	0.96**	0.90**	0.82**	1.00		0.93	
M-EBS Classism	-0.07	-0.05	-0.06	-0.13	-0.18	-0.21	-0.15	1.00	0.92	
* = Significance <.05										
** = Significance <.01										

Table 12 Therapeutic Relationship Correlations													
Low-Income Vignette Group - N=82													
Question/Construct	Like to Work with Me	Benefit From Me	Benefit in General	Severe Disorder	Miss Apts.	Resist	M-DSIS Basic Needs	M-DSIS Amenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Would like to work with client	1.00												N/A
Benefit from Working with Me	0.67**	1.00											N/A
Benefit in General from therapy	0.36**	0.46**	1.00										N/A
Has a Severe Disorder	-0.10	-0.06	-0.21	1.00									N/A
Will Miss Appointment	-0.09	-0.02	-0.06	0.19	1.00								N/A
Will Be Resistant	-0.24*	-0.12	-0.47**	0.36**	0.35**	1.00							N/A
M-DSIS Basic Needs	-0.17	-0.04	-0.02	-0.08	0.20	-0.11	1.00						0.97
M-DSIS Amenities	-0.16	-0.20	-0.04	-0.09	0.07	-0.17	0.84**	1.00					0.96
M-DSIS Power	-0.19	-0.18	-0.05	-0.04	0.08	-0.06	0.72**	0.86**	1.00				0.97
M-DSIS Prestige	-0.20	-0.18	-0.14	0.00	0.11	-0.05	0.66**	0.75**	1.00				0.90
M-DSIS Total	-0.20	-0.16	-0.06	-0.06	0.13	-0.11	0.90**	0.95**	0.93**	1.00			0.91
M-EBS Classism	-0.03	-0.05	0.13	-0.09	-0.01	-0.03	0.2	0.11	0.03	0.14	0.13	1.00	0.87
Middle Class Vignette Group - N=64													
Question/Construct	Like to Work with Me	Benefit From Me	Benefit in General	Severe Disorder	Miss Apts.	Resist	M-DSIS Basic Needs	M-DSIS Amenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Would like to work with Client	1.00												N/A
Benefit from Working with Me	0.82**	1.00											N/A
Benefit in general from Therapy	-0.07	-0.03	1.00										N/A
Has a Severe Disorder	-0.09	-0.01	0.15	1.00									N/A
Will Miss Appointment	-0.22	-0.18	-0.01	0.40**	1.00								N/A
Will be Resistant	-0.19	-0.14	-0.24	0.44**	0.57**	1.00							N/A
M-DSIS Basic Needs	-0.05	0.01	-0.09	-0.28*	-0.11	-0.25*	1.00						0.96
M-DSIS Amenities	0.01	0.04	-0.14	-0.19	-0.12	-0.21	0.94**	1.00					0.96
M-DSIS Power	-0.01	0.05	-0.26*	-0.30*	-0.13	-0.24	0.82**	0.80**	1.00				0.97
M-DSIS Prestige	0.04	0.14	0.00	-0.22	-0.19	-0.22	0.73**	0.73**	0.64**	1.00			0.90
M-DSIS Total	-0.01	0.06	-0.14	-0.27*	-0.15	-0.25*	0.97**	0.96**	0.90**	0.82**	1.00		0.93
M-EBS Classism	-0.10	-0.12	0.14	0.11	0.42**	0.14	-0.06	-0.13	-0.18	-0.21	-0.15	1.00	0.92

* = Significance < .05
** = Significance < .01

Table 13 Clinical Primary Intervention Choice Correlations															
Low-Income Vignette Group - N=82															
Construct/ Question	Weekly Therapy	Bi-Weekly	Twice a Week	In-Home Therapy	Family Therapy	Psychoed Career	Psych. Med. Doc	Soc. Worker	M-DSIS Basic Needs	M-DSIS Amenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Weekly Therapy	1.00														N/A
Bi-Weekly	0.45**	1.00													N/A
Twice a Week	0.33**	0.18	1.00												N/A
In-Home Therapy	0.12	0.21	0.07	1.00											N/A
Family Therapy	0.27*	0.40**	0.33**	0.29**	1.00										N/A
Psychoed	0.32**	0.25*	0.20	0.18	0.32**	1.00									N/A
Career Counseling	-0.01	0.12	0.14	0.34	0.02	0.25*	1.00								N/A
Psychiatrist	-0.04	0.02	0.05	0.23*	-0.03	0.02	0.55**	1.00							N/A
Medical Doctor	-0.21	-0.08	-0.03	0.18	-0.05	-0.05	0.39**	0.71**	1.00						N/A
Social Worker	-0.07	0.16	0.16	0.14	0.02	0.01	0.28*	0.40**	0.34**	1.00					N/A
M-DSIS Basic Needs	-0.17	-0.05	-0.12	0.04	0.04	-0.05	0.17	-0.18	-0.13	0.00	1.00				0.97
M-DSIS Amenities	-0.13	0.06	-0.20	-0.02	-0.06	-0.14	0.03	-0.29**	-0.30**	-0.04	0.84**	1.00			0.96
M-DSIS Power	-0.18	0.15	-0.19	0.05	0.02	-0.06	-0.02	-0.22	-0.14	0.07	0.72**	1.00			0.97
M-DSIS Prestige	-0.23*	-0.07	-0.18	0.02	-0.04	-0.12	-0.03	-0.21	-0.09	0.15	0.66**	0.78**	1.00		0.90
M-DSIS Total	-0.19	0.03	-0.19	0.02	-0.01	-0.10	0.05	-0.25*	-0.18	0.04	0.90**	0.93**	0.72**	1.00	0.91
M-EBS Classism	-0.06	-0.05	0.06	-0.11	0.05	-0.10	-0.05	0.06	0.02	-0.05	0.20	0.11	0.03	0.14	0.87
Middle Class Vignette Group - N=64															
Construct/ Question	Weekly Therapy	Bi-Weekly	Twice a Week	In-Home Therapy	Family Therapy	Psychoed Career	Psych. Med. Doc	Soc. Worker	M-DSIS Basic Needs	M-DSIS Amenities	M-DSIS Power	M-DSIS Prestige	M-DSIS Total	M-EBS Classism	Chronbach's Alpha
Weekly Therapy	1.00														N/A
Bi-Weekly	0.34**	1.00													N/A
Twice a Week	0.31*	0.05	1.00												N/A
In-Home Therapy	0.21	0.22	0.46**	1.00											N/A
Family Therapy	0.29*	0.34**	0.23	0.46**	1.00										N/A
Psychoed	-0.04	0.23	0.21	0.45**	0.40**	1.00									N/A
Career Counseling	0.09	0.09	0.26*	0.37**	0.22	0.40**	1.00								N/A
Psychiatrist	0.10	0.26	0.20	0.35**	0.30*	0.24	0.40**	1.00							N/A
Medical Doctor	-0.08	0.05	0.24	0.17	0.13	0.22	0.40**	0.34**	1.00						N/A
Social Worker	0.14	0.14	0.39**	0.52**	0.29*	0.39**	0.51**	0.36**	0.44**	1.00					N/A
M-DSIS Basic Needs	0.03	-0.03	-0.03	-0.30*	-0.21	-0.09	-0.22	-0.10	-0.22	1.00					0.96
M-DSIS Amenities	0.06	0.04	0.03	-0.24	-0.08	-0.11	-0.28*	-0.02	-0.27*	-0.19	0.94**	1.00			0.96
M-DSIS Power	0.00	-0.08	-0.13	-0.44**	-0.29*	-0.29*	-0.36**	-0.19	-0.33**	-0.29*	0.82**	0.80**	1.00		0.97
M-DSIS Prestige	0.10	0.05	-0.13	-0.19	-0.01	-0.19	-0.23**	-0.21	-0.29*	-0.19	0.73**	0.73**	0.64**	1.00	0.90
M-DSIS Total	0.05	-0.01	-0.06	-0.33**	-0.18	-0.18	-0.31*	-0.13	-0.30*	-0.25	0.97**	0.96**	0.90**	1.00	0.93
M-EBS Classism	-0.23	0.04	-0.1	-0.08	-0.10	0.11	-0.07	0.12	-0	-0.11	-0.06	-0.13	-0.18	-0.21	0.92

