CLASS BIAS IN THE THERAPEUTIC RELATIONSHIP: A CALL TO BIOETHICISTS

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

---

by
Zachary Louie
December 2021

Thesis Approvals:

Nora Jones, PhD Thesis Advisor, Center for Urban Bioethics

ABSTRACT

Bioethicists have made great strides in identifying and addressing biases that can negatively impact healthcare outcomes. However, the scope of these efforts has rarely included mental healthcare, such as psychotherapy. Discussion of healthcare biases also does not address socio-economic class as adequately as it should. In what follows, I argue that class related biases may be detrimental to the effectiveness of mental health treatment. Unconscious class biases may harm the relationship between a psychologist and patient in ways that are not adequately understood or appreciated. I also examine ways in which class bias may be incorporated into current anti-bias education and training practices.

Dedicated to Thomas J. Campion

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

In recent years, the field of bioethics has become increasingly concerned with addressing biases that may lead to unequal or unfavorable healthcare outcomes. These biases are often unconscious and consequently challenging to detect and address. Despite challenges, progress towards equitable care for diverse populations has been made. These advancements are encouraging, but there are still critical blind spots that must be addressed. One of these blind spots is the impact that social class and class biases can have on the relationship between a psychologist and a client in therapy. The few researchers who have attempted to better understand the impact of class on the relationship between psychologist and client have almost universally noted the lack of attention the topic has received (Ballinger & Wright, 2007; Balmforth, 2009; Kim & Cardemil, 2012; Lott, 2002; Liu et al., 2004; Lui et al., 2007; Pope & Arthur, 2009; Smith et al., 2011; Thompson et al., 2012; Trott & Reeves, 2018). In what follows, I will attempt to show that the impact of class on the therapeutic relationship is a potentially significant force, which needs to be more adequately recognized and appreciated. I will further assert that if bioethicists are committed to equitable health outcomes, then mental health practices and class deserve far more attention than they have hitherto received in the field.

The biases that may impact healthcare outcomes (both physical and mental care) stem from various factors. Race, gender, age, weight, disability, mental illness, drug use, and many other factors may engender bias. Often, these biases are entirely unconscious. These biases are held and acted upon by well-meaning people with pure intentions. Virtually all of us have developed various biases for one reason or another. Those of us

that endeavor to be fair, accepting, and amiable must realize that we are not above or immune to these unconscious biases.

Class bias, or classism, is similar to those factors just mentioned. It can be explicit or subtle. It can be intentional, or it can be unconscious. Unfortunately, even the unconscious variety can be incredibly harmful. I suspect that many will think that they do not harbor any class bias. Many will insist that they are fair and open-minded. I must again assert that although there is an essential difference between intentional classism and subconscious bias, the results are not always different. Class bias, in any form, could be too significant to overlook.

In order to see just how subtle (yet impactful) this bias can be, I suggest the reader consider the following experimental results by Darley and Gross (1983). Darley and Gross divided college students into two groups. Each group was shown a different video of the same grade-school girl performing a verbal test. The girl's performance on the test is identical in each video. However, elements such as her clothes, visual background (a playground), and verbal information about her parents' occupations and education were changed in order for the girl to appear upper class in one video and lower class in the other. Keep in mind that the girl's performance on the test is consistent between the different videos. Despite this, those who watched the 'upper-class' version of the video rated the girl's performance on the test as exceeding her grade level. In contrast, those who watched the 'lower-class' video rated her performance as below her grade level. Not even a fourth-grade girl is immune to our unconscious judgments about class. The participants did not just perceive a difference in performance; the perceived difference was dramatic. The slight difference in appearance and familial background led to

dramatic differences in assessment. So again, I insist that we not assume ourselves to be above such judgments. Small and subtle queues can have an impact that is too large to be taken for granted.

