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Influence of Social Class Perceptions on Attributions Among Mental Health Practitioners

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Abstract

Objective: A vignette-based study assessed the influence of social class attributions toward a hypothetical client's difficulty. **Method:** 188 licensed mental health professionals who were recruited through professional listservs completed an online survey after reviewing one of two versions of a vignette describing a hypothetical client that varied based on social class cues. **Results:** As expected, this sample of licensed mental health practitioners detected social class differences based on the descriptors of the hypothetical client across the two vignettes. These perceived social class differences, however, did not impact participants' attributions toward the client for causing or solving her problems, level of Global Assessment of Functioning score ascribed to the client, or willingness to work with the client. **Conclusions:** There was no evidence that participants differentially ascribed attributions based on social class. Implications and directions for future research are provided.

Keywords

social class attributions, clinical impressions, vignette-based experimental design

Research has documented that negative stereotypes toward individuals who are from lower social class backgrounds are common (e.g., Cozzarelli, Wilkinson, & Tagler, [19]; Johannesen-Schmidt & Eagly, [37]). Lott ([41]) argued that many psychologists share these prejudices and Smith ([62]) posited that psychotherapists have attitudinal barriers that contribute to them engaging in classist behaviors in their clinical work. Perhaps these prejudices are also reflected in the dearth of research on attitudes toward poverty and the lack of a sophisticated understanding of attributions based on social class indicators in relationship to psychotherapy (e.g., Cozzarelli et al., [19]; Thompson, Cole, & Nitzarim, [70]; Williams, [76]). The purpose of this study was to examine the extent to which mental health practitioners' attributions toward a hypothetical client varied based upon the social class cues used to describe the client in two versions of a clinical vignette.

Attributions of Social Class

Attribution theories suggest that in an effort to make sense of the world, humans search for explanations for events (e.g., Weiner & Kukla, [74]). We rely upon heuristics, stereotypes, and cognitive attributions in order to guide our decision-making and actions. Although attention to attributions specifically related to social class is limited (Cozzarelli et al., [19]), much of the research that does exist is based on the Theory of Planned Behavior (TPB; Ajzen, [2]). The TPB suggests that attitudes influence intentions, which subsequently impact behaviors. As such, an individual's beliefs or causal attributions of social class influence that person's interactions with others (Bullock, [10]; Cozzarelli et al., [19]).

One area that has received attention with regard to attributions of social class is the extent to which people make cognitive attributions that are internal (about the person) or external (due to external circumstances). Cross-cultural investigations have demonstrated that US participants tend to attribute low-income status to individualistic or internal factors (e.g., Bullock, Williams, & Limbert, [12]; Cozzarelli et al., [19]; Kluegel & Smith, [39]) whereas non-US participants tend to attribute it to external or structural factors (e.g., Nasser, [49]). Within the USA, examining specific demographic characteristics has produced conflicting findings. Some research (Bullock, [10]; Cozzarelli et al., [19]; Shirazi & Biel, [60]) has indicated that men, European Americans, persons of higher social class, and more educated

individuals are more likely to have internal attributions of social class in comparison to women, non-European Americans, and individuals who are from lower social classes or less educated. In contrast, other research (e.g., Nasser, [49]; Reutter et al., [56]) has demonstrated that these demographic characteristics are not important predictors of attributions.

These mixed findings may be an indication of the complexity of attributions regarding social class. For example, Kluegel and Smith ([39]) argued that both individualistic and societal explanations for poverty are often simultaneously endorsed in US culture. Although many recognize that structural barriers that make overcoming low social class difficult exist, the belief that these barriers can be surmounted by hard work is widespread. Ideologies behind the "American dream" and a belief in meritocracy suggest that individuals get what they deserve; low social class results from a lack of effort and can be overcome by hard work (e.g., Cozzarelli et al., [19]; Rubin & Peplau, [58]). Further, individual's economic context and life experiences contribute to implicit attitudes and assumptions related to social class position (Sue & Sue, [69]).

