Spring 2008

Social Class Bias and the Clinical Relationship

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Regis University
College for Professional Studies Graduate Programs
Final Project/Thesis

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SOCIAL CLASS BIAS AND THE CLINICAL RELATIONSHIP

by

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A Research Project Presented in Partial Fulfillment
of the Requirements for the degree
Master of Arts
Specialization in Psychology

REGIS UNIVERSITY

November, 2007

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Has been approved

December, 2007

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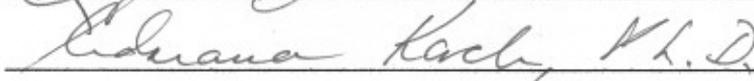
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ABSTRACT

Social Class Bias and The Clinical Relationship

This research project focuses on exposing clinician's and/ or graduate students to

the occurrence of social class bias and its effect on the clinical relationship. This project

was designed as a workshop that can be incorporated into a classroom presentation or

continuing education workshop. This project consists of three primary components: (1) a

mock diagnosis, that exposes the participants to the possibility that their clinical

judgment can be biased by social class, (2) presentation of relevant literature exposing the

incidence of social class bias within the clinical relationship, and (3) an post-presentation

survey designed to improve the relevance and efficacy of the presentation for future

participants. Through the post-presentation survey it was indicated that this field of study

is needed in the clinical community and was relevant to the participants. It also showed

that it was lacking in the participants graduate programs, which needs to be addressed.

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Chapter 1

INTRODUCTION

Social class bias in treatment is a fundamental issue that arises in the clinician client relationship. This bias has been shown to impact treatment, diagnosis, and prognosis. The rising rates of poverty as well as the rising rates of diagnosed mental illness due to improved screening and early diagnosis begs the question what can be done to improve the clinicians ability to see and deal with this bias in the therapeutic setting. This bias developed through class consciousness has been shown to not only impact the clinician's judgment but also the client's expectations of treatment, follow-up and follow through with treatment, resistance, and expectations from the clinician.

William Cockerman states that, "Class consciousness (an awareness of common interests with others in the same socio-economic circumstances) is viewed by Marx as the key element in how a person interprets reality and organizes his or her behavior" (Cockerman, 2003, p. 162). The purpose of this project is to alert clinicians and clinicians in training to the adverse effects class bias has on the therapeutic relationship.

Poverty in the United States

As of 2006 according to the United States Census Bureau, "37.0 million people lived in poverty" (United States Census Bureau, 2006). The National Institute of Mental Health (NIMH) estimates that currently, "26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. When this is applied to the 2005 U.S. Census residential population estimate for ages 18

and older, this figure translates to 57.7 million people" (National Institute of Mental Health, 2006). The 2006 population estimate from the Census Bureau rested at 301,948,168 individuals with 37.0 million of those at or below the poverty level.

The poverty level for the United States is defined by amount of US dollars earned per year gross by the Department of Health and Human Services. The poverty line based on a model for a family of four is currently set at $20,650.00 for FY 2007. Within the past decade the poverty line has risen by $12,910.00; from $7,740 to $20,650.00 annual gross income respectively (Department of Health and Human Services). This line delineates the lowest level of the social class structure for the United States, with its inherent biases and stereotypes.

Social Implications of Social Class

Social class is an aspect of being for every individual regardless of country of origin, ethnicity, or culture. It is an undeniable reality of life. Social class carries with it implicit and overt rules of behavior, boundaries, and ramifications for members of that particular class group. Its presence is far too important to simply overlook, ignore or at worst bias the clinicians view of the client or vice versa within the therapeutic setting. Yet, this aspect of the clients being is often overlooked by both the clinician and client in the therapeutic setting. Individuals seeking therapy are dealing with a broad spectrum of issues both intrapersonal and interpersonal, one of these being the social status aspect of their lives. Individuals struggle constantly to find meaning and their place as it pertains to their current social status, the status of their family of origin, and the interaction of both.