CHAPTER 2: RETHINKING CLASS AND CLASSISM

Before delving into a discussion of classism's effect on the therapeutic relationship, it is essential to be clear about what is meant by terms such as social class and classism. As Liu et al. (2004) note, defining social class is often an inconsistent process with certain variable included or excluded, in a seemingly arbitrary manner. Many variables may be linked to a person's social class. A person's income, job title, and education level are common variables. Others such as neighborhood qualities, access to healthcare, and immigration status have also been included in research (Kim & Cardemil, 2012). I suspect many of us are used to thinking about class as something defined by some combination of these various features. I believe this is a mistake. I bring them up only to contrast them with the understanding of social class that I will employ in the remainder of this discussion. An in-depth explanation of the complexities of social class is beyond the scope of this discussion. However, a rough, high-level understanding should allow us to see how and why social class impacts the therapeutic relationship.

The understanding of social class I want to present does not just use various data points to stratify people into groups. Instead, it emphasizes how people's perceived group identification affects how they think and navigate their lives. As Kraus et al. (2012, p. 546) describe, an "individual's social class is a context rooted in both the material substance of social life (wealth, education, work) and the individual's construal of his or her class rank, and is a core aspect of how he or she thinks of the self and relates to the social world." Social class is more than just facts about a person's wealth; it is a lens through which people perceive themselves, others, and the world around them. It impacts how we think and act and cannot helpfully be expressed in just raw numbers. Our

perceived class may influence our desires, our motivations, and emotional experiences. Liu et al. (2004) assert that if counseling psychology understood social class only as objective variables such as income or education, psychologists would understand little about how class impacts the inner psychological world of a person.

Having modified (and enhanced) our understanding of social class, we may also need to revise our intuitive notion of classism. Our intuitive definition of classism revolves around prejudice against (or in favor) of people belonging to a particular social class. This intuitive definition is, I believe, an excellent definition of conscious and explicit classism. However, there is more to the story when unconscious bias is involved. It seems plausible to suggest that classism is not always mere prejudice. Classism can also be expressed through distancing. This distancing can be physical or mental. The idea is that classes tend to retreat away from one another and create worlds that are foreign and unknown to that class's outsiders. As Lott (2002, p. 102) describes, "Through cognitive distancing and institutional and interpersonal discrimination, the nonpoor succeed in separating from the poor and in excluding, discounting, discrediting, and disenabling them."

We need not carry out intentional prejudice against other classes in order to see harmful effects. We subconsciously divide and distance ourselves until members of other classes become incomprehensible strangers. We do not understand their lives, their beliefs, their cognitions, or emotions. We need not see them as lesser (or greater) in order to be harmful. We need only to see them as other. Others with which we share little resemblance and that we cannot possibly relate to or understand. This otherness is the understanding of classism that I will utilize in the remainder of this discussion. Fueled by

our perception of otherness, we subconsciously carry out the "excluding, discounting, discrediting, and disenabling" Lott describes. It is this otherness that might contaminate and undermine the relationship between a psychologist and their client.

I hope to have made clear that classism is not overt hatred and discrimination. It can also be subconscious judgments and assumptions about people we do not relate to and do not identify with. We can now examine and understand how class differences and classism may enter into the relationship between a psychologist and a client. I will adopt the term therapeutic relationship to describe the interpersonal dynamics involved between psychologist and client. I want to start by noting an inherent problem with this dynamic. A problem that must be adequately understood because it may doom therapeutic relationships before the individuals involved even meet.

CHAPTER 3: CLASSISM AND THE THERAPUTIC RELATIONSHIP

The problem is that disparity between a psychologist's social class and a client's social class is incredibly common. By virtue of their profession and education, psychologists tend to be middle class (Liu et al., 2007; Pope & Arthur, 2009). Keep in mind that their own class identification brings a range of beliefs, desires, and attitudes unique to their class. Unlike the largely middle-class population of psychologists, clients come from various backgrounds and may be from poorer, working-class backgrounds. In fact, conditions that may lead a person to seek therapy, such as depression, and anxiety, are more common among the lower class. Both the psychologist and the client bring with them the psychological imprint of their class. If these classes happen to be different, then a perception of difference and otherness can arise and begin to fester immediately. In short, the difference in class invites subconscious judgments and assumptions that can set the therapeutic relationship back, even before the individuals have said "hello."