Social Class and Psychotherapy

Attributions related to social class are important to consider within the context of psychotherapy because social class bias has been consistently documented in relation to psychotherapy referrals, psychotherapy utilization rates, and psychotherapy outcomes. For example, findings have demonstrated that clients from lower-class backgrounds are less likely to be referred to therapy that is insight-oriented rather than supportive in comparison to their peers from more middle and upper-class backgrounds (e.g., Franklin, [26]; Levy & Kahn, [40]; Neumann, Salganik, Rabinowitz, Bauer, & Kastner, [51]; Rabinowitz & Lukoff, [53]). Research has also indicated that psychotherapy clients from lower social class backgrounds are less likely to access mental health care given a myriad of barriers (e.g., Nadeem, Lange, & Miranda, [48]) and that they have higher rates of discontinuing therapy (e.g., Miranda, Azocar, Komaromy, & Golding, [44]; Siefert, Heflin, Corcoran, & Williams, 2000) in comparison to clients from more upper-class backgrounds.

Studies have provided evidence of disparities in treatment outcomes across client social class. For example, research has indicated that post-treatment scores on the Beck Depression Inventory were higher for samples of clients from lower social class backgrounds as compared to post-treatment scores from published CBT outcome studies with samples that are primarily from middle-upper class backgrounds (Miranda, Azocar, Organista, Dwyer, & Areane, [45]; Organista, Muñoz, & González, [52]). Others (e.g., Cohen et al., [17]; Falconnier, [22]) have used secondary analysis of data from clinical trials to demonstrate disparities in outcomes. Cohen and colleagues ([17]) showed that individuals who occupied the low-income census tracts responded less to treatment and reported greater incidences of suicidality than their counterparts who occupied the higher-income census tracts regardless of treatment condition. Relatedly, Falconnier ([22]) indicated that lower SES (as measured by Hollingshead's Two-Factor ISP), but not education or family income, was related to decreased improvement across three treatment conditions for individuals with depression. In another study, Falconnier ([23]) demonstrated that individuals who were depressed and from lower social class backgrounds had lower improvement ratings with regard to work functioning than their middle-income counterparts who were also depressed across three treatment conditions.

Psychotherapist Perceptions and Attributions

In light of the evidence on the general effect of attributions on people's behavior, therapists' attributions may partially account for the differences observed in referrals, utilization rates, and outcomes. Scholars and practitioners (e.g., Bullock, [11]; Goodman, Pugach, Skolnik, & Smith, [31]; Lott, [41]) have argued that mental health practitioners are not immune to making attributions and inferences based on social class. Empirical support for variations in therapist perceptions of clients based upon social class characteristics has also been demonstrated (e.g., Hillerbrand, [35]; Rowden, Michel, Dillehay, & Martin, [57]; Smith, Mao, Perkins, & Ampuero [63]; Stein, Green, & Stone, [67]). Similar to findings with samples from the general population (e.g., Bullock et al., [12]; Cozzarelli et al., [19]), mental health practitioners were more likely to attribute problems of clients from lower-income backgrounds to internal or dispositional factors rather than to external factors (Batson, [8]; Gambrill, [28]; Wills, [77]).

Some authors (e.g., Appio, Chambers, & Mao, [4]; Ballinger & Wright, [6]; Bullock, [11]; Goodman et al., [31]; Lott, [41]; Smith, [62]) have gone further to suggest that psychotherapists have biases and stereotypes against individuals from lower-income backgrounds, although studies have yielded mixed results. For example, there is some empirical evidence suggesting the presence of negative clinical judgment bias in that clients from lower social class backgrounds were more likely to receive higher ratings of pathology or symptom severity than their counterparts from higher social class backgrounds (e.g., Abramowitz & Dokecki, [1]; Trachtman, [72]). Results from Hillerbrand's ([35]) retrospective investigation of 163 files at a university counseling center demonstrated that lower SES clients were perceived by therapists as less successful in therapy and as having "resolved less psychic conflict" (p. 253) than their middle and upper SES counterparts. Schnitzer ([59]) argued that stories regarding clients from low-income backgrounds have been passed along within psychotherapy circles that reveal unexamined classist assumptions about individuals who are poor, including: "they don't come in" (p. 572), "they're so disorganized" (p. 574), and "they don't care" (p. 575). In their study with graduate student counselors in training, Smith et al. ([63]) demonstrated that participants who evaluated the hypothetical client who was presented as working-class had significantly less favorable impressions regarding future work with the client than participants who evaluated the three other vignette conditions (low-income, middle-class, and wealthy).