* = Significance < .05

** = Significance < .01

CHAPTER IV

Discussion

Classism Scores

One of the primary assumptions that underlined the hypothesis of this study was that mental health professionals would hold varied levels of classism, which would be comparable to the general population. To the contrary, average score for the M-EBS scale were quite low compared to what one would expect from the general population or even counseling trainees. This has several potential explanations. One possibility is that increasing cultural competency standards may have impacted the study. Individuals may have been trained to consider economic privilege as a component of a client's cultural identity. Training in cultural competency may have mitigated the classist attitudes. Another possibility is that those that are attracted to helping professions tend to be less classist compared to the general population. These results could have also been because of a priming effect which occurred within the survey. Individuals may have given socially desirable answers for fear of being viewed as prejudiced. Another possibility is that a priming effect may have occurred because of the order of the survey. As individuals were forced to consider their own social class when they filled out the M-DSIS, they may have been better able to identify with the poor and therefore less judgmental. This last possibility

seems the least likely though, because of the similarities in classist beliefs regardless of M-DSIS scores or vignette received.

Finally, one other possibility is the change in the dominant discourse in America related to class differences. Over the last few years several social class related news topics including the Occupy Wall Street Movement, the post-recession bank bailouts, and the vilification of the “One Percent” in the media may have impacted what the general population believes around social class inequality. Although it is unlikely that any of these news stories would remove classist beliefs from those who generally endorse them, it is possible that it could have influenced those who previously disagreed with classist statements. These individuals may have been more likely to give a “stronger” disagreement response. In simpler terms, those who were already liberal in terms of social class inequality may have become even more so as a result of these social changes. With this in mind, it may be more appropriate to think of the study in terms of variations of cultural competency as opposed to outright classist beliefs. In addition, this also provides evidence that mental health professionals tend to not endorse classist beliefs in survey studies.

Hypothesis 1: Lower Class Vignette vs. Middle Class Vignette

Hypothesis 1a

Hypothesis 1a stated that clinicians who receive the lower class vignette would endorse lower GAF scores than those who receive the middle class vignette. This hypothesis was partially confirmed. Before interpreting these results, it is first important to discuss the clinical versus statistical significance of these findings. Although clinicians did rate the low-income vignette as having significantly lower

overall GAF scores both with and without treatment, the overall impressions were still relatively close from a clinical standpoint. For example, the mean lower class vignette with treatment score was 65, while the middle class vignette was 68. These numbers do represent a significant statistical difference, but clinically represent a fairly similar AXIS V diagnosis. It is unlikely that the three-point difference would dramatically affect a treatment plan for most clinicians. It is also important to acknowledge the wide variation in GAF scores, which is related to the subjective process used by clinicians to evaluate functioning, a common critique of the GAF (Grootenboer et al, 2012).

These results should also be considered with caution because of the inherent differences in terms of functioning for varied SES levels. It would not necessarily be classist to believe that a low-income individual may not be able to “function” at the same level as someone from the middle class. Even though the low-income individual had the same symptoms, clinicians may have factored in other forms of self-care accessible to the middle class individual due to their elevated status. They may have believed this person could afford medication and high quality mental health providers. They may have also believed the individual could afford to take time off, or have access to outside amenities such as vacations, a gym membership, quality food, and in-patient treatment for substance abuse if need be. All of these possibilities lend themselves to an overall higher “level of functioning” compared to the low-income individual regardless of symptoms.

With this in mind, it is still important to consider the statistical significance. Overall, these results indicate that clinicians are more likely to endorse a slightly

lower GAF score regardless of treatment or prognosis for those with low-income characteristics. One interesting consideration is that therapists seemed to believe that both clients would improve/decompensate by roughly the same amount of “GAF points”. The relative mean scores between the with treatment score and without treatment score were very similar (Middle Class Vignette $m = 9.44$, and Lower Class Vignette $m = 10.84$). This shows that there were limited differences in terms of overall decomposition/improvement between the groups. The statistical differences seemed to be a result of initial GAF score differences as opposed to prognosis over time.

These findings are interesting for a variety of reasons. First, this implies that there seems to be a certain level of classism going on with clinician’s even if at an unconscious or semiconscious level in terms of AXIS V diagnoses. This seems to only occur in terms of initial diagnosis as opposed to beliefs about improvement or decompensation. There are a variety of reasons this may have occurred. One possibility is that clinicians may have viewed the client’s symptoms as more extreme because of her lower social class or less extreme because of the middle class client’s social class. This supports previous research indicating that those from lower social classes are viewed as “sicker” despite having similar symptoms to others of varied social class (Lorion, 1974). Another possibility is that clinicians made assumptions about the low-income client’s coping skills, intelligence, or social support that led them to give the low-income client lower scores. They may have associated her lower class status with deficits in these areas. A final possibility is that clinicians may have made assumptions about outside stressors that the low-

income individual may have to endure that the middle class individual would not (childcare costs, a lack of insurance, less disposable income, etc).

One positive to come from this study is that it appears clinicians believed that therapy could help each client at similar rates and that the client would decompensate at similar levels. So despite potential classism in initial diagnosis, there does not seem to be differences in terms of treatment predictions. This result provides evidence that clinicians believed they could help each client at a similar rate and that social class was not a major factor in their decision-making. This seems to indicate that little classism was present in their belief that the client would benefit from therapy. This is backed by the limited differences in perceptions of the therapeutic relationship as well. An alternative theory is that the vignette didn't provide enough of a cognitive prime for individuals to consider how social class differences may have impacted long-term prognosis. If the vignette had mentioned some type of more long-term chronic stressors, more social class related differences may have occurred.

Hypothesis 1b

Hypothesis 1b stated that clinicians who receive the lower class vignette will endorse more negative stereotypes (High negative stereotype/low positive stereotype scores) than those who receive the middle class vignette. This hypothesis was not confirmed. Negative stereotypes were not endorsed at a higher level in either group. It should be noted that a few individual stereotypes were endorsed at a higher level though, despite the overall significance being absent. The middle class individual was viewed as lazier and weaker than the low-income client, which was

counter-intuitive to the assumptions of this hypothesis. The only area in which the low-income individual was evaluated more negatively was in terms of intelligence and education in the positive stereotypes scale. These domains are unsurprising as one of the manipulated variables in the study was a higher level of education in the middle class vignette. It seems likely that clinicians naturally made the assumption that a higher level of education was equated with a higher intelligence level.

Although endorsing a lower level of intelligence due to lack of education does not directly indicate any level of classism, it does subtly ignore the barriers which may prevent low-income people from attaining a degree. An individual could still be very intelligent, but be forced into a working class job out of necessity. It seems clinicians viewed this as an unlikely possibility for the low-income individual within this study. Overall there were no significant differences in positive or negative stereotypes. As a result, it seems logical to deduce that the manipulation of social class variables within the study did not prime negative classist stereotypes for the clinicians.

One possible explanation for the lack of differences is that clinicians generally do not hold classist stereotypes, and instead hold a sympathetic view of the poor. This seems to be validated by greater level of judgment being present for the middle class vignette. Clinicians may have believed that the low-income client was more of a victim of difficult circumstances while the middle class client had some type of moral deficit that would not let them succeed. Another possibility explanation could be problems within the vignette. It is possible that clinicians were

more likely to provide socially desirable answers if they figured out what the vignette was about and did not want to seem discriminatory.

