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Effective psychotherapy with low-income clients: The importance of attending to social class

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Abstract

The purpose of this article is to explore some of the issues associated with conducting psychotherapy with low-income clients. Throughout the article, we draw from our specific clinical experiences working with low-income Latina mothers in a depression prevention program. The themes that we address regarding class and psychotherapy are in the areas of assessment of social class, integration of class issues into the therapy process, and managing differences in social class between therapists and clients. As we discuss these themes, we provide concrete recommendations in order to advance awareness and effectiveness in working with economically disadvantaged populations.

Keywords

Psychotherapy; low-income; social class

The demographics of the U.S. are changing. Considerable media and scientific attention has been given to U.S. Census estimates that suggest by the year 2050 the number of European-American U.S. residents will be below 50% of the total U.S. population (U.S. Census Bureau, 2008). Practicing psychologists as well as psychotherapy researchers have begun to respond to these demographic trends, with a commensurate increase in the research and clinical attention to issues of culture in psychotherapy (e.g., Bernal & Sáez-Santiago, 2006; Cardemil, 2010; Castro, Barrera, & Holleran Steicker, 2010; Hall, 2001; Hwang, 2006).

Despite the positive strides that have resulted from this expansion of conceptions of psychotherapy to consider sociocultural influences, most of this work has been limited to conceptualizations of culture that focus on specific racial, ethnic, and cultural groups. Much less psychotherapy research has paid explicit attention to other sociocultural dimensions, including social class (Liu et al., 2004; J. Smith, 2000; L. Smith, 2009; Levy & O'Hara, 2010). As a result, many unexamined assumptions about psychotherapy, including the help-seeking process, the development of the working alliance, and conceptions of positive outcomes, have been rooted in the predominant, middle-class worldview (Liu, 2001). Unreflective use of this worldview can be particularly problematic with low-income clients, who may operate with a different set of assumptions regarding some or all of these psychotherapy-related processes. Indeed, there is some evidence that because the psychotherapy process is rooted in a middle-class worldview, it may not be meeting the needs of low-income clients (Falconnier, 2009). For example, considerable research has

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found that individuals from low-income backgrounds are less likely to seek formal mental health services (Levy & O'Hara, 2010), a fact that is especially true for those low-income individuals who identify as racial and ethnic minorities (Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001). When they do seek out services, low-income individuals and racial/ethnic minorities are less likely to receive evidence-based interventions compared to those who do not belong to underrepresented and underprivileged groups (Le et al., 2010; Miranda et al., 2005), and more likely to prematurely terminate mental health services (e.g., Organista, Muñoz, & Gonzalez, 1994).

These examples of how psychotherapy may not be meeting the needs of low-income clients are concerning, particularly given the dearth of scholarship examining social class and psychotherapy. Indeed, given the clear need for this work, it is puzzling why relatively little attention has been given to class and psychotherapy. A major factor is likely the various barriers that interfere with the efforts of low-income individuals to access mental health service, resulting in fewer opportunities to investigate what works in therapeutic interventions. Such barriers include, but are not limited to, logistical problems like transportation and child care, perceived stigma and mistrust in the mental health care system, and cultural differences in help-seeking and idioms of distress (Goodman et al., 2010; Krupnick & Melnikoff, 2011; Levy & O'Hara, 2010).

We suspect that in addition to these reasons, mental healthcare providers face their own psychological barriers when working with low-income clients. These include their assumptions of what constitutes 'good therapy,' as well as both negative stereotypes and idealizations of people who are poor, which can result in differential and inadequate treatment (Liu et al., 2007). L. Smith (2005; 2009) further delineates classist attitudinal barriers that reproduce additional blind spots. She posits that there lingers an assumption that low-income clients will not benefit from psychotherapy and would instead respond to more immediate material and practical help. In addition, therapists may feel overwhelmed and helpless when confronted with some of their clients' often bleak circumstances (L. Smith, 2005). These conscious feelings may also be accompanied by an uneasy discomfort or unconscious fears that result from witnessing the pain and suffering produced by economic disparities—disparities that are particularly salient given psychologists' own marked privilege in an unequal system of power.