On the other hand, in his review of research from 1974 to 1996, Garb ([29]) argued that the presence of bias in clinical judgment has only been detected in studies where sample sizes were limited (e.g., $n = 49$ versus $n = 266$). Garb concluded that there was no evidence that clients portrayed as being from a lower class were diagnosed as having more severe symptoms than clients portrayed as being from a middle or upper class. Instead, he suggested that there may be a tendency for practitioners to under-detect pathology in samples with individuals from middle or upper-class backgrounds.

One explanation for this body of findings offered by scholars relates to therapist difficulties in connecting with clients from different social class backgrounds. Results from prior research offer some support for this hypothesis. In explaining results from their meta-analysis of client dropout, Wierzbicki and Pekarik ([75]) called for more research on social class and psychotherapy based on their conclusion that "lower-class clients may differ from therapists in several important respects, including education, value systems, and expectations concerning the nature and duration of therapy" (p. 193). Similarly,

Garb ([29]) noted that therapists are more likely to identify as middle or upper class, which may allow them to more easily empathize with clients from similar backgrounds. Sue and Sue ([69]) argued that clinical judgment is impacted by therapists' conscious and unconscious preconceptions that result from socialization experiences based upon their own economic context.

Results from qualitative interviews (Balmforth, [7]; Chalifoux, [15]) provide support for some of these assertions. In particular, findings from interview data with clients who identified as being from low-income backgrounds highlighted clients' perceptions that their therapist could adequately understand and empathize with them because of evident differences in social class. This was cited as contributing to the clients' tendency to withhold information in session and to client's perceptions of the ability of psychotherapy to meet their needs.

Current Study

In order to understand factors that may contribute to these findings, authors (e.g., Dougall & Schwartz, [21]) have suggested that we need to better understand therapists' perceptions of clients' motivation and therapists' attributional judgments (Chen, Froehle, & Morran, [16]) about the client. Because effective treatment requires accuracy in therapist judgment (Witkin, [78]), investigating therapists' attributions toward clients from varied economic backgrounds is critical in order to identify factors that may contribute to greater accuracy in inferences and thereby provide competent clinical care for clients from all social class backgrounds.

The purpose this study, therefore, was to examine licensed mental health practitioners' attributions toward a hypothetical client, "Pat," who was depicted in one of two versions of a vignette that varied by social class cues using a vignette-based experimental design. Given the recommendations of others (e.g., Thompson & Subich, [71]; Williams, [76]) that objective and categorical descriptors of social class (i.e., social class category, income level) are limited in their ability to capture social class-based experiences, the vignettes were written to include information about Pat's occupation, the occupation of Pat's children's father, and Pat's level of financial concern. We assessed practitioners' attraction toward working with Pat, attributions of responsibility toward Pat for causing and solving her problems, and diagnostic impressions of Pat using the Global Assessment of Functioning (GAF). Based on the suggestions of scholars (e.g., Schnitzer, [59]; Sue & Lam, [68]) and findings from empirical research (e.g., Chalifoux, [15]; Smith et al., [63]), the following hypothesis was proposed:

Hypothesis: Mental health practitioners presented with Vignette A (working to lower-middle class) will report lower GAF scores, lower attraction to working with Pat, lower willingness to work with Pat, and will ascribe higher levels of personal responsibility to Pat for causing and solving her problems than those who are presented with Vignette B (middle to upper class).

Method

Participants

A total of 208 individuals started the survey and 192 (92%) completed 80% of the survey. The participants, from 38 different US states, District of Columbia, and Canada, were predominantly White, straight, women, doctoral-level practitioners who identified themselves as middle to upper-middle class. Participants identified a range of theoretical orientations, including: Adlerian, eclectic,

humanistic, psychodynamic, feminist, cognitive, and behavioral. Detailed demographics of the participants are provided in Table I.

Table I. Participant demographics.