According to Joellyn Ross, "Social class is one of the least discussed-most significant- issues in American life. Although rarely mentioned, perceptions of one's social class status strongly affect how people feel about themselves, about others, and about their families"(Ross, 1995, p. 338). This issue often dictates how people interact and perceive others and their actions. Social class also impacts treatment because psychologists, psychiatrists, and therapist much like medical personal are only obligated to provide emergency psychiatric care such as suicidal or homicidal ideations for individuals without regard to payment. Outside of this emergency care boundary they are allowed to set forth a payment scale and accept or deny clients based on their ability to meet this requirement.

As stated in the American Psychological Association's (APA) ethics code under section 6.04 Fees and Financial Arrangements,

> (a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.
> (b) Psychologists' fee practices are consistent with law.
> (c) Psychologists do not misrepresent their fees.
> (d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)
> (e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)
> (American Psychological Association, 2002).

Sub-section D offers important insight into the client-therapist relationship with its implied notion of reduced treatment and termination based on fees. This issue is

address albeit in a perfunctory fashion in the text *The Essentials of Family Therapy*

referring to the middle to upper class status of therapists,

> They have little appreciation of the obstacles their poor clients face and of the
> psychological impact of those conditions. When poor clients don't show up for
> appointments or don't comply with directives, some therapists are quick to see
> them as apathetic or irresponsible. In many cases, this is also the way poor people
> come to see themselves- and that negative self-image can be the biggest obstacle
> of all (Nichols & Schwartz, 2005, p. 220).

In the article *The Benefits of Marriage Reconsidered*, researchers looked at the

topic of upward and downward mobility and it's interrelation with marriage as an

economic variable. The researchers posed the question, "does marriage promote stability

and economic well-being" (Wells & Zinn, 2004, p. 65).

The researchers looked at 30 white married couples in a rural community. The

families were broken-down into middle-class, working-class and poor. The respondents

were surveyed about their "residential mobility, marital history, household composition

changes, employment stability and length of present marriage…" (Wells & Zinn, 2004, p.

68). Based on their responses the families were placed into three categories high,

moderate, and low stability households.

Based on these criterion Wells and Zinn found that all the middle class families

were in the high stability group, the working class families had six in the high stability

group, six moderate and five low stability. The poor families had none that rated high

stability, four were moderate and five were low. Wells and Zinn stated that,

> Finding a relationship between family stability and social class is consistent with
> the literature. The economic distress literature finds a strong relationship between
> economic instability and family instability. Economic distress is clearly associated
> with lower levels of marital and family satisfaction… Marital conflict frequently

increases as partners become hopeless, depressed or hostile in the face of financial hardships (Wells & Zinn, 2004, p. 74).

This finding is corroborated in the article *Social Class Tensions within Families*. This article looked at the tensions caused by the upward and downward social class mobility of individuals and families. Joellyn Ross states, "The upward or downward social class mobility of an individual family member can result in tensions between the individual and the rest of the family, tension which is heightened because it rarely is identified and named as a class issue" (Ross, 1995, p. 338).

Purpose of Project

The main purpose of this project is to educate clinicians and clinicians in training to social class, the effects of social on individuals, and the occurrence of social class bias as an inherent part of society as well as a component of the therapeutic relationship. Ross identified that the lower class have a pervasive sense of economic anxiety, powerlessness, and despair concerning life and its future prospects. This exemplifies the idea of class struggle and the need to educate clinicians regarding this situation. This is supported by the concept of conflict theory. According to James Coleman and Harold Kerbo, "Conflict theorists see a diverse collection of individuals struggling for wealth, power, and prestige… people are constantly struggling with one another and themselves to find meaning" (Kerbo & Coleman, 2002, p. 14).

Viktor Frankl supports this assertion of finding meaning when he stated,

A man who could not see the end of his 'provisional existence' was not able to aim at an ultimate goal. He ceased living for the future… Therefore the whole structure of his inner life changed; signs of decay set in… The unemployed worker is in a similar position. His existence has become provisional and in a certain sense he cannot live for the future or aim at a goal (Frankl, 1959, p. 70).