Our clinical and research experiences have led us to conclude that working effectively with low-income clients requires explicit attention to issues of social class throughout the therapy process. Because this explicit attention is multifaceted and ongoing, it requires critical self-reflection and a willingness to engage with the very common feelings of discomfort that arise when working with issues of diversity. In this article, we consider when and how to attend to issues of social class when conducting psychotherapy with low-income clients. We focus on the assessment of social class, the incorporation of social class issues into the therapy process, and the management of social class differences between therapist and clients. Throughout the article, we draw from our specific clinical experiences working with low-income Latina mothers in a depression prevention program. We use these experiences to concretize the different ways that therapists can consider how to integrate social class issues into their work.

Definitions of Social Class

Because this article is focused on clinical work with low-income populations, it is important to first articulate our view of social class. From our perspective, a comprehensive understanding of social class requires a recognition of its institutional structure, its domains and qualities, and its intersections. First, we agree with Andersen and Collins (2007) who

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reject an individualistic definition of class. As they posit, class (as well as gender, race, ethnicity, sexuality, and age) is not an attribute that resides in the self. Rather, it is a manifestation and consequence of systems of power and inequalities reproduced by institutional structures. These structures include social institutions such as economic systems, families, and cultural hegemonies that create divisions among relative classes of privilege and disadvantage (Kliman, 1998). As such, these institutional forces maintain the differential access to resources and oppressive relations among people, and constitute the personal and political consequences of classism (Lott & Bullock, 2007). Hence no one is immune to the impact of such structural class divisions. In addition, interpersonal and intrapsychic classism (i.e., internalized) becomes enacted by stereotypes, prejudice, and discrimination. Therefore, self-awareness and reflection about one's own biases are necessary to address classist behaviors and attitudes.

Second, regarding domains and qualities of social class, we believe that Liu and colleagues (2004) have provided the most rigorous description of the complexities of the concept and culture of social class. One of the most salient and significant parts of their definitions is the fluid and relational aspect of class, as different contexts shift individuals' perceptions, experiences, and feelings about their class identity. For instance, drastic economic changes at national or local levels can produce different configurations of relationships among classes, and these new relationships may alter class identities. In addition, we agree that social class groups are permeable, yet are also imbued with cultural norms and values. Particularly because class divisions in this country have remained largely stable and undisrupted (Rosenblum & Travis, 2009), different class cultures have evolved and people's tastes, priorities, goals, and worldviews widely diverge across class lines. Furthermore, like Liu and colleagues (2001, 2004) who emphasize the intrapsychic, interpersonal, and the aforementioned sociological aspects of class, we believe that these domains are interrelated and inseparable (L. Smith et al., 2009).

Finally, another significant aspect of social class is its intersections with other dimensions of social identities. As many scholars have argued, the intersections of race, ethnicity, class, gender, and other social identities have both separate and interconnected impacts on a person's development, everyday life, and relations to people and institutions (Amott & Matthaei, 1996; Constantine, 2001; Hooper, 2010). Furthermore, these identities are continuously in flux and can be transformed subtly or dramatically by changes in social systems. Therefore they are not static or clear-cut, but dynamic and relative constructs. Most relevant to this article is the widely documented reality of differential poverty rates according to race and ethnicity, gender, and age. These differences are even more striking when one considers the disparities in wealth between majority and minority groups, men and women, as well as between other marginalized populations and dominant groups (Lott & Bullock, 2007). Furthermore, disparities in terms of access to mental health care are also divided across intersecting social locations. For example, underprivileged populations who reside in rural settings face greater barriers for obtaining adequate and timely care (Hooper, 2010; Petterson, et al., 2009). Hence, researchers and practitioners must also remain aware of how various social variables interact to perpetuate a system of oppression and inequality.

Although we consider class identity relevant to all individuals, in this article we focus on low-income populations in accordance with the main objectives of this special issue. We also limit our discussion to the United States, as both authors conduct research and clinical practice in this country. In addition, while recognizing the importance of language, we use several interchangeable terms to refer to people who struggle economically and who have relatively low social standings, including the low-income, people who are poor, economically disadvantaged, and underprivileged.