Category	Subcategory	M (SD, range) n (%)
Age		42.05 (11.54, 22–77)
Years of practice		12.70 (9.13, 1–43)
Gender	Genderqueer	1 (1%)
	Other	2 (1%)
	Women	134 (70%)
	Men	55 (29%)
Race/ethnicity	Asian/Asian American	5 (3%)
	African American/Black	8 (4%)
	Hispanic/Latino/Mexican/Mexican American	4 (2%)
	Mixed	11 (6%)
	Other	2 (1%)
	White/Anglo/Caucasian/European American	160 (83%)
Sexual orientation	Bisexual women	9 (5%)
	Bisexual man	1 (1%)
	Lesbian women	8 (4%)
	Gay men	5 (3%)
	Queer	6 (3%)
	Questioning	1 (1%)
	Straight	159 (83%)
Disability	Yes	9 (5%)
	No	183 (95%)
Social class	Lower class	2 (1%)
	Working class	5 (3%)
	Lower-middle class	16 (8%)
	Middle class	87 (45%)
	Upper-middle class	63 (33%)
	Upper class	5 (3%)
Education	Master's	45 (23%)
	EdD	1 (1%)
	PsyD	39 (20%)
	PhD	90 (47%)
Specialization	Clinical psychology	102 (53%)
	Counseling psychology	51 (27%)
	Educational psychology	1 (1%)
	Marriage and family therapy	4 (2%)
	Other	6 (3%)
	School psychology	1 (1%)
	Social work	19 (10%)
Setting	Community mental health center	38 (20%)

	Forensic	9 (5%)
	Hospital	28 (15%)
	Private practice	20 (10%)
	School (K-12)	1 (1%)
	Shelter	1 (1%)
	University/college counseling center	65 (34%)
	Veterans Affairs	12 (6%)
	Academic/faculty	8 (4%)

Vignette

Both versions of the vignette began with an identical description of Pat.

Pat is a 32-year-old mother of two children (ages 3 and 5) who is currently pregnant with her third child. Pat presents to counseling because she has become increasingly concerned about her recent, repeated absences from work due to pregnancy-related concerns (i.e., nausea and back pain), difficulty concentrating, and intermittent experiences of panic. Pat reports taking anti-anxiety medication for a year when she was 29, and stated that her experience of panic attacks has increased as her due date approaches.

Vignette A portrayed Pat as a working- to lower-middle-class woman and Vignette B portrayed Pat as a middle- to upper-class woman. Social class cues (i.e., Pat's occupation, the children's father's occupation, and level of financial concern) varied across the vignettes. In Vignette A, Pat was described as working full time as "an administrative assistant at a hair salon for the past 4 years" and in Vignette B Pat was described as working full time as "a chemist for the past 4 years." With regard to financial concerns, in Vignette A Pat is described as becoming "increasingly worried about her ability to provide for her growing family and feels guilty about being a single parent" whereas in Vignette B Pat is described as becoming "increasingly worried about her ability to care for her growing family given her demanding work schedule." Finally, Vignette A stated that Pat is uncertain how much money she will receive in child support from the children's father who "works in construction" and Vignette B stated that Pat receives child support from the children's father who "works as a physician." Gender was held constant and no information regarding race/ethnicity was provided so as to avoid potential confounds.

The vignettes depicting Pat were written by the authors and were piloted in two phases. First, a focus group was conducted with six counseling psychology trainees who provided their overall perceptions of Pat, including mental health and social class. The vignettes were modified based on the feedback to incorporate greater clarity in the social class and mental health descriptors. Next, 18 psychology graduate student trainees completed the online survey. These pilot data indicated preliminary evidence of observed differences across the two vignettes as expected. Participants assigned to Vignette A rated Pat's income as being significantly lower than those who were assigned to Vignette B ($M = 3.25, SD = 2.76$ and $M = 5.50, SD = 1.65$, respectively; $t[16] = 2.03, p = .047$ [.030, 4.47]) and participants assigned to Vignette A rated Pat's social class category as significantly lower than those who were assigned to Vignette B ($M = 2.00, SD = .76$ and $M = 4.40, SD = .70$, respectively; $t[16] = 6.98, p < .001$ [1.67, 3.13]).

Measures

Internal consistency reliability estimates for all scales are reported in Table II.

Table II. Means, standard deviations and correlations among primary variables.