One other possibility is that the vignette itself was not “controversial” enough to elicit any anger toward the low-income person. For example, it is possible that more negative classist stereotypes would have been primed if the vignette had mentioned that the client was on welfare or disability, had given up on trying to get a job, had some type of criminal record, or neglected her children to a greater degree as a result of holding multiple jobs. The inclusion of these political “hot topics” within the study may have been more likely to prime negative stereotypes and hence created the hypothesized outcome. With this in mind, in terms of this study it appears that low-income clients are not assigned a higher level of negative stereotypes than middle class clients upon entering therapy.

Hypothesis 1c

Hypothesis 1c stated clinicians who received the lower class vignette would endorse less personal forms of treatment than those who receive the middle class vignette. This hypothesis was not confirmed. Clinicians showed no significant differences between the types of treatment they would endorse with the exception of a higher likelihood of referring the middle class client to a psychiatrist. This result may have a few different explanations. The first is that clinicians may have believed that the low-income client’s psychological symptoms were more directly tied to environmental stressors as opposed to biological processes. They may have believed that the middle class had no obvious stressors that would be causing her symptoms, while assigning assumed stressors to the low-income client. Her

problems were therefore more likely to be attributed to a biological disposition. Another possibility is that the clinicians may have believed that the middle class individual was more likely to gain access to psychiatrist and be able to follow up with a prescription if necessary.

Overall, the cognitive distancing theory of classism did not seem to play itself out in this component of the study. This seems to indicate that therapists are not as likely to engage in distancing, at least in terms of intervention choice for low-income clients. One possibility for this lack of distancing could again be increasing cultural competence in the field mitigating classism. Another possibility is that individual therapist preferences for treatment modalities may have interfered with the study. For example, many individuals may have refused to perform in-home therapy for any client regardless of any information about the client. For example, the majority of men may have felt this way and slightly skewed the results. Another possibility is that the therapeutic relationship itself created enough social distance for the individual to not be impacted by the client's lower social class. For example, they would be willing to engage in a therapeutic relationship with the individual because of the helping nature and power differences within the relationship, but may not be willing to socialize with this individual in other contexts. In other words, because the clinician would be interacting with the person as "part of their job" they would not have to fear the negative ramifications of socializing with low-income people. Overall, this study does not seem to indicate that social class differences in clients impacts clinician preferences for treatment modalities.

Hypothesis 1d

The final component of Hypothesis 1, Hypothesis 1d, stated that clinicians who receive the low-income vignette would have less optimistic expectations for the therapeutic relationship than those who receive the middle class vignette. This hypothesis was not confirmed. The hypothesis actually proved to be counter-intuitive as clinicians showed preference for wanting to work with the low-income client over the middle class client and believed the low-income client would benefit more from working with them.

In order to understand these results it is first important to put them in perspective. Regardless of which vignette clinicians received, clinicians endorsed high scores in terms of wanting to work with the client as well as the believing the client would benefit from working with them. With this in mind, the scores were exceptionally high for the low-income client for these categories. When considering these results together it seems that the clinicians believed that they personally could help the low-income individual and were enthusiastic about the opportunity to do so. This component of the study seems to endorse the sympathetic theory of classism, meaning that the clinicians connected with the client's strife, and believed that she would be a good candidate for their own therapy practice. When this result is considered with the GAF score hypothesis results this becomes even more interesting. Despite clinicians believing that the low-income client would benefit more from working with them, clinicians endorsed similar GAF score improvement ratings in both groups. This presents a disconnect within the clinicians belief around improvement and their actual assignment of GAF scores.

Like the previous hypothesis, the cognitive distancing theory of classism did not seem to play itself out in this component of the study. Social desirability could have been another possible problem within this aspect of the study. Individuals may have felt it was wrong to not want to help the client and therefore felt compelled to do so. The most likely solution seems to be that clinicians felt a greater sense of urgency with helping the low-income women compared to the middle class women, hence providing evidence for the sympathetic view of classism. These clinicians may have felt that they could help this client to a greater degree because of their economic situation.

Hypothesis 1 Summary

The first hypothesis compared clinicians who received the low-income vignette with those that received the middle class vignette. The study indicated that there were no significant differences in terms of stereotype endorsement between clinicians who received a low-income vignette and those that received an identical middle class vignette (with the exception of modified social class indicators). Analysis indicated that the lower class vignette was given a lower GAF score regardless of whether or not the potential client received treatment. Mental health professionals were also more likely to endorse wanting to work with the low-income client and believing that the low-income client would benefit from working with them compared to the middle class client. The only treatment difference detected was that mental health providers were more likely to refer the middle class client to a psychiatrist.

Hypothesis 2: High M-DSIS Score vs. Low M-DSIS Score

Hypothesis 2a

All the sub-hypotheses within Hypothesis 2 were underlined by the belief that those of whom have had exposure to a low income/working class lifestyle (less cognitive and behavioral distance) would be less likely to hold classist beliefs and engage in classist behaviors in therapy. This was consistent with Liu's subjective definition of classism as well as Lott's cognitive and behavioral distancing view of classism. Hypothesis 2a stated that clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) would endorse more classist views (High M-EBS) than those who have faced this type of oppression (Low M-DSIS scores). This hypothesis was not confirmed. Although there was one difference based on social class of origin (lower class vs. lower middle class), when put into perspective, the difference was between strongly disagreeing and disagreeing with the majority of the classist statements. Some level of distancing may account for the difference between the groups, but clinically it is still relatively small. One explanation for this small difference is that individuals who were identified as being from lower-middle class backgrounds may feel the greatest perceived threat of being viewed as poor. As a result, they may feel the need to maintain some level of cognitive distance between themselves and the poor in order to separate their sense of identity. There may be a few reasons for these results. The first and most obvious is that social class of origin is not a strong predictor of classist beliefs. Another possibility is that the M-DSIS may have primed individuals to be more socially conscious of social class differences. As a result this may have

impacted their choices when filling out the M-EBS. Finally, individuals may have given socially desirable answers as a result of not wanting to appear prejudiced. Overall, it appears that there is a limited relationship between clinician's social class of origin and their attitudinal classist beliefs.

Hypothesis 2b

Hypothesis 2b stated clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores), who receive the low-income vignette, will endorse more negative stereotypes (High negative stereotype/low positive stereotype scores) than those who have faced more oppression (Low M-DSIS scores). This hypothesis was not confirmed. These results seemed to indicate very different outcomes than what would be expected. There were no differences in overall negative stereotypes across the social class of origin groups. Contrary to theory, it appears that those from upper class backgrounds tended to endorse positive stereotypes at a higher rate than those from any other group. What was even more interesting were the positive stereotypes which seemed to drive these differences. The clinicians from upper class backgrounds were more likely to see the client as strong and proud (concerning positive stereotypes), and less lazy, angry, and weak (concerning negative stereotypes), compared to those from other SES backgrounds. These results were no longer significant when examining the middle class vignette. In fact, not a single positive or negative stereotype appeared significant when examining the middle class vignette across SES groups. This provides evidence for a unique interaction between the upper class background of clinicians and priming of positive stereotypes for low-income clients.

When examining these results in greater detail, some more interesting differences occurred. The majority of the significant differences were between those with upper class backgrounds and the lower middle, middle, and upper middle class backgrounds. Surprisingly, there were no significant differences between those that were identified as coming from a lower class background and those who were identified as coming from an upper class background. Although both groups' results seem relatively similar, it is possible that this is occurring for very different reasons. The clinicians from lower class backgrounds may identify with the low-income client and as a result see them as more positive. It is taken for granted that those who came from lower-class backgrounds engaged in some positive social mobility because of their higher-level degree. This may have impacted how clinicians from low-income backgrounds evaluated the client in terms of stereotypes. For example, a clinician may be proud of themselves and their family for working hard and providing the opportunity to get a higher degree. They may have then believed that the client in the vignette may also share these prideful feelings. This could account for higher scores with those from lower-class backgrounds. The clinicians from the upper class background may be experiencing cognitive dissonance between their own background and the clients in relation to equality. There method of reducing this cognitive dissonance could be to enhance the quality of the low-income client's character. As a result clinicians from low-income backgrounds may be more likely to project some of their own feelings onto the low-income client, while those from upper class backgrounds may have been more likely to endorse positive characteristic to reduce dissonance.