This sentiment is echoed by Ross in her article, "…one working class individual stated, People of a higher class have a power to judge… because they seem internally more developed human beings…" Ross (1995, p. 339).

Ross' article was based on case studies and deals more with the clinical issues surrounding social class. According to Ross our view of social class is that it is permeable as long as the individual works hard enough they will go up. This is based on the Calvinist work ethic and the capitalist survival-of-the-fittest economic system (Ross, 1995). This set of social norms leads to the idea that if someone is not working hard enough to gain in social class, they are deserving of their low social status and all of the ramifications therein.

This leads into the question posed in the beginning. Would a clients SES bias psychologists, psychologists, and physicians to diagnose an individual with a more severe mental illness or a more dire prognosis and how would this impact treatment? Would it be prevalent? How can this bias be contained or diminished in the clinical setting? This question was asked and studied in 1972 by Donald Routh and Keith Young in 1972. In the study Routh and King refer back to a study completed by S.D. Lee in 1968 in which he asked subjects who were psychiatric physician residents to a recording of clinical session, then asked the subjects to diagnose the clients. They were previously made aware of the SES clients.

According to Routh and King, "These physicians, Lee found tended to ascribe more severe psychopathology to the man when they thought his background was a lower-class one…" (S.D.Lee as cited in Routh & King, 1972, p. 202). In their replicated study Routh and King found the class effect between clinicians and students showed

"that class had a significant effect on ratings for both students and clinicians" (Routh & King, 1972, p. 204). The study found that clinicians were more likely to diagnose the client as being in need of professional help than the students based off perceived social class.

The current study agreed with Lee's (1968) finding that social class has an effect on clinical judgment which was also indicated by Himmelfarb and Senn's study (as cited in Routh & King, 1972) which indicated that class variables tend to sway subjects in their clinical judgment. These findings in addition to societies growing wealth gap and increase in diagnosed mental health issues ranging from ADHD to schizophrenia dictate that the issue of social class bias in the therapeutic setting is addressed and that a viable solution be developed and implemented. Biases cannot be eradicated in their entirety but they can be brought out from behind the shadows and exposed. Through this exposure the clinician can develop the needed insight to work through his or her biases and help their clients work through theirs in a mutually healthy and ethical manner befitting this relationship.

Definition of Terms

The following are uncommon English terms that are often used by clinicians:

- APA: American Psychological Association, professional organization for clinicians and clinicians in training.

- NIMH: National Institute of Mental Health, government organization charged with the study and tracking of mental health and mental health related issues.

- SES: Socioeconomic-Status, social group based on economic resources (i.e. low, middle, high class).

- Social Class Mobility: The ability for an individual or groups to move from lower to upper class and the reverse.

- DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision. Diagnostic tool used by clinicians to diagnose metal health disorders.

- GAF: Global Assessment of Functioning. A scale (1-100) that is used in diagnosis to determine the client's current level of functioning within their life.

- Multiaxial Diagnosis: Five axes based on criterion from the DSM-IV-TR that clinicians use to diagnose individuals with mental health disorders.

Chapter Summary

This chapter focuses on thee introduction to the notion of social class bias as a component of society. Biases constantly arise within the clinical relationship. With proper training, supervision, and therapy the clinician is able to work through these. The key element to working through biases is to be cognizant of their presence. The implications of social class as well as its ingrained nature in American and global cultures needs to be addressed.

This chapter introduces the reader to class issues that exist historically and currently. With the inclusion of current indicators of poverty, how social class is ranked, and how individuals internalize their social class, which affects their mental health.

Chapter 2

LITERATURE REVIEW

The literature review for this applied research project makes use of six areas of academic study to enhance the ability to identify and understand the implications of social class bias within the clinical relationship. This project employs research on the global view of social stratification, definition of class, effects of social mobility, social class bias affecting clinical judgment, and ethical practices within the clinical relationship.