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The Family Coping Skills Program: Working with low-income Latinas

Although our research and clinical work experiences have occurred in a variety of settings, in this article we focus on a shared clinical research experience that has significantly informed our approach to working with low-income clients: our joint development and evaluation of a depression prevention programs for low-income, Latina mothers entitled, *The Family Coping Skills Program* (FCSP). The FCSP was developed specifically for work with low-income populations, and as such, has cultural and class considerations woven into the fabric of its structure. For example, its focus is on prevention, rather than on treatment, due to its potential for providing early mental health services to individuals who might otherwise not seek out such services. Given that low-income individuals are less likely to seek out formal mental health services, our aim in the development of the FCSP was to contribute to efforts to reduce the mental healthcare disparities that disproportionately affect individuals from low-income and cultural minority backgrounds (Muñoz & Mendelson, 2005).

In brief, the FCSP is a six session group-based cognitive-behavioral intervention that has two primary aims. First, participants learn and practice a set of concrete coping skills that can be used to regulate negative emotions, and second, participants experience social support through exposure to other mothers who have had common life experiences. In addition to the group component, the FCSP integrates two separate family sessions into the program, whereby each participant and one adult family member (e.g., spouse, partner, other supportive adult) meet with the intervention leader twice over the course of the program. The primary goals of the family sessions are to introduce the program staff to family members, and to provide some psychoeducation around depression and stress, stress management, and problem-solving (for a comprehensive description of the program and presentation of research evaluation, please see Cardemil et al., 2005 and Cardemil et al., 2010).

Although the FCSP is primarily a cognitive-behavioral intervention, it is also influenced by narrative modalities and the Stone Center's Relational-Cultural model (Walker, 2004). Such influences inform our general guiding principles including an emphasis on meaning-making in human behavior and social relations, the fundamental assumption of the self as relational and fluid (Yeh & Hunter, 2005), as well as a more critical perspective that seeks to address problems of inequality by means of systemic action (Kim et al., 2007).

To date, we have evaluated the FCSP in a small, uncontrolled pilot trial and a small, randomized trial. Preliminary analyses have been very positive, both regarding outcome (i.e., reduction of depressive symptoms) and process (i.e., very high retention rates and participant satisfaction) (Cardemil et al., 2010). We believe that much of the success of the FCSP has resulted from our explicit attention to issues of social class, thus providing a good example of how to incorporate these issues into clinical work and research.

Working with low-income clients: Explicit and ongoing attention to social class

Our experiences working with low-income clients have shown us that it is critical to attend to social class issues in an explicit and ongoing manner. These experiences have highlighted important issues regarding social class and psychotherapy in three primary areas: (1) the assessment of social class, (2) the incorporation of social class issues into the therapy process, and (3) the management of differences in social class between therapists and clients. Effective clinical work with low-income clients necessitates consideration of issues in all three of these areas. In this next section, we discuss these three areas, providing

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concrete examples from our experiences with the FCSP in order to advance our understanding and effectiveness in working with economically disadvantaged populations.

I. Assessment of social class

Working effectively with individuals from low-income backgrounds first requires an accurate and comprehensive assessment of clients' class status and identity. Assessment of social class allows clinicians to begin to understand the lived experiences of their clients, which can help set the stage for the development of a strong therapy alliance. An initial intake is the most obvious place to begin asking these questions, as they can be easily folded into an initial assessment format. However, it is important that the assessment process continue throughout the course of treatment, as information shared in session may provide further information regarding the ways that clients' everyday lives are impacted by economic circumstances.

Include multiple and complex variables in the assessment of social class— Our sense is that the most common assessment of social class involves the collection of data on income, education, and occupation, and yet our experiences, as well as that of other scholars in this area, highlight how inadequately these variables capture the complexity of social class (L. Smith, 2009; Lott & Bullock, 2007). As such, when assessing social class for research and clinical practice, we encourage a more in-depth assessment than is currently the norm. For example, understanding clients' wealth, including assets and savings, can provide information about a family's ability to recover from unexpected or emergency situations (e.g., sudden job loss, medical emergency, etc). Other aspects of clients' class that are important to assess include neighborhood characteristics, access to health care, immigration status, and possible financial responsibilities for extended family. Kliman (1998) also recommends that clinicians assess the social class of partners and extended family, and not to assume homogeneity of social class backgrounds within families of clients.