One theoretical idea from feminist theory that lends itself well to these results is the concept of benevolent discrimination. The concept was originally introduced in terms of benevolent sexism by Glick and Fiske (1996) and describes pro-social behaviors and beliefs that continue to perpetuate male superiority. This behavior is seen in many chivalrous acts that men engage in on behalf of woman. Although these acts are well intentioned, they are underlined by the belief that women are fragile and less capable than men. A similar idea can be generalized to the upper class therapist's attitudes toward low-income client within this study. Although upper class psychologists endorsed pro-social attitudes about the low-income client (i.e. proud and strong), this was underlined by the belief that the low-income client should be proud and develop strength from their social position, despite facing oppression, discrimination, and poor working conditions and agency. It is also interesting that only those from upper class backgrounds engaged in this type of benevolent behavior, which could indicate an inherent belief in their ability to evaluate "good poor" vs. "bad poor" despite lacking their own subjective experience within a lower social position.

Another possibility is that those in the middle class groups may be the ones actually engaging in the distancing behavior. Individuals from the middle class groups may have more to gain from distancing themselves from the poor in terms of maintaining their own social status. Those of middle class origin may feel the need to differentiate themselves from the low-income clients and therefore see the client more negatively. Their method of doing this was by not assuming positive attributes and endorsing slightly more negative views. Those from the lower class group and

upper class group may have less to prove in terms of class differentiation. Those from the lower class may have had to come to terms with their place in the social hierarchy because of the daily barriers they experienced. Those from the upper class may be more “class blind” and therefore less judgmental of those from lower class groups.

Hypothesis 2c

Hypothesis 2c stated that clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores), and received the low-income vignette, would endorse lower GAF scores than those who have faced more oppression (low M-DSIS scores). This hypothesis was not confirmed. Like many of the previous results, this seems to be counterintuitive to traditional classism theory. There was no difference in terms of GAF with treatment for any social class of origin group for the low-income vignette, but there was a difference without treatment. Clinicians from upper class backgrounds, once again proved to be more optimistic than those from other backgrounds. As described before, this may have been attributed to cognitive dissonance. Those from upper class backgrounds may not have been able to cope with the idea of the low-income client continuing to decompensate, and as a result needed to be optimistic about their outcomes without treatment. Another possibility is that those from a lower class and lower middle class backgrounds had a more pessimistic view compared to other social class of origin groups. This could be based on personal experience with the difficulty of rising out of a low-income background. These individuals may believe that it is

unlikely that the low-income client's life will improve without some type of intervention.

In addition, those from lower class backgrounds tended to be more pessimistic about GAF with TX scores compared to all groups with the (exception of the middle class group) for the middle class vignette. There are a few different possible explanations for these results. One possibility is that those from the lower class background tended to see the middle class client as "sicker." Clinicians from lower class backgrounds may be more likely to believe that there is incongruence between the client's status in life and their psychological well-being. As these individuals would be primed to be aware of social class indicators (having risen in social class themselves) they may have had to justify the client's condition. In simpler terms, those from low-income backgrounds may have a more difficult time understanding why a person with middle class status would be experiencing mental health symptoms to this extent.

It also should be noted that there is a possibility of an interaction effect with present SES. The preliminary analysis presented evidence of a potential interaction effect within the low-income vignette between perceived current SES and GAF without treatment scores. Current SES could also be a cause of cognitive dissonance with the low-income client. Individuals who currently live a higher class lifestyle may also be less likely to connect with low-income people and therefore more likely to elevate their prognosis.

Hypothesis 2d

Hypothesis 2d stated that clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) and receive the low-income vignette, will have less optimistic expectations for the therapeutic relationship than those who have faced more oppression (low M-DSIS scores). This hypothesis was not confirmed. None of the therapeutic relationship indicators proved significant in any of the groups. This seems to provide evidence that social class of origin has little to do with expectations for low-income clients. As previously described, other possibilities for this lack of results may have to do with social desirable responses or clinicians across all groups adhering to the sympathetic view of classism and inflating their scores.

Hypothesis 2e

Hypothesis 2e stated that clinicians who report their family of origin as facing less social economic oppression (High M-DSIS Scores) and received the low-income vignette, will endorse less personal forms of treatment than those who have faced more oppression (low M-DSIS scores). This hypothesis was not confirmed. There were no significant differences within the low-income vignette for any of the therapeutic options. This leads one to believe that clinician social class of origin is not likely a good indicator of cognitive and behavioral distance for low-income clients.

There was one significant treatment option in the middle class vignette group. Clinicians from low-income backgrounds were significantly more likely to want to perform in-home therapy in the middle class vignette group. This result

seems to link a relationship between growing up in a lower class environment and willingness to enter middle class homes to perform therapy. Although these results don't provide an obvious answer, one possibility is that clinicians from low-income backgrounds may associate a middle class household with safety and security. The clinicians may have felt they would not be harmed and would feel comfortable providing services from the home. They may not have felt this same level of safety within the low-income household. If the second possibility is true, it may present a certain level of internalized classism within the low-income background clinicians. They may have attributed higher levels of danger, dirtiness, or other negative qualities to the low-income individual's household, which they did not attribute to the low-income household. Another possibility is an interaction affect between sex and vignette group. The low-income group tended to have fewer men and as a result may have been skewed toward providing in-home therapy.

Hypothesis 2 Summary

The second hypothesis also looked at differences between the two vignettes, but took into consideration the social class of origin of the mental health providers. Providers were broken into five categories based on their subjective experience of social class while growing up. Those from lower middle class backgrounds tended to hold the most classist beliefs, although these beliefs were still relatively low. Those from upper class backgrounds tended to endorse higher positive stereotypes for the low-income client compared to those from middle class or lower-middle class backgrounds. Specifically, those from upper class backgrounds saw the low-income client as more proud and strong, and less lazy, angry, or weak than other groups.

There were no significant differences in terms of stereotypes in the middle class vignette for any social class group.

Those from upper class backgrounds were also more likely to be optimistic about GAF scores without treatment overtime compared to the lower-middle class group. One possible explanation for this is that those from upper class backgrounds experienced cognitive dissonance between themselves and the client or engaged in benevolent classism. As a result they may have enhanced the low-income client's character while other groups did not (with the exception of those from lower class backgrounds themselves). This is further evidenced by the absence of any meaningful differences across social class of origin groups in terms of stereotypes in the middle class vignette group. Those from lower class backgrounds also tended to rate the middle class client more negatively in terms of GAF without treatment. One possibility is that those from low-income backgrounds tended to view the middle class client as "sicker" in order to rationalize the discrepancy between their middle class identity and mental health symptoms. This was further evidenced by correlations indicating a connection between social class background and belief that the client had a severe disorder/would not benefit as much from therapy. There were no significant differences in terms of treatment modality or perceptions of the therapeutic relationship in the low-income vignette group across social class groups. One treatment variable was significant in the middle class vignette group. Those from lower class backgrounds were more willing to perform in-home therapy in the middle class background. It is believed this may be a result of an interaction

effect with sex and greater perceived safety in middle class households for clinicians from lower class backgrounds.