Global View of Social Stratification

Social stratification is an inherent part of human social structure both in the historical and current context. Social stratification appears in many forms within our society, such as in class hierarchy, organizational hierarchy, hierarchy within the armed forces, religious hierarchy, academic hierarchy, and bureaucratic hierarchy. Within each of these strata of our society there are innumerable layers that are imbedded. Each level within the strata has determined and dictated normed behaviors of their members. Gerhard Lenski clarifies this idea in his statement; "…each class can be subdivided into more homogenous subcategories or subclasses…" (Lenski, 1966, p. 76).

As stated previously, societies by nature dictate the behaviors of their members with social norms and values. These individuals in-turn create micro-societies or subgroups where they perpetuate stratification. These societies both macro and micro include within them the rules that dictate the acceptance or non-acceptance of social class

permeability. Societies may adhere to strict social class systems with minimum

permeability such as castes, through a highly permeable class structure where members

can move up and down. Regardless of the level of social class permeability that is

accepted in the society, it is based on the ever-present phenomenon of social stratification

(Levine, 1998).

These examples of class structure by nature are inclusive of social biases between

the social classes and all that those biases entail, based on disparity of wealth, power, and

education. Gerhard Lenski details this phenomenon in his book *Power and Privilege*

when he states, "the members of every power class share certain common interests with

one another, and these shared interests constitute a potential bias for hostility toward

other classes" (Lenski, 1966, p. 76). Although potential hostility can exists it is not a

prerequisite for social class biases to emerge.

The caste system within Indian culture is an example of a strict socially normed

class stratification system. While the system appears harmonious strong biases exist as a

social norm. The caste system dictates a very concrete set of behaviors of each member;

this has come to be seen as advantages for keeping an ordered society. According to

Terence Callaham and Roxanna Pavich:

> There are five different levels of the system: Brahman, Kshatriya,
> Vaishya, Shudra, and Harijans. Within each of these categories are the actual
> "castes" or *jatis* within which people are born, marry, and die. They all have their
> own place among each other and accept that it is the way to keep society from
> disintegrating to chaos" (Callaham & Pavich, 1998).

Stratification as exampled with the Indian caste system is a necessity for a

cooperative and functional society, stratification is seen as a necessity to divide labor and

duties in addition to motivating the group's members to comply with their given roles

(Levine, 1998). Levine expounds on social stratification:

> If the rights and prerequisites of different positions in a society must be unequal, then the society must be stratified… Social inequality is thus an unconsciously evolved device by which societies insure that the most important positions are conscientiously filled by the most qualified person (Levine, 1998, p.88)

While stratification an inherent and useful facet of social structure, the presence of biases, stereotypes, and hostility towards the other group members becomes a confounding variable within daily social interactions that need to be accounted for within the therapeutic relationship.

Definition of Class

Another important facet of social stratification is social class as an expression of socioeconomic status (SES) alone. SES is a reality of life and expression of identity for every human being regardless of country of origin, ethnicity, or culture. It is an undeniable reality with its implicit and overt rules of behavior as well as its social ramifications for breaching these conventions. Class structure has generally been ascribed to individuals based upon their occupation such as a priest, warrior, white or blue collar, and property or as seen in caste and monarchy based societies heredity.

The SES of the individual, family or group has progressively defined social class. Social class in the United States is intrinsically intertwined with power (or lack there-of), social norms (as represented by the Calvinist work ethic and capitalist ideals), as well as family interactions (Ross, 1995). Karl Marx indicated that class is the relationship

between the individual's property and wealth as being an indicator of their class.