Lott (2002, p. 108) finds that "The literature on beliefs amply illustrates cognitive distancing and the fact that poor people tend to be seen as other and lesser in values, character, motivation, and potential. Such beliefs complement the deliberate or indirect exclusion of low-income people from full participation in social institutions." If a psychologist were to (even subconsciously) view a client as "lesser in values, character, motivation, and potential," there is a potential that the therapeutic relationship becomes too damaged to yield a positive result. Despite their subconscious and unintentional nature, these judgments could be massively detrimental to a relationship between people.

Smith et al. (2011) conducted a study with 200 graduate students in either clinical or counseling psychology programs. The study's goal was to see if a client's social class

impacted the early diagnostic impressions of the participants. The study was mainly concerned with investigating the possible correlation between a ‘belief in a just world’ (BJW) and the formation of negative attitudes to the poor and working class. BJW is a personal belief about justice where a person generally believes that people get what they deserve and deserve what they get. The participants were presented with one of four written case vignettes and then asked to respond to questions using a 7-point bipolar semantic differential. All four vignette variants depicted a fictional subject named Michael, who struggled to find employment within the television industry after the end of a television station internship. Michael is described as having trouble sleeping and increasingly concerned that his former coworkers are spreading unfavorable evaluations of him throughout the industry. The vignettes vary only in their description of Michael's class background. The four Michael variants are: a low-income custodian receiving welfare benefits, a blue-collar union worker for a power company, a middle-class suburbanite working for a nationally known tax firm, or an affluent manager of his wealthy family's financial and philanthropic endeavors.

Believers in BJW tend to think that another person’s success or suffering is deserved. This meritocratic view is prevalent throughout western society and depicts a fair world of little to no injustice. However, BJW may lead to criticizing and blaming victims even when there is no reason to believe that the victim was responsible for his or her misfortune (Rubin & Peplau, 1975). Smith et al. found that " participants that viewed the world as a place where people deserve what they get tended to anticipate that sessions with lower socioeconomic clients would be less comfortable and less meaningful. They tended to see lower socioeconomic clients as more highly symptomatic and lower

functioning. Additionally, Smith et al. state that when BJW was specifically considered as a factor, the lower income vignette condition resulted in significantly more unfavorable clinical estimations.

Just as with the Darley and Gross study, the Smith et al. study shows that perception of a person's social class can dramatically alter impressions, even when the facts we ought to care about remain constant. Still, it may be objected that in these studies, facts about class are too apparent, more evident than they would be in a realistic meeting between two individuals who have never met. In the Smith et al. vignettes, details of the subject's class background were explicitly stated. The Darley and Gross study may have included more subtle hints, like clothes and the playground's look in the background. Nevertheless, stated information about the child's parents makes the child's class background quite clear. Here again, I must insist that we not underestimate our ability to take queues from subtle details. Thompson et al. (2012) indicate that clothing, jewelry, hairstyle, body language, and attractiveness may all elicit class perception. We cannot discount visual cues. Smith et al. show the impact on impressions and opinions class can have, but we cannot assume that such explicit details are needed for those impressions.

Hasty judgments and generalizations about different classes are not the only danger to the therapeutic relationship. The distancing and unfamiliarity involved in classism create a divide that even well-meaning people cannot easily bridge. "Unconscious distancing from the poor overrides the better intentions that clearly exist among psychologists, with the result that the poor are "disappeared" from many psychologists' professional and personal worlds" (Javier & Herron, 2002). Psychologists

may be left in a position where they genuinely believe in a client's potential and want to help them. However, unfamiliarity with different classes' lives and psychological worlds may leave them unsure of how to assist them.

Balmforth (2009) conducted interviews with six clients who identified themselves as working class and viewed their therapist as middle class. Balmforth's goal was to examine if the clients felt that the social class difference affected the therapeutic relationship. Interviewees noted a perceived imbalance of power between themselves and their counseling psychologist. Balmforth notes that this imbalance was felt most powerfully when the psychologist seemed to have a "lack of understanding of different life experiences, different access to opportunities, and how a lack of financial resources restricts, or at least affects, life choices." The pure intentions of the psychologist are not always enough to overcome the divide of otherness in a relationship.