Correlation Discussion

Correlational analysis was also performed to further explore Hypothesis I and II across the various dimensions of the M-DSIS. In terms of stereotypes there were some interesting findings. In the low-income vignette group there were three significant relationships. First, negative stereotypes positively correlating with M-EBS classism scores while positive stereotypes negatively correlated. This indicates that there was a connection between holding classist beliefs and endorsing positive/negative stereotypes about the low-income client. This is important as it provides evidence that there is a connection between holding classist beliefs and negative beliefs about low-income clients among clinicians. Specifically, the M-DSIS social power subscale correlated with positive stereotypes. This provides evidence that the variable that drove upper class individuals to endorse the low-income client with more positive stereotypes was their family of origin social power. This implies that the specific component that may be creating the most cognitive dissonance in upper class clinicians was their family of origin's ability to affect the community around them. As a reminder, M-DSIS social power is defined as one's perceived ability to use social connections to influence the world around you. The conclusion that can be drawn from this analysis is that clinicians, who grew up with a high sense of economic privilege in terms of influencing the world around them, are more likely to evaluate a low-income client positively in terms of stereotypes.

In terms of GAF scores, GAF without TX correlated with M-DSIS social power and M-DSIS total after controlling for perceived current SES. This once again leads one to believe that social power has a relationship with positive evaluations of the low-income client. GAF without treatment scores also correlated negatively with M-EBS classism in the low-income vignette. This indicates that those who endorsed lower levels of classism were more likely to believe that the client had a higher GAF without treatment score in the low-income group. This is an interesting finding as it connects classist beliefs with poorer predictions of outcomes in the low-income vignette.

In the middle class vignette group all, components of the M-DSIS correlated with the GAF with TX scores. The M-DSIS basic needs subscale correlated the strongest while the M-DSIS social prestige scale correlated at the weakest level. This further validates and informs the previous interpretation that clinicians from lower SES backgrounds tended to be more pessimistic about the middle class client's success in treatment. It appears that those from lower class backgrounds who tended to not get their basic needs met as a child were less likely to believe that therapy would be helpful for the middle class vignette.

In terms of treatment options there were no significant relationships in the low-income vignette. This is consistent with the lack of differences in this area in Hypothesis II. This further validates that social class of origin is not a good predictor of intervention choice for the low-income vignette. Although this analysis was designed to specifically look at the low-income vignette, it is still worth noting some relationships in the middle class vignette. Those who scored high on the M-DSIS

social power subscale were less likely to believe the client would benefit in general from therapy. This may inform the differences in GAF with treatment scores further. It appears that one of the more powerful driving forces in low-income individuals being pessimistic about therapy for the middle class vignette was the amount of social power their family of origin had. Those who scored high on the M-DSIS basic needs scale and M-DSIS social power scale also were less likely to believe the client had a severe disorder. This provides further evidence that clinicians from low-income backgrounds were more likely to see the middle class client as “sicker” and more pessimistic about treatment outcomes with the middle class client.

Consistent with this, those who had lower M-DSIS basic needs subscale scores were also more likely to believe that the middle class client would be resistant in therapy. Finally, those that endorsed higher levels of classism also believed that the middle class client would miss more appointments. This may have been a result of a more pessimistic overall world view for some clinicians and could have been mediated in the low-income vignette by sympathy for the low-income client.

Finally, although no significant relationships came to light in the ANOVA for social class of origin in the low-income vignette, a few correlations were recorded. Those that scored high on M-DSIS amenities were less likely to refer to a medical doctor and a psychiatrist as a primary intervention for the low-income vignette. This could imply greater classist distancing, although this seems unlikely because the medical doctor option was also connected to M-DSIS scores in the middle class vignette (the psychiatry option was also very close to significance in the middle

class vignette). Another possibility is that those who came from families with higher economic privilege were more likely to believe that they could help the client without the need for a medical referral regardless of which vignette. This could be related to higher self-efficacy in those from upper class backgrounds as opposed to classism. In addition, those that scored high on M-DSIS social prestige were less likely to endorse willingness to perform weekly therapy with the low-income client. It could be that those who grew up with a high level of social prestige were more likely to want to distance himself or herself from a low-income client. This is further supported, as this difference did not occur in the middle class vignette.

Finally, there were several significant relationships in terms of treatment options and the middle class vignette. Only those that seem to have social class ramifications are discussed at length below. Those that scored high on M-DSIS social power were less likely to be willing to perform in-home therapy, family therapy, or a psychoeducation class even when sex was controlled for in the correlation. This connection was not present in the low-income vignette. This may indicate that those who grew up with higher social power were less likely to go “out of their way” for the middle class client and have stancher boundaries around what they are willing to do.

All components of the M-DSIS also correlated negatively with a referral to career counseling in the middle class vignette. This provides evidence that there was an inverse relationship between social class of origin and willingness to refer to career counseling. This may indicate that those who grew up with economic privilege were less likely to see the middle class client’s career as one of the primary

problems. This may be a component of privilege as individuals from higher social class backgrounds would be less likely to have had unpleasant jobs and maybe less likely to make connections between psychological symptoms and work. It is very interesting that this did not occur in the low-income client vignette. There are two potential possibilities for this difference. One could be that clinicians viewed the low-income person as having less mobility in terms of changing careers. Another possibility is that clinicians generally view career exploration as a middle class activity as opposed to something low-income people engage in.

Summary of Correlational Discussion

Several aspects of the study were clarified through the correlational analysis. First positive and negative stereotypes were shown to have a connection to classist beliefs in the low-income vignette alone. This indicates a connection between primed stereotypes and classist beliefs. This provides evidence that classist beliefs may manifest as judgmental attitudes against low-income clients. Those who held classist beliefs were also more likely to predict that the low-income client would do worse without therapy. This indicates that classist beliefs may manifest as assumptions that clients will decompensate without treatment.

Further information came to light and validated the prediction that clinicians from lower class backgrounds tended to be more pessimistic of the middle class vignette. Specifically, a lack of social power in the family of origin seemed to be connected to beliefs that the client would not benefit from therapy. Also clinicians who experienced less of their basic economic needs met, and feeling less of a sense of social power in their family were more likely to see the middle class client as

having a severe disorder. Finally those that felt they had less of their basic economic needs met were also more likely to see the middle class client as resistant to therapy. Each of these seems to validate the interpretation that clinicians from low-income backgrounds are more pessimistic about the effectiveness of therapy for the middle class vignette, while those high in these areas are more optimistic.

Finally a connection between lower levels of social prestige and willingness to perform weekly therapy provided some evidence for classist distancing against the low-income client. There also seemed to be a connection between those who had access to amenities and referral to a medical doctor/psychiatrist although this may have more to do with self-efficacy around treatment as opposed to classism as similar relationships occurred in both vignettes. There also seemed to be a connection between higher social power in family of origin and boundaries around performing in-home therapy, family therapy, and a psychoeducation course. This indicates that clinicians were less likely to do these types of therapy with the middle class vignette. It was predicted that this may have been a result of a more sympathetic stance toward the low-income client. Finally, there seemed to be a unique relationship between SES of origin and referral to career counseling that was unique to the middle class vignette. It was hypothesized that those from upper class backgrounds would be less aware of the connection between psychological symptoms and work, while being more likely to think of career exploration as a middle class activity.

Limitations

This study had several important limitations that could be addressed in similar studies in the future. The first is the use of a “no class” control group in future vignette studies. Although this study utilized the middle class group as a comparison, there could be some merit to utilizing a vignette that is vacant of any social class indicators. This could provide a clearer picture of how the presents of social class factors change attitudes regardless of what they are. This data could then be compared against a variety of social class backgrounds. One of the challenges of doing this is the need for a large sample size. In order to have multiple groups and have the ability to do truly in-depth within group analysis, it would be important to have a larger sample of participants. This could also provide an opportunity for individuals to look at data through path analysis. Exploring how individuals react to different social class vignettes after being primed about their own social class could provide important information on the unconscious effects of classism.