According to Marx:

> What makes wage-labourers, capitalists and landlords constitute the three great social classes? …the identity of revenues and sources of revenue. There are three great social groups whose members…live on wages, profit and ground-rent respectively, on the realisation of their labour-power, their capital, and their landed property (as cited in Levine, 1998, pp.41-42)

Marx's definition succinctly answers and delineates what has become the common notion of class systems in American society; that the individual's current wealth dictates their social class, thus indicating that class is permeable and transient in nature. The definitive titles of class systems in America are referred to as; high or upper class, middle class, and low or lower class (Hollingshead & Redlich, 1958). These definitions exclusively refer to the member's socioeconomic status (SES), ignoring education level or family of origin. Each of the three class groups has within it other subgroups into which it can be divided (Lenski, 1966). For the sake of clarity this study will focus on the three main groups of class and references to them will be inclusive of the subgroups located within.

Max Weber looks at social class similarly to Marx with the addition of power and social honor as components to the stratification. Weber states,

> The structure of every legal order directly influences the distribution of power, economic or otherwise, within its respective community… social honor, or prestige may even be the basis of economic power, and very frequently has been. Power, as well as honor, may be guaranteed by the legal order (Levine, 1998, p. 43).

This structure of social class as it has been and is defined excludes many other social factors of the individual when labeling their class group, for example; the individuals level of education, acts of compassion, sense of social justice or personal

integrity. It is merely a quantifiable expression of wealth that denotes social superiority with inferred moral superiority.

Effects of Social Mobility

"Social class is one of the least discussed –and most significant –issues in American life" (Ross, 1995, p.338). Social class in American society while being extremely overt with material representation is generally not discussed in open forum outside of academia. This 'blind-eye' allows American society to perpetuate a view that social class systems are highly permeable. This view of a highly permeable society endorses that the ultimate goal of every individual is to rise above one's social class whether current or original.

This mobility is viewed through a collective social lens as being an admirable achievement for the individual. Seldom if at all is the individual's upward mobility viewed as a stress inducing life event. The same view though is not held for the converse action of downward mobility in one's life. Yet, the permeability of SES can and does cause cognitive dissonance within the individual, family of origin and social strata both current and original.

Ross observes that the view of permeable social class is that as long as the individual works hard enough they will raise their social class; this is seen as being based on the Calvinist work ethic and the capitalist survival-of-the-fittest economic system that is pervasive in the United States (Ross, 1995). This set of social norms leads to the perception that if someone is not working hard enough to gain in social class, they

are deserving of their low social status. For example, they are often seen as either lazy or intellectually incompetent and all of the ramifications therein.

Ross states, "The upward or downward social class mobility of an individual family member can result in tensions between the individual and the rest of the family, tension which is heightened because it rarely is identified and named as a class issue" (Ross, 1995, p. 338).

The implications of neglecting to mention or even acknowledge tensions within the system as being class based are tremendous. As previously referenced social class is an identity which is a source of being socially connected to a group, whether that group is identified as low, middle or upper class. The individuals identify their being with the norms of their strata; they understand their social responsibilities and find comfort in their familiar surroundings. Ross identified that the lower class had a pervasive sense of economic anxiety, powerlessness and despair concerning life and its future prospects, which were relatively absent in the middle and upper classes (Ross, 1998). Viktor Frankl supports this when he states:

> A man who could not see the end of his 'provisional existence' was not able to aim at an ultimate goal. He ceased living for the future… Therefore the whole structure of his inner life changed; signs of decay set in… The unemployed worker is in a similar position. His existence has become provisional and in a certain sense he cannot live for the future or aim at a goal (Frankl, 1959, p. 70).

Social class permeability causes many forms of distress and tensions within the individual, family and social system. Ross has identified three categories of social class tensions that occur within families:

1. When one family member achieves significantly more-or less-than others, and then does not fit in with the family group because of attempts to

2. Marrying someone who is "up" or "down" in social class from the family-of-origin, which can cause conflict regarding which spouse's social class standards and customs will prevail, melding the two families, etc.
3. Divorce and remarriage, causing class differences between children and one parent. (Ross, 1995, p. 340)