Balmforth also highlights how the client's perception of otherness can shape their experience. Balmforth calls out an extensive list of poignant quotes from the interviews on varying aspects of the therapeutic relationship. Speaking directly about how the class difference made them feel, one interviewee stated, "I feel that because of the difference in our social class that I often feel quite inadequate" (Balmforth, 2009: p. 14) Balmforth posits that the feelings of inequality a person may experience in their life may be tacitly reproduced in the therapeutic relationship.

Thompson et al. (2012) conducted semi-structured interviews with 16 low-income counseling clients. All participants had attended at least six psychotherapy sessions within six months before the interview. Thompson and colleagues made several important observations about these interviews. Firstly, all 16 of the interviewees

acknowledged that they had a sense of being lower class compared to the therapist and that the salience of social class impacted their experiences in the sessions. Interviewees expressed that they felt feelings of "judgment and disconnection." Some interviewees "described feeling stigmatized by their therapist." The social class difference resulted in clients feeling "unheard" and unable to establish a positive therapeutic relationship.

Trott and Reeves (2018) created a questionnaire-based study, in part, to better understand how perceived differences in social class between a client and therapist might impact the therapeutic relationship. As well as understand how these differences are experienced. Questionnaires included both quantitative questions and questions prompting open-ended responses. The questionnaire methodology would lessen the depth and detail of responses (compared to the interview style used by Thompson et al.). However, it would allow for a greater number of responders to provide information. Forty-five questionnaires from a combination of middle- and working-class responders were analyzed.

Trott and Reeves observe that "a quarter of respondents reported social class as having a negative impact on their relationship. Several respondents, perceiving themselves to be in a lower social class to their therapist, reported holding back: they put up defenses and felt disconnected." Included in their findings is a quote from a respondent stating, "Looking back, I wasn't always open with her. [I] was not able to be wholly myself." A responded says concerning social class difference, "I'd like to think it didn't matter – but if I'm honest, it probably did! I didn't stay with him for long because I had a sense that our worlds were quite different"(Trott & Reeves, 2018, p. 15). The different social class perceptions do not just hinder the therapeutic relationship; they

could end it altogether. Trott and Reeves conclude that consciously or unconsciously social class and classism are powerful forces in the therapeutic relationship that might disable the relationship regardless of social class similarity or disparity.

So far in this discussion, I have looked at the implications of classism when it follows a top-down direction. This fits with our familiar/intuitive understanding of classism: dominance, superiority, and oppression. However, this is not the interpretation of classism that I insisted upon earlier. In this discussion, I am interested in classism as the perception of otherness that leads to distancing, hasty judgments, and discrediting (among other things). Notice that on this interpretation of classism, there is nothing that necessitates a top-down flow. I would now like to turn to some implications of bottom-up classism, which may also serve as detrimental to a therapeutic relationship.

In the Trott and Reeve study just discussed, one questionnaire respondent, is quoted stating, "…it makes me feel uncomfortable to think of my social class because it immediately makes me put people above or below me and I don't like that, yet still do it!" (2018, p. 11). Notice that this response specifies "above or below." Like this respondent, I suspect many of us classify and make judgments about otherness, regardless of whether the other is perceived as above or below. We have already seen testimony of lower-class clients withholding information or being hesitant to be honest. Trott and Reeve quote another response, saying, "I was cautious talking about my family of origin for fear of being judged. I had a very privileged upbringing. I was not as open as I might have been." The perception of social class differences seems to sew doubt and uncertainty even in this bottom-up direction. Otherness is experienced by both the psychologist and

the client. Each individual feels the distance, unfamiliarity, and mistrust of the type of classism I have emphasized.

It may be objected that the studies I have discussed provide a minimal sample size. I am inclined to agree. This minimal amount of research is, I think, insufficient for any sweeping conclusions to be boldly asserted. However, bold conclusions are not my aim. Recall that this discussion's first goal is to convince the reader that classism and its effects on the therapeutic relationship are an underappreciated and insufficiently attended to field of inquiry. The studies I have just discussed are only a beginning. I believe these studies show that there is a problem worthy of further investigation and understanding. Classism, even when unconscious, is too potentially harmful to be ignored. Beneficial and equitable therapeutic outcomes demand that we take up the challenge of exploring class-related dynamics.