	Vignette A	Vignette B							
Variable	M	SD	M	SD	α	1	2	3	4
1. CSS AC	11.84	4.17	12.32	3.69	.83	–			
2. CSS AS	14.16	3.01	13.42	2.83	.91	.268	–		
3. GAF	63.03	8.30	61.83	7.05	–	–.050	.027	–	
4. TPRQ	12.15	7.07	12.57	7.91	.68	–.339	.030	.027	–
5. PCQ	9.86	2.05	9.63	2.14	.86	–.176	.100	.045	.559

Note. CSS = Cause and Solutions Scale: AC = Cause, AS = Solution; GAF = Global Assessment of Functioning; TPRQ = Therapist Personal Reaction Questionnaire; PCQ = Professional Contact Questionnaire.

$p \leq .05$, *** $p \leq .001$, two-tailed.

Therapist Personal Reaction Questionnaire (TPRQ)

The 15-item TPRQ (Tryon, [73]) was used to assess therapists' reactions toward Pat as a potential client. Items are rated on a 5-point Likert-type scale ranging from 1 (*not characteristic of my present feelings*) to 5 (*highly characteristic of my present feelings*). A sample item is "I like this client more than most." There are nine positively phrased items (range 9 to 45) and six negatively phrased items (range –6 to –30). Scores are summed so that total scores range from –21 to 39. Higher scores indicate higher levels of therapist overall attraction to working with the client. The TPRQ has been demonstrated to have acceptable internal consistency reliability (alphas ranging from .75 to .80; Mohr, Israel, & Sedlacek, [46]; Mohr, Weiner, Chopp, & Wong, [47]; Tryon, [73]). Higher TPRQ scores have correlated positively with continuation in therapy (Tyron, [73]). Mohr et al. ([46]) demonstrated that counselors who view bisexuality as a stable and legitimate sexual orientation scored higher on the TPRQ in reference to a hypothetical client who was depicted as bisexual than counselors who did not view bisexuality as legitimate and stable.

Cause and Solution Scale (CSS)

Causal attributions and responsibility for Pat's difficulties were assessed using the CSS (Karuza, Zevon, Gleason, Karuza, & Nash, [38]). The CSS consists of two subscales, Cause (i.e., perceived cause of a person's problems) and Solution (perceived solution to a person's problems), with three items each. The CSS was initially developed for use with clients, and was adapted for this study in order to make it relevant to the vignette. For example, the question "To what extent do you feel the client could have controlled the cause of his/her problems?" (Cause subscale) was changed to "To what extent do you feel that Pat could have controlled the cause of her problems?" A sample item from the Solution subscale is "To what extent do you feel Pat can control the solution to her problems?" Responses are scored on a 7-point Likert-type scale ranging from 1 (*not at all*) to 7 (*very much*). Total scores for each subscale ranged from 3 to 21 and higher scores indicate that Pat is ascribed stronger attributions and greater responsibility for causing and solving her problems.

Despite its brevity, the CSS subscales have been demonstrated to have sufficient internal consistency reliability over a series of studies. Alphas ranged from .61 to .88 for the Cause Scale (Burkhard & Knox,

[13]; Hayes & Erkis, [32]; Hayes & Wall, [33]) and from .61 to .79 for the Solution Scale (Bailey & Hayes, [5]; Burkhard & Knox, [13]; Hayes & Erkis, [32]; Hayes & Wall, [33]; Karuza et al., [38]). Two-week test-retest reliability has been estimated to be .86 (Cause) and .70 (Solution; Bailey & Hayes, [5]). The subscales positively correlated with the Derived Cause and Solution scales of the Helping Coping Orientation Measure and were unrelated to empathy (Burkhard & Knox, [13]).

The Global Assessment of Functioning Scale (GAF)

The GAF is a single-item measure of global psychological, social, and occupational functioning that comprises Axis V of the DSM-IV-TR (American Psychiatric Association, [3]). The instructions direct scorers: "Do not include impairment in functioning due to physical (*or environmental*) limitations" (p. 34). The GAF is used by mental health professionals to rate clients on a unidimensional scale from 1 to 100, with higher scores indicating better functioning. Evidence of concurrent validity and inter-rater reliability for the GAF has been demonstrated across a number of studies (e.g., Hilsenroth, Ackerman, & Blagys, [36]; Ramirez, Ekselius, & Ramklint, [54]; Startup, Jackson, & Bendix, [66]).