Based on these tensions Ross feels as though the most likely family member to be seen in the therapist office would be the more upwardly social mobile individual. Ross found that the deliberately upwardly mobile individual is most likely to reject their family-of-origin. Conversely those who find their upward social mobility unplanned will generally try to stay connected to their families becoming unaware of the changes in their behaviors and attitudes, leading to denial regarding these intrapersonal changes. In addition to these behaviors Ross found that families of a downwardly mobile individual or family had a tendency to reject and disengage from them socially. Ross further states,

> …the belief, well known within social psychology, that one's status can be enhanced by associating with those of the social status in which one would like to be included. Likewise, status aspirations can be jeopardized if one socializes with those of lower status. Both sides, the upwardly mobile member and the family, are aware that the decrease in time is related to and is a way of defining status differences (Ross, 1995, p. 344).

These overt and hidden messages tend to cause dissonance within the family system. Family members may feel that the member who has achieved financial success should share, whereas the upwardly mobile family member's response is likely to come from the Calvinist lens.

Social Class Affecting Mental Health and Marital Stability

The topic of the interrelatedness of social class and psychological dysfunction has been studied as early as 1937 in a study by H.W Dunham. In his study Dunham explored and found a correlation between mental illness and social class. Schizophrenia was the mental illness at the focus of this study. This correlation between socio-economic status (SES) and mental illness begs the question whether social class correlates negatively to marital interaction.

According to Joellyn Ross, "Although rarely mentioned, perceptions of one's social class status strongly affect how people feel about themselves, about others, and about their families"(Ross, 1995, p. 338).

Individuals seeking therapy are dealing with a broad spectrum of issues both intrapersonal and interpersonal, one of these being the social status aspect of their lives. Individuals struggle constantly to find meaning and their place as it pertains to their current social status, the status of their family of origin and the interaction of both. Conflict theorists support the idea of class struggle as causation for dissonance within the individual and system. A lower SES 18 year old female schizophrenic patient in a mental health facility wrote in her diary:

> What would we be without work, what would become of us? I think they would soon have to enlarge the cemeteries for those who went to death of their own accord. Work is the opiate for suffering and grief. When all the joints in the world threaten to fall apart, when the light of happiness is extinguished and our pleasure in life lies wilting, only one thing saves us from madness: work….(Burton, Lopez-Ibor, & Mendel, p.131, 1974).

This shows that even the patient, who is considered by her diagnosis to be detached from reality understands that being useful in society, is an integral part of being

mentally healthy and that the environment in which one exists contributes to ones health and identity.

According to James Coleman and Harold Kerbo, "Conflict theorists see a diverse collection of individuals struggling for wealth, power, and prestige… people are constantly struggling with one another and themselves to find meaning" (Kerbo & Coleman, 2002, p. 14). The topic of upward and downward mobility and its affect on marriage intertwines itself with social class. As a social institution marriage defines the partners as a single unit for purposes of social class. Additional factors such as divorce or death cause shifts in the social strata causing mobility either up or down.

Wells and Zinn posed the question, "does marriage promote stability and economic well-being" (Wells & Zinn, 2004, p. 65). The researchers looked at 30 Caucasian married couples in a rural community. All participants had children who were either in the second or third grade. The families were broken-down into middle-class, working-class, and poor. Middle class was defined as employed full-time as an administrator, professional, or manager. Social class was further delineated by earnings, middle class earning $45,000 or above, working class $25,000-$40,000 and poor $20,000 and under.

The respondents were surveyed about their "residential mobility, marital history, household composition changes, employment stability and length of present marriage…" (Wells & Zinn, 2004, p. 68). Based on their responses the families were placed into three categories high, moderate and low stability households. Wells and Zinn defined high stability households as those that had long-term relationships, stable economic resources, low residential mobility, and stable household composition. Low stability had fluid

household composition, insecure economic resources, unstable relationship histories as well as insecure housing.