Classism may be especially difficult to expose within ourselves because it is not an omnipresent part of our cognitive processes. Our class identity is not something that is frequently in the focus of our conscious mind. Kim and Cardemil (2012, p. 9) observe that class identity "goes largely unnoticed until it bumps up against an Other. The encounter frequently amplifies Otherness on both sides, as one experiences oneself as separate from the Other." I would like to think that anyone who has read this far into the discussion has, at some point, paused to try and think what classist beliefs or assumptions might be swirling unconsciously in their mind. If Kim and Cardemil are correct, this may be a challenging task to succeed at. Beliefs about our class identity and any classist biases that might follow are not just waiting to be uncovered by a few moments of introspection.

They lie dormant and cleverly hidden until otherness arrives to agitate and wake them from their slumber.

I hope to have said enough to convince the reader of this discussion that classism is a potentially severe detriment to therapeutic outcomes and mental health care. I believe the studies just discussed make it quite clear that classism is worthy of more investigation and better understanding. Of course, a psychologist or bioethicist interested in facilitating better mental health outcomes is not just concerned with what the potential hindrances are. We are also interested in what we might do to overcome the obstacles we find in our way. I would now like to discuss how class difference and classism might be helpfully addressed within the therapeutic relationship.

CHAPTER 4: ADDRESSING CLASSISM: ROLE OF THE BIOETHICIST

None of the suggestions in what follows should be seen as any sort of emphatic or fervent endorsement. Like classism's effects, the steps towards a solution also need further research and attention. What follows will be a discussion of what I find to be a plausible and promising first few steps towards combating classism in the therapeutic relationship. I have not claimed to fully understand the impact of classism on the therapeutic relationship. What I have claimed is that the few existing studies show that it warrants a fuller understanding. Similarly, I do not claim to know how to overcome classism in the therapeutic relationship. What I claim is that the current research may provide some helpful insight, although this insight may still require further development and elucidation.

In the last paragraph, I used the phrasing "overcome classism," but that begs the question of what it means to overcome a bias. The more I think about what it means to overcome a bias, the less sure I am of what that amounts to. There are, I think, two different ideas we have in mind when we think of overcoming a bias. The first is the ultimate goal. The ultimate goal in overcoming a bias is to remove the bias from society. To ensure that a particular cognitive bias virtually unencumbers our institutions of government, education, and healthcare. The ultimate goal is a long-range target that likely includes many incremental steps. These incremental steps are the personal goals. Personal goals related to overcoming a bias are about individuals learning how to prevent biases from impacting their endeavors. In order to achieve our ultimate goal, we need to know what the personal goal entails. After all, it will be the personal overcoming of bias that will be needed when a psychologist and a client are in session.

The personal path to overcoming classism I want to discuss may seem somewhat counterintuitive. However, I believe the research and testimony I will share below indicates that this counterintuitive approach is worth seriously exploring. When we think of overcoming biases, it is tempting to think about how we might hide it, suppress it, or ignore it. However, none of these tactics do anything to help us unlearn our biases. The process I want to discuss is the process of purposefully including discussion about class within the therapeutic relationship. Class is not something that the psychologist and client should attempt to ignore. Class is something that can be talked about freely and openly.

Kim and Cardemil (2012) present their three primary areas of social class discussion in therapy: (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. Kim and Cardemil go on to assert that effective clinical work with low-income clients necessitates consideration all three of these areas. I want to highlight the importance of each of these three areas, beginning with (1) the assessment of social class.

I have stressed that a potentially serious problem with class disparities in the therapeutic relationship is that the psychologist may not be able to relate to and understand the thoughts and feelings of clients from another class. If class is never discussed within the relationship, neither party will have anything but their own assumptions and judgments to work from. The assessment of social class is a process through which the psychologist can ask questions about a client's experiences, perspectives, and how social class has influenced their identity. Kim and Cardemil claim, "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" (2012, p. 5) Liu et al. (2004) also seem to have a belief along these lines, believing that understanding classism might enable counseling psychologists to better comprehend people's motivations for actions. Put slightly differently, the assessment of social class can begin to reduce the otherness involved in a relationship with class disparity.