Professional Contact Questionnaire (PCQ)

The original six-item PCQ developed by Crawford, Humfleet, Ribordy, Ho, & Vickers ([20]) investigated therapists' level of willingness to work with clients who have contracted HIV/AIDS. Two items that were adapted from the PCQ by Hayes and Erkis ([32]) were used to evaluate participant's willingness to work with Pat. The items were: "How likely would you be to take Pat on as a client?" and "How likely would you be to refer Pat to another therapist?" (reverse-scored). Items were rated from 1 (*very unlikely*) to 6 (*very likely*). Total scores range from 2 to 12, with higher scores indicating more willingness to work with Pat.

In the Crawford et al. ([20]) study, these two items discriminated between psychologists' reactions to clients with AIDS and to those with leukemia such that psychologists were more likely to refer a client with AIDS out than a client with leukemia and were less likely to accept a client with AIDS than to accept a client with leukemia. Hayes and Erkis ([32]) demonstrated that therapists indicated less willingness to work with a client with an unknown source of HIV infection in comparison to a client who contracted HIV through a blood transfusion or sex.

Procedure

Participants were recruited from listservs for professional organizations, (e.g., Society for Psychotherapy Research, APA practice listservs, and ACCTA) and via email (email addresses were obtained using the National Register's "Find a Psychologist" database and through the Association of Psychology Postdoctoral and Internship Centers database). Recruitment postings called for licensed mental health professionals who have worked with at least one client in psychotherapy within the past 12 months. These inclusion criteria were selected in an effort to recruit practitioners who had recent experience with at least one client so as to ensure that the person was still actively engaged in providing mental health treatment. The inclusion criteria allowed participation from practitioners whose primary duties include tasks such as administration, supervision, training, and research but who are still actively involved with client care. Participants were provided with information about the study and the link to the online survey to complete at their leisure. Upon proceeding to the survey, participants reviewed the informed consent form, which documented IRB approval.

All participants reviewed two vignettes. First, each participant was presented with a distraction vignette depicting a 20-year-old European American man who is experiencing "romantic relationship issues." This vignette has been used in previous investigations of therapist reactions to bisexual clients (Mohr et al., [47]). With permission from the authors, we used this vignette to minimize the likelihood that participants would be immediately aware of the focus of this study. Participants completed the CSS and GAF based on the distraction vignette.

Next, participants reviewed one of the two versions of the experimental vignette depicting Pat and completed the TPRQ, CSS, and GAF based on their perceptions of Pat. Participants were randomly assigned a vignette version by the online survey software (Qualtrics). Participants who agreed provided their contact information to be entered into a \$10 gift card drawing for an online retailer (one of every ten participants was selected). All identifying information was collected independently from responses to the survey items.

Results

Relationships among the primary variables are presented in Table II. Results from the correlation matrix indicated that perceptions that Pat was responsible for causing her problems were negatively related to attraction to working with Pat and willingness to take Pat on as a client. Participants assigned to Vignette A (working to lower-middle) rated Pat's social class significantly lower than those who were assigned to Vignette B (middle to upper) on income ($M = 2.63$, $SD = 1.88$ and $M = 7.34$, $SD = 3.04$, respectively; difference = -4.71 [-3.97 , -5.45]; $d = -1.86$; $t[181] = -12.61$, $p < .001$) and social class category ($M = 2.35$, $SD = .85$ and $M = 4.80$, $SD = .67$, respectively; difference = -2.45 [-2.23 , -2.67]; $d = -3.20$; $t[180] = -21.62$, $p < .001$).

The primary hypothesis, however, was not supported by the data for any scale. GAF scores did not significantly differ between the two vignettes ($t[176] = -.956$, $p = .34$). The two groups also did not differ on their attraction ($t[171] = .37$, $p = .71$) or willingness ($t[178] = -.74$, $p = .48$) to work with Pat. Results from the CSS indicated no differences for the Cause ($t[184] = -1.11$, $p = .27$) or Solution ($t[184] = -1.55$, $p = .12$) subscale.