The next limitation is the overall whiteness of the sample population. Although 14.10% of the sample did not identify as white, the vast majority of the group did. As racial struggles are often intertwined with social class oppression it would be important in future studies to include a more diverse sample. This would provide an excellent opportunity to explore whether the race of a clinician impacts their perspective on individuals from different economic backgrounds as well.

The next limitation has to do with the variety of topics covered in the vignette. Although this study focused on family size, occupational prestige, income,

and education as the primary indicators of social class in the vignette, other factors could also be utilized. For example, having a vignette in which an individual has been receiving some form of subsidized income, assisted childcare, low cost housing, unemployment, or other social services may be more likely to prime classist attitudes and behaviors. Another possibility is giving an employment history, as this would provide a career trajectory of the individual. Other valuable factors include additional family expenses, assets, race and ethnicity, more detailed educational history, insurance information, and access to healthcare.

Another limitation to this study is the length of time measured for the GAF scores. Although the one, three, and six month trajectory provides valuable insight into clinicians long term prognosis for the client, it may miss some of the short term dynamic changes that could occur in briefer models of therapy such as solution focused, CBT, or brief dynamic therapy. It could also be questioned whether any low-income individual could afford to spend that much time in therapy due to limitations with finances, insurance, and work schedule. In the future it may be wise to include multiple modalities and time frames for treatment as a means of completing a clinician's clinical picture.

The final limitation has to do with inherent intersectionality concerns related to the underlying constructs within the study. Although preliminary analysis was used to control for some confounding variables, there was still some inevitable issues with the chosen demographics of the vignette client. For example, the use of a female client, with a specific set of symptoms, working a specific job inherently rules out and factors in a range of inherent beliefs from the therapists that may have little

to do with classism. For example, it is likely these results could have looked different had the vignette client been a male construction worker as opposed to a female fast food manager. Future studies should try to use demographic concerns that elicit as neutral a reaction as possible in order to preserve the integrity of the construct.

Implications for Practice

This study has several implications for the practice of professional psychology. The first implication indicates that mental health professionals do not appear to endorse classist beliefs and do not display general classist attitudes. From a cultural competency perspective it implies that those from low-income backgrounds are less likely to receive treatment from professionals who hold overt negative beliefs about their life circumstances or place in the social hierarchy.

Although this study indicates that mental health providers do not necessarily hold outright classist beliefs, social class differences may slightly impact diagnosis. Specifically, individuals currently living a low-income/working class lifestyle may be more likely to receive a lower GAF score despite having similar symptoms to someone of a higher SES. This further validates previous research that people from low-income backgrounds tend to be pathologized at a higher rate compared to other social class groups. Clinicians should be aware of this potential problem and take measures in their agency/practice to guard against bias in AXIS V diagnosis.

A counselor's social class of origin may also impact diagnoses of low-income people. Specifically, this study seems to indicate that those from upper class backgrounds may evaluate low-income clients more positively both in terms of belief in positive stereotypes and GAF without treatment. One hypothesis is that

these clinicians may be experiencing cognitive dissonance as a result of their own history of economic privilege. Arguments could be made that this is a relatively harmless process, as low-income individuals receiving false positive regard may not impact treatment. This still should be observed, as it does not represent an unbiased perspective and could cause treatment difficulties. In addition, clinicians from upper class backgrounds maybe more likely to terminate therapy early if they are overly optimistic about low-income clients in need. These overly positive attitudes and stereotype assignments may also be used to justify not following up with clients from low-income backgrounds or ignoring more severe concerns.

What could be considered more damaging is the result that clinicians from low-income backgrounds tended to be more pathologizing and less confident about treatment for middle class individuals. Although the study was designed to detect prejudice toward low-income clients, the study seemed to indicate that those from low-income backgrounds judged the middle class client more harshly in terms of predictions about the therapeutic relationship.

One way this information could be utilized is through multicultural competence training. Those who come from privileged/disadvantaged backgrounds could be taught to self-monitor for these biases and therefore provide more objective and culturally competent care for clients of various economic backgrounds. Specifically those from economically advantaged backgrounds should be careful to monitor cognitive dissonance in terms of working with low-income people. Those from low-income backgrounds should be cautious to not be overly

critical of those who may hold more economic privilege than what they are accustomed to.

Implications for Future Research

This study holds several significant implications for future research. The first is that a more subtle and sensitive measure for classism is needed. A scale development project could be done that specifically looks at micro aggressions that low-income people face and a scale could be developed from this. This would provide a realistic and subtler way of detecting social class bias. The almost universal disagreement with the classist statements on the M-EBS seems to indicate that the test is too overt to be applied to clinicians. It may also be useful to utilize a social desirability scale with any classism measure in order to guard against socially desirable answers.

Another implication is that cognitive dissonance as a reaction to social class inequality and the sympathetic view of classism are both ideas that should be explored in greater detail. These concepts seem to be the most predominant themes throughout the study, yet there is little evidence to support either of these ideas in the literature. Likewise, it is important to continue to examine cognitive distancing and social class of origin as a subjective experience that mitigates classism. This study does not seem to support the latter theories and there are not enough studies on classism to draw any type of meaningful and cumulative conclusion on the subject matter.

Finally, a more cumulative look at the therapeutic relationship when there is social class differences between client and counselor could be valuable. This study

only touched on counselor views of the therapeutic relationship and it would be valuable to look at client views as well. It would also be interesting to look at real life dynamics as opposed to theoretical ones. A study that monitors therapist behaviors while working with clients from various economic backgrounds could be valuable.

Conclusion

Ultimately, this study sheds new light on how social economic status in the therapeutic relationship may impact treatment. It has been traditionally understood that low-income people experience greater prejudice than middle class people in therapy, and that therapists from upper class backgrounds would be more likely to engage in this type of discrimination because of their lack of exposure. The present findings indicate that this is a much more complex issue that does not have a linear relationship. Social class variables alone do not seem to prime damaging stereotypes, although they do seem to influence components of diagnosis, beliefs about the therapeutic relationship, and whether one will be referred to a psychiatrist in a variety of ways which do not always put low-income people on the losing side. When taking into account the social class of the therapist, stereotypes and diagnosis were relevant but therapeutic relationship and referral options seemed to have less of an impact. These findings seem to move away from a traditional “lack of exposure translates to prejudice” model of classism and toward a more complex and dynamic model. In essence, instead of asking “How does social class impact treatment?” we should be asking “How does a clinician’s social class impact a specific component of treatment with an individual of a specific social

group?" This stands in opposition to making assumptions about uniform prejudice across upper social class groups in therapy. In future research, it will be important to explore aspects of treatment, as well as client-clinician-treatment interactions, separately and not make the assumption that classism will have equal effects across the board.

APPENDICES

Appendix A Vignettes

Middle Class Vignette

Marie is a 31-year-old woman with two children. Her children's names are Bre (4 years old) and Michael (6 years old). Marie obtained her B.A. in business in 2004 and currently works as a manager at a corporate office. She enjoys going to movies, going out to restaurants and bars on the weekends with friends, and reading books at home. Marie generally works between 40 and 50 hours a week and makes roughly 50,000 dollars per year. She comes into counseling reporting that she is feeling anxious for no reason and sometimes has difficulty getting out of bed. The client used to drink to the point of intoxication when she was younger, but only does this occasionally (once every three weeks) currently. She reports losing patience quickly at home with her daughter and occasionally breaking out into tears for no obvious reason. She reports that she has had trouble maintaining romantic relationships for the past few years and that her relationships usually end in bad break ups. She further states that she is having trouble concentrating at work and may get lost in her thoughts and worries. Sometimes the anxiety has gotten intense enough where she has left work fifteen minutes early. One time three months ago she left work halfway through the day because she felt an unprovoked sense of distress that manifested as muscle tension and feeling short of breath.