In addition to considering a variety of current markers of social class, we encourage clinicians to ask for a historical account of their client's economic well-being, and to allow narrative space for clients to elaborate on their own perceptions of how this account has affected or shaped them. For example, understanding childhood experiences of social class can help clinicians to conceptualize a client's class identity development or social class worldview (Liu et al., 2004). This in turn can shed light on the largely ineffable, emotional process by which we come to identify ourselves as part of, or outside of, class-based communities and ideologies.

Examine how social class intersects with other sociocultural dimensions of identity—It is also important to recognize that a comprehensive assessment of social class cannot truly isolate it from the many other sociocultural dimensions with which it intersects. While it is undoubtedly true that poverty is associated with certain characteristic lived experiences, there is tremendous variability in how poverty is experienced. Gender and race/ethnicity are two of the most obvious factors that interact with social class, but there are important others, including age, sexual orientation, and ability status. Providing truly contextually competent care requires a deeper understanding of these factors at a macro level and in the lives of the particular clients (Hays, 2008).

In our work with the FCSP, we used a multidimensional approach that understands culture as a contextual phenomenon that includes gender, socioeconomic status, and the larger systemic barriers individuals encounter in their daily lives. This understanding requires sensitive assessment of socioeconomic issues, both through direct questioning and through interpretation of the narratives that participants told when they first met us. For example, in

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our initial intake sessions, we would learn that many of our participants had no personal form of transportation, were working multiple jobs, and had difficulty paying their bills. In addition, participants in the FCSP regularly expressed concerns with inadequate housing, unsafe neighborhoods, and insufficient medical care. However, our attention to class needed to also take into consideration the broader social context of the participants. As Latina mothers, many of our participants experienced their financial stress through lenses of gender inequity and prejudice and discrimination. For example, our participants would share stories of male partners who would make unilateral decisions about family finances that were often not in the best interests of the family and the children. We would hear stories of disenfranchisement and disempowerment, whereby participants had been poorly treated by different social agencies, including healthcare and welfare. Carefully attending to these issues played a critical role in the early development of a strong therapy alliance, which we believe played an important role in the high participant retention and engagement of the FCSP.

In sum, assessment of social class serves an important and ongoing role in helping clinicians work with social class issues. This assessment should go beyond the usual markers of social class in order to more fully understand clients' experience of class status, and it requires the integration of information from direct questioning and client-initiated narratives.

II. Integrating social class considerations into clinical practice

A comprehensive assessment of social class sets the foundation for attending to social class issues in clinical work, and our experiences working with low-income clients have highlighted for us the importance of continuing to comprehensively and explicitly attend to these issues throughout the course of treatment. There are many different ways in which this attention to social class issues can occur, including in the structure of the clinical practice, its delivery, and the explicit content of the clinical work (Cardemil et al., 2010). We now address each in turn.

Structural considerations—Structural considerations address the organization of the intervention or clinical work, many of which are assumed or unexamined. For example, common structural considerations include those regarding the modality (e.g., individual, group, an integrated approach) and dosage (e.g., number and frequency of sessions) of the intervention (Cardemil, 2010). Finding ways to address issues of social class in clinical work should include some consideration of adaptations to the structure of the therapy itself. Good examples of structural adaptations to the therapy process can be found in the literature on cultural adaptations of interventions (Castro et al., 2010; Miranda et al., 2005). Because the vast majority of cultural adaptations have focused on low-income, racial/ethnic minority populations, these adaptations have generally been made with the expectation that they would increase the acceptability and attractiveness of the intervention to low-income clients. Some of the most innovative adaptations have included the addition of educational sessions to standard psychotherapy, including ongoing case management to supplement therapy, or the use of paraprofessionals to deliver the intervention (Grote, Swartz, & Zuckoff, 2008; Miranda et al., 2003, Miranda, Azocar Organista, Dwyer, & Areane, 2003; Vega, Valle, Kolody, & Hough, 1987).

In our own work with the FCSP, we incorporated structural considerations regarding social class in several ways. First, we explicitly decided to deliver the intervention using a group-based format. It was our hope that participants would find commonalities in terms of their cultural background (since they were all Latina mothers), but also with regards to their life experiences, both positive and stressful. The shared life experiences that emerged through group discussions highlight the integrative nature of culture and class and included stresses

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and successes associated with immigration and integration into U.S. culture, changing familial gender roles, experiences with prejudice and discrimination, and the lack of financial resources. As a result, the group modality cultivated a capacity for and practice of empathic joining as instrumental agents for psychological change (Walker, 2004). In addition, group discussions can be conducive to reflections about the systemic impact of inequality, whereby individual experiences of suffering may be understood in the context of a more collective struggle. Indeed, many of our participants seemed to benefit from hearing each others' accounts of economic struggle and disadvantage, as they recognized and explicitly acknowledged that their shared experiences offered some evidence that systems-level pressures were contributing to their lived experiences.