The second area Kim and Cardemil list is the incorporation of social class issues into therapy. When a psychologist understands the class identity and experiences of a client, they can use this knowledge within the therapeutic process. This might involve identifying detrimental or maladaptive thinking or behavior that stems from a client's class experience. It could also involve simple acknowledgment and understanding of the stresses that lower-income clients may face. Stresses such as financial problems, having to personally care for elderly family members, or jobs with erratic scheduling practices. Thompson et al. (2012) state that clients found the ability to discuss concerns related to finances, employment, and housing as relevant to connecting with their therapist. Thompson et al. go on to report that clients felt that a therapists' explicit acknowledgment of social class and the incorporation class-related discussion in treatment contributed to positive experiences for clients. It seems that incorporating class into the therapeutic process may be beneficial to the relationship and lead to better outcomes.

The third area listed by Kim and Cardemil is the management of differences in social class between therapists and clients. This management is carried out through continuous series of openness and critical self-reflection. When people are open about class, we are presented with an opportunity to challenge our assumptions. When we

reflect on conversations about class, we begin to better understand the identities of others and ourselves. Trott and Reeves, in their study discussed above, report that respondents found that having a therapist from a different social class allowed some respondents to challenge their prejudices and assumptions. This opportunity was, respondents indicate, key to helping them grow. The management of class differences is a self-reflective process through which we de-mystify other classes and undo the otherness that may have endangered the therapeutic relationship's trust. This self-reflective process is in line with other research as well. Pope and Arthur (2009, p. 56), addressing the challenge class poses to the practice of therapy, assert, "We advocate for reflective practice that includes increased self-awareness for working across cultures, including working with clients from diverse socioeconomic backgrounds. This is essential for psychologists to consider how they view client issues, including causal factors, and to consider a fuller range of interventions."

When we incorporate class and manage class differences, we begin to relate and remove otherness. When we remove otherness, we may begin to unlearn the negative biases that are often held about the lower class. In a phone-based survey, Wilson (1996) found that respondents who had personal contact with a lower class individual were less likely than others to blame that individual for their circumstances. Simply being in contact with members of other classes can help dissolve the subconscious biases that might be at work in the therapy room. In short, when people discuss class openly and honestly and reflect on how that experience may challenge assumptions, better understanding and connectedness may emerge.

It is crucial that discussion of class impact not only the psychologist, but also the client. A psychologist may use class discussion to better understand the client, but the therapeutic relationship is still threatened if the client remains apprehensive. Happily, it appears that openness about class may have a positive impact on the client's side as well. Interviewees in the study conducted by Thompson et al. expressed positive reactions to the psychologist's effective management of social class. Thompson et al. report that clients positive experiences were attributed to their therapist's behaviors that communicated understanding and care, despite differences in social class. A relationship with trust was able to develop. Clients linked this relationship with their therapist to positive outcomes the ensued from the treatment. Further highlighting this positive impression, Thompson et al. report, that participants cited the importance of feeling respected by their therapists. Therapists who acknowledged life circumstances and demonstrated social class awareness helped give clients a sense of equality within the therapy room.

It seems that discussion and management of social class can have a positive and helpful impact on both a psychologist and their clients. At a minimum, the scarce research done on the topic shows signs of promise worth exploring. However, I do not want to overlook the that open discussions about class are likely not easy to have. Even if they might be ultimately beneficial, breaching the topic is likely uncomfortable. Balmforth (2009) notes that working class clients felt that responsibility for breaching the topic of social class belonged with the therapist. The working-class clients described how it felt like a large risk to bring up such a sensitive topic themselves. However the clients expressed a willingness to discuss class-related topics if they presented the opportunity to

do so by the therapist. This begs the question of what the best way is to approach the topic of class in therapy. It seems that, at least in certain situations, discussions involving class can be seen as beneficial. But how exactly should a psychologist know if, when, and how to bring up the topic? This is an important question. A question that I have no answer to. However, let me again stress my goal of convincing the reader that additional research and understanding for class' impact on therapy is warranted. The fact that I cannot address predictable and vital questions about the topic is just additional proof of my claim.