Low-Income Vignette

Marie is a 31-year-old woman with two children. Her children's names are Bre (4 years old) and Michael (6 years old). Marie obtained her high school diploma in 2000 and currently works as a manager at a fast food restaurant. She enjoys going to movies, going out to restaurants and bars on the weekends with friends, and reading books at home. Marie generally works between 40 and 50 hours a week and makes roughly 18,000 dollars per year. She comes into counseling reporting that she is feeling anxious for no reason and sometimes has difficulty getting out of bed. The client used to drink to the point of intoxication when she was younger, but only does this occasionally (once every three weeks) currently. She reports losing patience quickly at home with her daughter and occasionally breaking out into tears for no obvious reason. She reports that she has had trouble maintaining romantic relationships for the past few years and that her relationships usually end in bad break ups. She further states that she is having trouble concentrating at work and may get lost in her thoughts and worries. Sometimes the anxiety has gotten intense enough where she has left work fifteen minutes early. One time three months ago she left work halfway through the day because she felt an unprovoked sense of distress that manifested as muscle tension and feeling short of breath.

Appendix B Survey

Qualtrics Survey Software

<https://und.qualtrics.com/ControlPanel/Ajax.php?action=GetSu...>

Kipp Pietrantonio's Dissertation Survey

The information provided by the following brief survey will help us complete a research project required for a dissertation at The University of North Dakota. Please do not write your name on this survey because it is important that it remains anonymous and confidential. We appreciate the time you are taking to help us. Please try your best to complete the entire survey. There is no obligation to complete the survey, but filling out the survey in its entirety gives us the most accurate information possible.

PLEASE FILL OUT THE SURVEY IN ORDER AND DO NOT MOVE BACKWARDS AS YOU COMPLETE THE SURVEY. ALL INFORMATION WILL REMAIN ANONYMOUS AND CONFIDENTIAL.

I Understand

Please Identify your sex

- Male
- Female
- Gender Queer
- Transgender

Please Identify your Age

Please Identify what type of agency you work in?

Income Level (Cumulative Gross income for just you. Please circle income range)

- 0 -10,000
- 10,000-20,000
- 20,000-30,000
- 30,000-40,000
- 40,000-50,000
- 50,000-60,000
- 60,000-70,000
- 70,000-80,000
- 80,000-90,000
- 90,000-100,000
- 100,000 +

4. Income Level (Cumulative Gross Family Income. Please circle income range)

- 0 -10,000
- 10,000-20,000
- 20,000-30,000
- 30,000-40,000
- 40,000-50,000
- 50,000-60,000
- 60,000-70,000
- 70,000-80,000
- 80,000-90,000
- 90,000-100,000
- 100,000 +

What Race/Ethnicity do you identify with?

With what social economic class do you identify with?

- Impoverished
- Lower Class
- Working Class
- Lower Middle Class
- Middle Class
- Upper Middle Class
- Upper Class

7. What is your level of education? Choose the Highest Level you have completed:

- Less Than High School
- High School Diploma or GED
- Some College
- Associates Degree
- Bachelors Degree
- Masters Degree
- Doctoral Degree
- Vocational Degree
- Military Education

Please read the vignette closely, review the information on the next page if needed, and then answer the following questions

Marie is a 31-year-old woman with two children. Her children's names are Bre (4 years-old) and Michael (6 years-old). Marie obtained her Bachelor's Degree in the year 2004 and currently works as a manager at a corporate office. She enjoys going to movies, going out to restaurants and bars on the weekends with friends, and reading books at home. Marie generally works between 40 and 50 hours a week and makes roughly 50,000 dollars per year. She comes into counseling reporting that she is feeling anxious for no reason and sometimes has difficulty getting out of bed. The client used to drink to the point of intoxication when she was younger, but only does this occasionally (once every three weeks) currently. She reports losing patience quickly at home with her daughter and occasionally breaking out into tears for no obvious reason. She reports that she has had trouble maintaining romantic relationships for the past few years and that her relationships usually end in bad break ups. She further states that she is having trouble concentrating at work and may get lost in her thoughts and worries. Sometimes the anxiety has gotten intense enough where she has left work fifteen minutes early. One time three months ago she left work halfway through the day because she felt an unprovoked sense of distress that manifested as muscle tension and feeling short of breath.

The following text is only for review.

The **Global Assessment of Functioning (GAF)** is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living. The score is often given as a range, as outlined below:

91 - 100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81 - 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 - 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61 - 70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 - 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41 - 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31 - 40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21 - 30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11 - 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1 - 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

Using the information from the previous page please assign a Global Assessment of Functioning Score for the client based off the scenarios below. **DO NOT** put a range of scores; choose only an individual score for example a 73 and **not** 71-80.

What do you believe the clients current Global Assessment of Functioning Score is

What do You Believe the clients Global Assessment of Functioning Score will be after one month of individual psychotherapy?

What do You Believe the clients Global Assessment of Functioning Score will be after three months of individual psychotherapy?

What do You Believe the clients Global Assessment of Functioning Score will be after six months of individual psychotherapy?

What do You Believe the clients Global Assessment of Functioning Score will be after one month without any form of psychotherapy?

What do You Believe the clients Global Assessment of Functioning Score will be after three months without any form of psychotherapy?

What do You Believe the clients Global Assessment of Functioning Score will be after six months without any form of psychotherapy?

Please indicate how much you agree each of the attributes below apply to the client.

	Extremely unlikely a characteristic of the client	Very unlikely a characteristic of the client	Not likely a characteristic of the client	Likely a characteristic of the client	Very likely a characteristic of the client	Extremely characteristic of the client
Hardworking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Proud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intelligent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Oriented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Happy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strong	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friendly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lazy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stupid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dirty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uneducated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unpleasant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Immoral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weak	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mentally Ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have Too Many Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abusive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcoholic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Criminal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unkind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically Ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Promiscuous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unmotivated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inconsiderate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please indicate to what level you agree with the following statements. Some of the questions below ask about providing services. We realize your agency/clinic may not perform all these services listed below, but please answer the questions as if were possible to provide these service at your place of employment.

	Extremely Disagree	Strongly Disagree	Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Agree	Strongly Agree	Extremely Agree
I would like to work with this client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The client would benefit from working with me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This client would most likely benefit from individual therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The client has a severe disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This client is likely to miss appointments if scheduled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This client would be resistant in therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be willing to provide weekly counseling as my primary form of treatment with this client if she requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be willing to provide bi-weekly counseling as my primary form of treatment with this client if they requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be willing to provide individual therapy twice a week as my primary form of treatment with this client if she requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be willing to provide in-home visits as my primary form of treatment with this client if she requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be willing to provide in-office family therapy as my primary form of treatment if she requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would provide a psychoeducation class as my primary form of treatment with this client if she requested it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would likely refer this client to career counseling as my primary form of treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would likely refer this client to a psychiatrist as my primary form of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about your career at this point in time

How many hours per week do you generally perform psychotherapy with clients?

- 0
- 1-4
- 4-8
- 8-12
- 12-16
- 16-20
- 20 or more

Please select which of the following populations you work with. Please choose all that apply. Then please estimate the percentage of clients you have seen in your practice which fall into the categories. Please assign an actual percentage such as 75%. Your total should add up to 100%

- Clients living in poverty?
- Clients just making ends meet?
- Clients with adequate income to meet their needs?
- Clients whom have comfortable disposable income?
- Client whom are wealthy?

Family of Origin Information Form

Please complete the following information by filling in the blank corresponding with each item.

Please answer these questions for YOUR FAMILY OF ORIGIN.

For any sections that do not apply (Ex: if there is no male or female guardian), please type "N/A". We realize that some of the characteristics asked may have been applicable at some time and not others. Please try to think in terms of generality for most of your development.