Although not included as a formal hypothesis, we also tested for differences based upon participant characteristics. Participant gender, self-identified social class category, or number of years in practice as a mental health treatment provider did not relate significantly to any variable.

Discussion

This study used a vignette-based experimental design to understand the influence of social class perceptions among a sample of licensed mental health practitioners who, after reviewing a distraction vignette in order to minimize participants' ability to guess the nature of the study, were presented with one of two versions of a vignette describing a hypothetical client, "Pat." The depiction of Pat varied only on descriptors of Pat's social class (i.e., information about her occupation, the occupation of her children's father, and her level of financial concern). This allowed us to test for the effect of differences in perceptions of social class on practitioners' desire to work with Pat, diagnostic impressions of Pat's functioning, and attributions toward Pat for causing and solving her problems. As expected, results from the pilot and full sample indicated that participants detected social class differences based on the

descriptors of Pat across the two vignettes. Yet, these perceptions did not impact this sample of licensed mental health practitioners' ratings on any other variable. Specifically, there were no statistically significant differences on GAF scores, expressed willingness and attraction toward working with Pat, or attributions to Pat for causing and solving her problems between the two vignette conditions.

Results from the correlation matrix indicated a negative relationship between perceptions of Pat causing her problems and level of attraction toward working with Pat and reported willingness to take Pat on as a client regardless of vignette condition. Specifically, those participants who perceived Pat as more responsible for causing her problems were less attracted to working with her and less willing to take her on as a client. Although not a central hypothesis in this study, these results are interesting and highlight the need to further understand the relationship between attributions toward clients for causing and solving their problems and psychotherapy processes and outcomes.

These findings indicating that practitioners in this sample did not significantly differ in their perceptions of Pat even though they detected social class differences between the two versions of the vignette were somewhat unexpected based upon prior findings regarding differences in psychotherapy utilization rates, referrals, experiences, and outcomes among individuals from non-upper middle class backgrounds (e.g., Falconnier, [22]; Nadeem et al., [48]; Rabinowitz & Lukoff, [53]; Thompson et al., [70]). However, given the relative dearth of quantitative examinations of the impacts of practitioner perceptions of client social class within psychotherapy (Goodman et al., [31]; Stabb & Riemers, 2012) and the presence of some mixed findings in previous research (e.g., Garb, [29]; Smith et al., [63]), directional hypotheses may have been somewhat premature. There are several potential explanations for these findings.

First, the results may suggest hope that mental health practitioners are becoming increasingly more aware of the impact of social class on individual struggles. If so, the null findings may indicate that low income and its social stigma have declined in comparison to the past, although such conclusions cannot be drawn from our results. More research is needed in order to understand the implications of mental health practitioners' perceptions of their clients' social class background. For example, it may be that practitioners were able to appropriately disconnect from their emotional reactions or stereotypes when reviewing the vignettes, but would be less able to mask these responses when in the room with a client.

Second, there is a possibility that the mental health practitioners who participated in this study just happen to hold more balanced beliefs about economic mobility and systemic structural factors affecting social class. During the data collection period (Fall 2010–Spring 2012), increased media attention to class warfare and post-recession recovery dominated the local and national airwaves (e.g., Hill, [34]; Lubrano, [42]; McNally, [43]; Zweifel, [79]). At a national level, the emergence of the Occupy Movement, which drew attention to inequitable wealth distribution in the USA, also took place. It is, therefore, possible that awareness of systemic factors related to social class among participants may have been heightened. Indeed, much of the existing literature in this area is dated (e.g., Cozzarelli et al., [19]; Feather, [24]; Kluegel & Smith, [39]), thereby highlighting the possibility that attitudes and attributions related to social class continue to change over time. Although not directly tested, this explanation is consistent with findings that have demonstrated that increased exposure to poverty via

the media is related to individuals' heightened awareness of its systemic and harmful effects (Reutter et al., [55]).

Third, it is possible to interpret these results with skepticism and cynicism—that the participants were well aware of what responses are politically correct with regard to social class. We did not include a measure of social desirability in our study based on previous research that highlighted its limitations when assessing multicultural constructs (e.g., Boysen & Vogel, [9]; Castellanos, Gloria, Mayorga, & Salas, [14]). The fact that the study tested explicit (rather than implicit, e.g., Ajzen, [2]) attitudes and attributions should also be noted. Future research that examines implicit attitudes may yield different results.