The second clause in the title of this discussion is "A Call to Bioethicists." I include this because I believe that there is a responsibility for the field of bioethics to incorporate class and classism awareness into the ongoing push for diversity training and education in healthcare. Earlier I outlined both the ultimate and personal goals of overcoming classism. The therapeutic relationship relies on the psychologist and client adopting the personal goal of looking past biases, reflecting, and understanding each other. However, awareness and prompting of the personal goal require attention at an institutional level. If the various authors I have cited are correct in asserting that the topic of class in therapy has not received adequate attention in the field of psychology, then the bioethics community must intervene. Just as bioethicists have pushed for greater awareness of biases like racial, gender, and age biases in healthcare, class bias must be addressed.

I want to stress that in appealing to bioethicists, I do not mean to address a narrow audience of those with a particular job title or degree. I mean to address anyone who cares about the effectiveness and quality of health outcomes (including mental health)

and can impress the importance of class on an institution or community. Smith et al. (2011) have a similar goal in mind. In discussion about combating negative early counseling impressions based on class, they suggest that class awareness and education ought to begin during counseling and psychology graduate curricula. Especially given that many programs have already made multicultural preparation a foundational part of education and training. Although the lower class may not be thought of as a cultural group, their life circumstances seem sufficiently different and unique compared to middle-class counselors to warrant their consideration within a curriculum.

If class is to be included within academic training, along with other diversity education (such as race and gender), then perhaps bioethicists can use these existing practices as a guide. Compared to class biases, more research has been put into diversity topics such as race and gender. Luckily, it does not seem too far-fetched to suggest that successful methods of addressing these more traditional diversity topics might also apply to class. Byrne et al. (2015, p. 13) propose continual inclusion of diversity education in training throughout a curriculum. They say, "The educational intervention we advocate is a program of habit formation. It would involve multiple small interventions taking place at regular, frequent intervals at every stage of the curriculum." This statement by Byrne et al. is made about the general concept of implicit bias in healthcare, rather than specifically about class or mental health care. However, I see no obvious reason as to why it could not include those areas as well.

Also, writing broadly about unconscious bias in healthcare, Marcelin et al. (2019) say that the mitigating unconscious bias ought to be viewed as long-term goal that requires constant attention and repeated implementation of strategies that may reduce

biases. These strategies could be implemented at both institutional and individual levels. I believe the Marcelin et al. idea of constant attention and repetition of bias awareness, is similar to what Byrne et al. describe as intervention at regular and frequent intervals. Both parties seem to indicate that unconscious bias mitigation is something that requires a significant amount of conscious attention over time.

My call the bioethicist is a call to include class and classism in the ongoing push for diversity and inclusivity training. As healthcare institutions and academia become more attentive to unconscious biases, we must ensure that all sources of biases are accounted for. The role of the bioethicist has always been multifaceted. It could be to educate students or professionals. It could be to advise healthcare systems. It could be to serve as an interface between a community and an institution. As I stated earlier, a bioethicist is not a person with a specific degree or title. A bioethicist is a person who aims to improve the well being of a population by protecting and improving their health, and other interests. I believe it is time we start welcoming the field of psychology under the umbrella of bioethics.

CHAPTER 5: CONCLUSION

This discussion has covered several issues. First, I asked that we rethink our intuitive notions of class and classism. Following previous work in the field of psychology, I suggested that class be looked at as more than just statistics about income or education. I believe that the interpretation of class relevant to psychological practice views class as a lived experience; class can construct beliefs, motivations, and behaviors. Next, I asked that we rethink classism. I suggested that classism is not just prejudice in favor of a particular group. Classism is better understood as cognitive (and often physical) distancing away from other classes that leads to otherness. Armed with these new interpretations, I moved to my first objective. I hope to have made a compelling case that the little attention class bias has received in the field of psychology shows that it is deserving of further research and greater appreciation. I attempted to show that otherness could be a danger to the trust and judgments involved in the psychological relationship. I tentatively suggested that there is reason to believe that the intentional inclusion of class related discussion into the therapeutic process may be beneficial to the relationship. Here too I stressed the need for better understanding and attention. Finally, I declared that class and mental health care be included in the bioethicist's ongoing efforts to promote diversity and mitigate unconscious bias. The general public continues to destigmatize, be open-minded, and rethink mental health care. It is time for the field of psychology to return the favor.