A second structural consideration we made in order to be sensitive to the lives of our low-income participants was the use of a broad definition of family when arranging the family sessions. Although we modeled our family sessions on couples' therapy and so encouraged our participants to invite intimate partners, we also explicitly communicated to our participants that they were free to invite other important adult figures if they preferred. This flexibility was intended to communicate to the single mothers who participated in our program that their family structures were also valued and important; these participants typically invited mothers, siblings, neighbors, and friends to the family sessions.

Delivery considerations—In addition to integrating social class considerations into the structure of clinical work, it is also important to think about how the intervention is delivered when working with low-income clients. Specific examples of delivery considerations that have been highlighted in the cultural adaptation literature include increased self-disclosure on the part of the intervention leader, explicit discussion of the therapy process and its collaborative nature, and the provision of food during therapy sessions.

Considerations about intervention delivery do not have to be limited to therapist behavior and talk. In many ways, re-thinking how interventions themselves are delivered could go a long way towards being responsive to the lives of low-income participants. This re-thinking could include finding creative and flexible ways to reach out to the community to inform them about particular services. It could include partnering with non-traditional mental health providers, like schools, community centers, and churches that likely have well-established connections with the community. It could also include finding ways to provide services during non business-hours, as an acknowledgment of the fact that class plays a tremendous role in determining who can miss work for a therapy appointment and who cannot. A good example of this creativity can be seen in the work of those who have begun to document the utility of home-based psychotherapeutic services, often around maternal depression (Ammerman, Putnam, Bosse, Teeters, & Van Ginkel, 2010). Furthermore, it can be useful to consider connecting with traditional and community-based models of healing, including recruiting *promotoras* and informal community supports who are familiar with various idioms of distress and healing beliefs (Arcury & Quandt, 2007; Cook & Kilmer, 2010).

In our work with the FCSP, we considered carefully how we wanted to deliver the intervention so that it would be most acceptable to our low-income participants. In particular, we sought to balance the use of a friendly and relaxed atmosphere with one that respected our participants' autonomy and individuality. From the perspective of cultural sensitivity, this entailed balancing the Latino values of *personalismo* and *respeto*, but this approach also touched on important elements of class and gender. Many of our participants recounted stories of feeling ignored, disrespected, or devalued by healthcare providers or other representatives of social systems, and so it was important to us that we convey our very real feelings of respect for them, their families, and the many successful ways that they

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were managing the complicated stressors in their lives. One concrete way that we attempted to convey this respect was to explicitly de-emphasize the expert role of the leader and to remind our participants of their extensive expertise in a variety of areas of their own lives, including parenting (as mothers of) young children, learning how to navigate living in a new country, and helping care for other family members. We also showed respect for our participants' lives by being very flexible with scheduling assessments and group meetings, and by providing transportation and on-site childcare to those participants who needed it.

Explicit discussion of social class issues—Discussions about socioeconomic issues should also be woven into the fabric of therapy sessions. These issues might be raised directly by clients, but most commonly they emerge in the course of natural discussions about lived experiences. Therapists can also play an active role in directing therapy discourse to engage these issues. For example, many of the more structured, manualized interventions direct discussion through the use of role-play scenarios or stories that bring alive the thematic and didactic material. Framing these exercises around issues of social class allows therapists to help clients identify and modify maladaptive approaches to coping in ways that are contextually relevant.

In our work with the FCSP, we integrated discussions about social class into both the didactic and discussion-based material, which included stories, worksheets, and role-play exercises. The explicit aim of this material was to teach and practice several fundamental cognitive-behavioral coping skills. For example, one of the role-play situations that tends to lead to considerable discussion describes a mother who wants to throw a *quinceañera* (sweet 15^{th} birthday celebrated in many Latin American cultures) celebration for her daughter, but is unable to find the money to do so. Another example that invariably generates discussion involves the use of babysitters to provide childcare. Many of the participants in our program have told us that they have a strong desire to never leave their children in the care of a non-family member (often connected to the Latino value of *familismo*, but also related to a general feeling of vulnerability to predators), but that economic circumstances have required them to act against this desire. These exercises increase group cohesion among our participants, highlight the utility of particular coping skills with real-world, relevant life problems, and introduce some discussion of the systemic nature of social class.