How many people lived in your household? Remember to select each that apply first before writing in a number

- Adults
- Children and Minors

For the mother/guardian/female head of household:

What was her race/ethnicity?

For the mother/guardian/female head of household:

What was/is her occupation?

For the mother/guardian/female head of household:

What was/is her highest level of education?

For the father/guardian/male head of household:

What was his race/ethnicity?

For the father/guardian/male head of household:

What was his occupation?

For the father/guardian/male head of household:

What was his highest level of education?

What would you estimate your annual household income was from your birth to age 12?

- 0-\$4,999
- \$5,000-11,999
- \$12,000 – 18,999
- \$19,000 – 24,999
- \$25,000 – 79,999
- \$80,000 – 150,000
- \$150,000 – 249,999
- \$250,000 – 499,999
- \$500,000 and up

Please use this scale to answer the following questions. These questions ask you to compare your parents/guardians to what you think the average citizen of the United States was like when you grew up. (Ex: if you believe your parents were equal to the average U.S. citizen in terms of the financial resources needed to obtain additional education experiences, you would mark average.)

	Very Much Below Average	Below Average	Average	Above Average	Very Much Above Average
Ability to give their children additional educational experiences like ballet, tap, art/music classes, science camp, etc.?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to afford to go to the movies, restaurants, and/or the theater on a regular basis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to join a health club/fitness club	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to afford regular dental visits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to afford dry cleaning services on a regular basis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to travel recreationally?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to travel overseas for business and/or please?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to shop comfortably in upscale department stores such as the Boston Store, Saks Fifth Avenue, or Talbot's?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potential for receiving a large inheritance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to secure loans with low interest rates?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to hire professional money managers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to go to a doctor or hospital of their own choosing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to hire others for domestic chores (e.g. cleaning, gardening, child care, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to afford prescription medicine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to afford elective surgeries and/or high-cost medical examinations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For your parents/guardians compare what was available in terms of type and/or amount of resources to what you believe is available to the average citizen of the United States. (Ex: if you believe your parents/guardians were equal to the average U.S. citizen in home(s), you would mark average)

	Very Much Below Average	Below Average	Average	Above Average	Very Much Above Average
Home(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Land	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stocks and Bonds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Computers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
New Appliances (Washers, Dryers, Refrigerators, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amount of Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of High School(s) Attended	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life Insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of Health Insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Savings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maids or Cooks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Close Connections to the Rich and Powerful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of Health Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please indicate how your parents/guardians compared to the average citizen in their ability to do the things below using the same scale. (Ex: if you believe your parents/guardians are equal to the average U.S. citizen in their ability to contact people in high places for a job or position, you would mark average)

	Very Much Below Average	Below Average	Average	Above Average	Very Much Above Average
Contact people in high places for a job or position	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contact people who can help you/them get out of legal problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Start in a high-profile position of responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Get information and services not available to the general public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Control how your group is represented in history, media, and the public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Receive a fair trial	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Become a millionaire by legal means	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Control the type and amount of work of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Control the salary and compensation of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence the laws and regulations of your state/city/town	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence state or federal educational policies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence the policies of a corporation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence where and when stores are built and operated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence where and when waste treatment facilities are built and operated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influence the decision-making of foundations, charities, hospitals, museums, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Compared to how society values or appreciates the average U.S. citizen, how does society value or appreciate your:

	Much Less	Less	The Same	More	Much More
Ethnic/Racial Group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Socioeconomic group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nationality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Compared to how society values or appreciates the average U.S. citizen, how does society value or appreciate the...?

	Much Less	Less	The Same	More	Much More
Neighborhood in which you lived?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type of home you lived in?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Places where your parents/guardians shopped?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Places where you relaxed and had fun?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type and amount of education your parents/guardians had?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type of car your parents drove?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Position your parents/guardians held in society?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Compared to how society values or appreciates the average U.S. citizen, how does society value or appreciate your . . . ?

	Much Less	Less	The Same	More	Much More
Physical Appearance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Occupational Success?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial Success?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Abilities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Economic Background?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please read the following statements and select the answer that corresponds with how much you agree or disagree

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
People who stay on welfare have no desire to work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Welfare keeps the nation in debt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People who don't make much money are generally unmotivated.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homeless people should get their acts together and become productive members of society	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Too many of my tax dollars are spent to take care of those who are unwilling to take care of themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If every individual would carry his/her own weight, there would be no poverty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are more poor people than wealthy people in prisons because poor people commit more crimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor people are lazy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most poor people are in debt because they can't manage their money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for your participation!!! You ROCK!

Appendix C

Email to Potential Participants

Message for Participants

Hello all,

My name is Kipp Pietrantonio and I am a doctoral candidate completing my Ph.D. in Counseling Psychology at the University of North Dakota. I am asking mental health professionals to please complete the following survey in an attempt to complete my dissertation. THIS SURVEY IS NOT FOR CURRENT STUDENTS. This is only for individuals who have completed their terminal degree. Licensure is not necessary for you to complete the survey.

The survey has three main components.

1. Demographics
2. Reading and reacting to a psychotherapy case vignette
3. Providing information on your background and opinions.

The survey should take between 10-15 minutes to complete. The survey has received a waiver of informed consent from the University of North Dakota Institutional Review Board and as a result you do not have to put any identifying information anywhere on the survey. Everything will remain completely anonymous and confidential outside of general information like your age, sex, type of employment, etc. We appreciate the time you are taking to help us. Please try your best to complete the entire survey. There is no obligation to complete the survey, but filling out the survey in its entirety gives us the most accurate information possible.

Please randomly choose one of the following links below to complete the survey. Please only click one link and complete only one survey.

https://und.qualtrics.com/SE/?SID=SV_3rwKH2XV9rmQcUB

OR

Appendix D Debriefing Form



Debriefing Form

Dear Participant:

Thank you for your participation in this study. Your participation will greatly help us in our understanding of what it means to work with individuals from various social classes in therapy. This study is multifaceted as it was designed to look at several important variables that would impact working with low-income people in a psychotherapy setting. The study focused on working mental health clinicians and their reactions to a vignette. The study includes a sample of three hundred mental health professionals from all over the country. The use of G-Power analysis indicated that for a medium effect size three hundred participants would be necessary to complete the study. Individuals have to be licensed or currently pursuing licensure in order to participate in the study.

The vignette included a case study of a woman who has a set of psychological symptoms, psychosocial stressors, and substance abuse issues. In one version of the vignette she comes from a low-income household and in the other she is from a middle class household. You received one of these two vignettes. The class difference between vignettes was dictated by her income, occupation, and education level, which have been proven to be the established indicators of social class. We were examining how counselors and psychologist may have different clinical impressions based on the social class differences. In addition to the above-mentioned information, we also examined your exposure to a low-income lifestyle and your general beliefs around people who can be identified as low-income via two separate scales. Overall this study was a cumulative look at your attitudes toward low-income people, your exposure to a low-income lifestyle, and your clinical interpretations of a vignette that included important important social class variables.

Once again we feel it is important to state that no information from your survey will be able to identify you. All answers will be kept confidential and all outcomes of the study will be reported in aggregate form only, ensuring that individuals cannot be identified as participants in the study. The forms will be separated and locked in separate file cabinets at the University of North Dakota and kept for a time period of three years and then destroyed. We don't expect you to experience any negative effects from participating in this study. There are also no direct benefits to you for participating. We do hope the findings will contribute to improved understanding of the affects of social class on individuals.

This study is being conducted by Cindy Juntunen and Kipp Pietrantonio, from the Department of Counseling Psychology and Community Services at the University of North Dakota. Any questions may be directed to Dr. Cindy Juntunen or Kipp Pietrantonio at (701) 777-3740. If you have any other questions or concerns about the study please call the Office of Research and Program Development at the University of North Dakota at (701) 777-4279.

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