SOURCES

Ballinger, L. & Wright, J. (2007). Does class count? Social class and counselling. *Counselling and Psychotherapy Research*, 7(3)

Balmforth, J. (2009). The weight of class': clients' experiences of how perceived differences in social class between counsellor and client affect the therapeutic relationship. *British Journal of Guidance & Counselling*, 37, 375-386

Black, M. M. & Krishnakumar, A. (1998). Children in low-income, urban settings: Interventions to promote mental health and well-being. *American Psychologist*, 53, 635–646

Byrne, A & Tanesini, A. (2015). Instilling new habits: addressing implicit bias in healthcare professionals. *Advances in Health Sciences Education* 20 (5), 1255-1262

Chen, E. Matthews, K. A. Boyce, W. T. (2002). Socioeconomic differences in children's health: How and why do these relationships change with age? *Psychological Bulletin*, 128, 295–329

Falconnier, L. (2009). Socioeconomic status in the treatment of depression. *American Journal of Orthopsychiatry*, 79, 148–158.

FitzGerald, C. & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics* 18, 19

Kearney, A. (2003). Class and Counselling. *C. Lago and B. Smith (Eds.), Anti-Discriminatory Counselling Practice*. (pp. 109-119) London: Sage

Kim, S. & Cardemil, E. (2012). Effective Psychotherapy With Low-income Clients: The Importance of Attending to Social Class. *Journal of Contemporary Psychotherapy*, 42(1), 27-35.

Kraus, M. W. Piff, P. K., Mendoza-Denton, R., Rheinschmidt, M. L., & Keltner, D. (2012). Social class, solipsism, and contextualism: How the rich are different from the poor. *Psychological Review*, 119(3)

Lorant, V., Deliege, D., Eaton, W., Robert, A., Philippot, P., & Ansseau, M. (2003). S Socioeconomic inequalities in depression: A meta-analysis. *American Journal of Epidemiology*, 157, 98–112.

Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist* 57,100–110

Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., Dunston, K., & Pickett, T. J. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology*, 51(1), 3-18.

Liu, W. M. Pickett, T. & Ivey, A. E. (2007). White middle-class privilege: Social class bias and implications for training and practice. *Journal of Multicultural Counseling and Development*, 35(4), 194-206

Marcelin, J. Dawd, S. Victor, R. Kotadia, S. Yvonne, M. (2019). The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It, *The Journal of Infectious Diseases*, Volume 220, Issue Supplement_2, Pages S62–S73

Pope, J. F. & Arthur, N. (2009). Socioeconomic status and class: A challenge for the practice of psychology in Canada. *Canadian Psychology/Psychologie Canadienne*, 50, 55–65

Sloan, T. S. (2003). Poverty and psychology: A call to arms. *S. C. Carr & T. S. Sloan (Eds.), Poverty and psychology*, 301–314.

Smith, L., Mao, S., Perkins, S., & Ampuero, M. (2011). The relationship of clients' social class to early therapeutic impressions. *Counselling Psychology Quarterly*, 24(1), 15-27.

Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, 60, 687–696.

Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: A grounded theory exploration of low-income clients. *Journal of Counseling Psychology*, 59(2)

Trott, A. & Reeves, A. (2018). Social class and the therapeutic relationship: The perspective of therapists as clients. A qualitative study using a questionnaire survey. *Counselling and Psychotherapy Research*, 18(2), 166-177.

Ware, N. C. Tugenberg, T. & Dickey, B. (2004). Practitioner relationships and quality of care for low-income persons with serious mental illness. *Psychiatric Services*, 55, 555–559