The focus of these exercises is not just limited to working on improving coping strategies. Indeed, in our experiences, these sorts of exercises often lead to storytelling by clients about lived experiences that highlight some of these same social class issues. By allowing ample time for this storytelling to occur, therapists can help clients make sense of their experiences while incorporating new meanings that might include an understanding of systemic contributions to their life difficulties. A systemic view of social class can indirectly provide a path to construct different meanings about one's socialized self, including aspirations and losses that may be linked to an upward mobility bias (Liu et al., 2007).

It is important to note that the end goal is not always to alter clients' usual tellings of their own stories. While of course it is important to detect those moments when clients' particular cognitive understanding or coping styles are unhelpful or maladaptive, it is also important to attempt to see how some putatively maladaptive coping might be adaptive in some circumstances, or at least how they have been important channels for perseverance and survival. By acknowledging gaps in our knowledge, therapists can avoid imposing narratives and values that may be inconsistent with their clients' lived experiences and class identities.

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Managing differences

Clinicians who work with underprivileged populations may be struck by a sense of difference in the comforts they take for granted, the kinds of everyday worries they experience, and their ability to move psychologically and physically in the world with relative ease while others are met with innumerable hurdles (Krupnick & Melnikoff, 2011). Therefore, managing this sense of difference between therapists and clients is critical to conducting effective clinical work. Being unable to work explicitly with this difference will limit the benefits accrued by incorporating social class issues in the assessment and therapy processes. Although there are many ways to improve one's ability to work with social class difference, our experiences have highlighted three in particular: practice of self-reflection, open acknowledgement of differences, and incorporating relevant community psychology approaches to our clinical work.

Practice critical self-reflection

Being a witness to inequality is sometimes painful and always destabilizing. Class identity, as with many forms of social identities, goes largely unnoticed until it bumps up against an Other. In fact, the encounter frequently amplifies Otherness on both sides, as one experiences oneself as separate from the Other. Feelings of helplessness and hopelessness can emerge, and clinicians may wonder how successfully they will be able to connect empathically with clients, imagine and stand where they stand, and be trusted to help them with their struggles.

We encourage the practice of reflecting on one's own areas of discomfort as well as the gaps in experience and privilege between therapists and clients. This self reflection can lead to powerful insights into our own blind spots, unconscious classist biases, and unchallenged assumptions. In fact, inward reflection can yield observations that can advance new ways of negotiating impasses and learning what works and what doesn't. For example, we have found that self-reflection about clinician feelings of helplessness often leads to an awareness that this helplessness is indicative of a deep sense of care in one's work. Rather than regarding it as a barrier, self-reflection can use helplessness as a motivator to learn more about how we can better serve clients whose lives may not be as familiar to us.

The practice of self reflection can also increase one's own process of developing and cultivating a sense of class consciousness, as we ourselves have to be aware of our *classed* identities in order to navigate differences and address potential blind spots. By understanding our own complex histories and experiences related to social class, we will better be able to give voice and attention to the full totality of our clients' social class identities.

Open acknowledgement of difference

We have found it extremely useful to openly acknowledge those differences between therapists and clients that are both salient and relevant to the clinical work at hand, and may include differences in culture, gender, or social class. Salient differences may also emerge in areas of expertise or lived experiences that are not shared between therapists and clients. Attending to these differences may feel uncomfortable at first, as clinicians may worry that it can destroy the illusion of commonality that facilitates the therapeutic endeavor. However, while ignoring these differences may seem like the easiest path, we believe that choosing to be silent about difficult topics is never a good example to set in psychotherapy settings. This is particularly true when clients may be reluctant to raise these topics on their own. Furthermore, while an emphasis on similarities may facilitate rapport building, acknowledging one's limited knowledge can lead to increased authenticity in relationships

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with clients. Clients may also benefit from taking a teaching role if and when we acknowledge our ignorance about many qualities of their social realities.