Limitations

Given the methodology of this study, it is also important to interpret these results within the context of the vignettes themselves. Although we modeled our vignettes from those in prior research (i.e., Mohr et al., [47]), the language used to describe Pat may have impacted the findings in a variety of ways. First, the descriptions of Pat were purposely written using neutral language in order to avoid the image of a client who may more closely align with popular stereotypes. Pat was presented with identical symptomology in both versions of the vignette and the vignettes did not imply that she had negative personal characteristics or ability levels.

Relatedly, scholars have highlighted the limitations of using specific terms to describe social class and have argued that objective descriptions of social class capture only part of the picture (e.g., Thompson & Subich, [71]; Williams, [76]). Had we provided more specific information regarding Pat's "objective" social class (i.e., actual income, definition of Pat as "living below the poverty line," information about Pat's participation in or qualifications for federal poverty programs), included a description of Pat as not currently working, or included more detailed descriptors of her internalized social status identity (Fouad & Brown, [27]; Thompson & Subich, [71]), results may have differed. Given prior findings indicating that individuals who are described to be associated with state or federal aid-based programs are viewed more negatively than other individuals who are perceived to be "poor" (Smith, [64]), it seems likely that attributions toward Pat may have been more negative had we described her as being poor, unemployed, receiving aid, or participating in poverty programs. Future research is needed in order to identify specific factors (e.g., employed versus unemployed, receiving public assistance, high-school graduate, type of job) that may contribute to mental health practitioners' explicit and implicit attributions toward clients.

Findings also are limited by the fact that we did not examine intersecting identities of Pat (e.g., gender, race/ethnicity, sexual orientation) so as to maintain sufficient statistical power and avoid potential confounds. Prior results (Gilens, [30]; Neubeck & Cazencave, [50]) suggest that a vignette depicting a woman who is also a member of an underrepresented racial or ethnic group would be rated more negatively than a European American man counterpart. It may be that our majority European American samples assumed that Pat was European American and therefore exempted her from blame. Future research is needed in order to test the extent to which findings would have varied across presentation of differing identities (Cole & Omari, [18]; Frable, [25]).

Results also may be limited by the sample. The sample included a diverse group of licensed practitioners across some domains (i.e., work setting, region of the USA, age) but was limited in other domains (i.e., women, individuals who self-reported being from more middle- to upper-class backgrounds, and individuals who identified as European American were overrepresented). Although no significant differences were detected by participant gender, years working as a psychotherapist, or self-reported social class background, the lack of a sufficient sample size across other identities prevented us from a more sophisticated assessment of differences. Future research is needed in order to better understand potential interaction effects that may occur based on client and therapist characteristics related to social class indicators, particularly given the suggestions of some scholars (e.g., Garb, [29]; Sue & Sue, [69]) that one's economic context interacts with one's ability to relate to, and empathize with, others.

Finally, there may be some concerns regarding measurement and design. The moderately low levels of internal consistency reliability demonstrated for the TPRQ represents a limitation. The relative unreliability of this measure may have influenced findings as lower reliability of the measures work against detecting differences (i.e., increased Type II error rates). With regard to design, future research that uses images and/or video clips of a hypothetical client could extend these findings. Finally, although the use of the distraction vignette was implemented in order to mitigate the possibility that participants would guess the nature of the study, it is unclear how this may have impacted participant responses.

Summary

Although no statistically significant differences were detected across the two vignettes on the outcome variables, these findings demonstrated that mental health practitioners notice clients' social class information. Coupled with results from prior research (e.g., Dougall & Schwartz, [21]; Falconnier, [22]; Garb, [29]), these findings highlight the need to continue to understand the relationship of social class to clinical practice. In this study, we asked licensed mental health practitioners to respond to the vignettes based upon the information provided whereas in actual clinical practice clinicians may gather different information from clients and may act in different ways depending upon their own economic contexts and that of the client. As such, we hope that future research investigates how social class attributions are linked to actions. While perceptions are indeed important, what ultimately matters with regard to social class is what we choose to do—e.g., how do psychotherapists actually respond to clients from lower income or class backgrounds?

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