In our work with the FCSP, we have acknowledged salient differences in our initial assessments through therapist self-disclosure. The therapists note their own cultural, gender, and educational backgrounds and explain their motivation for participating in the FCSP. During the course of the intervention, when salient moments of difference have arisen, we have generally attempted to manage them through our efforts to empower and give expert status to the participants. Thus, when asked about particular social services with which we are unfamiliar, we have used the group structure to ask group members for their perspectives. It is our sense that by conveying a willingness to discuss these topics, as well as an unwillingness to take on an expert role about topics with which we are unfamiliar, we have created a more genuinely authentic clinical environment in which participants can learn from the providers and each other, while also feeling respected for the expertise that they bring to the sessions.

Because there is no prescription for managing class differences in clinical work that can cover all situations, the most consistent way that we have navigated these distances in our work with the FCSP has been to strive to be centered vis a vis our personal and professional identities. Self-reflection can help therapists to develop a clear sense of self, as well as of personal and professional values that together can provide a valuable guide to navigating the tricky dynamics of social class. Moreover, our experiences have taught us the importance of speaking openly about difficult topics, being at peace with not having all the answers, and with learning from our participants.

Incorporate community psychology approaches

Another useful approach to managing differences between therapists and clients can be the incorporation of some aspects of community psychology. A community psychology orientation emphasizes a wide-reaching, collaborative approach to addressing oppressive and unequal institutions, and to advocate for more fair treatment and conditions for all individuals and families (Bullock & Lott, 2007; Constantine et al., 2007; L. Smith, 2009). It may mean stretching traditional roles to include participation in local task forces, non-profit organizations, and services that target underrepresented populations (Goodman et al., 2010). This non-traditional community involvement can open doors for psychologists to engage in important advocacy work and help foster improvements in social services for underprivileged populations. As people who hold power through knowledge and resources, we are well positioned to contribute to conversations and actions that promote social change.

Another way to enact a community psychology approach into our work of managing differences is to involve community members in both the development and dissemination of any intervention (e.g., Le, Zmuda, Perry, & Muñoz, 2010). Community members could include consumers of mental health services, active citizens, and local health practitioners that may already be connected to specific communities and may be more aware of their particular needs.

We incorporated a community psychology perspective in our work with the FCSP by conceptualizing ourselves as more than just therapists for an intervention. Because many of our participants did not have access to important sources of information, we quickly became a resource whereby we would find relevant information, answer any questions we could about its utility to them, and assist them in seeking out additional information or relevant services. This work has benefited us in some notable ways. Perhaps most significantly, it has aided us by deepening our understanding of clients' struggles as they encounter institutionalized forms of oppression that our privilege precludes us from experiencing on a

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daily basis. Another important consequence has been our own growth in learning about community resources, not only regarding mental health, but also educational, social, medical, and legal services. For example, our work with the FCSP has led us to become familiar with numerous local social service agencies, as well as the languages of these services (i.e. how food stamps work, where to access English as a Foreign Language classes, where one can find affordable day care, etc.) In essence, a community-based approach enables us to put into practice our belief that psychological treatment requires attention to social, cultural, family, in addition to individual aspects of behavior.

Concluding Thoughts

It is our hope that our reflections and recommendations will add to the growing body of literature encouraging clinicians and researchers to work more comprehensively with issues of social class and to find ways to overcome the barriers to working with low-income clients. We understand well the multiple challenges that may interfere with actively engaging with social class issues in clinical work. As noted earlier, although the logistical challenges to delving into this work are the most apparent ones, we believe that the most important ones are the psychological barriers that arise when working with low-income clients. Feelings of helplessness, fears of miscommunication, and uncertainty about how to work with low-income clients can be a powerful barrier to developing and maintaining a continued commitment to this work.

Some of these psychological barriers and fears may result from lack of personal experience working with individuals from different social classes, deficits in our clinical training, or even our own personal struggles with class issues. And yet, we also believe that we all have the capacity to work effectively with social class issues because regardless of class status, all of us have had to manage and learn from often painful contact points along the spectrum of class difference. Moreover, working with issues of social class can provide many rewarding moments that teach us about the limits of the social and health service systems; our own assumptions, blind spots, and biases; and the resilience of human beings when living through adverse conditions.

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