Based on these criterion Wells and Zinn found that all the middle class families (n=4) were in the high stability group, the working class families (n=17) had six in the high stability group, six moderate and five low stability. The poor families (n=9) none rated high stability, four were moderate and five were low. Based on their research Wells and Zinn stated that:

> Finding a relationship between family stability and social class is consistent with the literature. The economic distress literature finds a strong relationship between economic instability and family instability. Economic distress is clearly associated with lower levels of marital and family satisfaction… Marital conflict frequently increases as partners become hopeless, depressed or hostile in the face of financial hardships (Wells & Zinn, 2004, p. 74).

The data suggests that social class does indeed affect an individual's mental health, marital stability, and identity both social and internal. The understanding of this effect is paramount in the clinical setting for the proper diagnosis, prognosis, and treatment of the individual or family system.

Social Class Bias Affecting Clinical Judgment

Social class bias affecting clinical judgment is an important phenomenon to address. Social stratification or class strata exist within the context of American society. This stratification impacts mental health, family, and marital stability and a person's identity. The thought of clinician social class bias affecting clinical judgment is the next logical progression of thought. Does the social class of the clinician or the client play a

role in the therapeutic relationship? If so how much of a role, is it negative or positive? Furthermore, if social class causes bias and taints clinical judgment, the assumption would be that there would be an increase in the prevalence of more severe mental health diagnosis for those in the lower socio-economic status (SES) of our society.

This question is important to ask due to the permeability of the social structure in the United States. Would psychologists and psychiatrists be more inclined to diagnose an individual with a more or less severe mental illness based on a perception of their client's social class as opposed to theirs? Is this a prevalent phenomenon?

Clinicians currently utilize the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR)* to diagnose mental health issues as well as describe the severity of the diagnosis, to plan treatments and predict the client's prognosis. This is done through a multiaxial assessment, which consists of five axes. According to the DSM-IV-TR, "A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome" (DSM-IV-TR, 2000, p. 27). The five axes are:

- Axis I Clinical Diagnosis

- Axis II Personality Disorders, Mental Retardation

- Axis III General Medical Conditions

- Axis IV Psychosocial and Environmental Problems

- Axis V Global Assessment of Functioning

    (DSM-IV-TR, 2000, p. 27)

The two main axes that relate to the aspect of SES and clinical bias are axes IV and V. According to the DSM-IV-TR, "Axis IV is for reporting psychosocial and

environmental problems that may affect the diagnosis, treatment, and prognosis of mental

disorders (Axes I and II)" (DSM-IV-TR, 2000, p. 31). Issues included under axis IV

include problems related to the individuals primary support group, their social

environment, educational concerns, job, housing, economic, legal, and access to adequate

health care (DSM-IV-TR, 2000).

Axis IV of the DSM-IV-TR is concerned primarily with "reporting the

clinician's judgment of the individuals overall level of functioning. This information is

useful in planning treatment, and measuring its impact, and in predicting outcome"

(DSM-IV-TR, 2000, p. 32). Axis IV utilizes the *Global Assessment of Functioning Scale*

(GAF), which is a scale of 0 (lowest level of functioning) to 100 (highest), which is

"divided into 10 ranges of functioning. Making a GAF rating involves picking a single

value that best reflects the individual's overall level of functioning… It should be noted

that in situations where the individual's symptoms severity and level of functioning are

discordant, the final GAF rating always reflects the worse of the two" (DSM-IV-TR,

2000, pp. 32-33).

The level of subjectivity affording by axis IV lends itself to the

introduction of social class bias. When two clients present with the same Axis I diagnosis

on a multiaxial assessment with the exception of GAF scores will have different

prognoses and severity of diagnoses. While this sounds like an arbitrary scoring system is

not designed to be. Yet, by allowing human subjectivity clouded by social class bias to

intervene it can be misconstrued to be.

The disparity between GAF scores can be explained by this example; a client with

moderate depression and a GAF score of 80 has a 'better' prognosis than a client with

moderate depression and a GAF score of 60. This is based on the numerical level and the associated definition of each score. The score of 80 for example reads, "If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork)," whereas the score of 60 is defined as, "Moderate symptoms OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers)" (DSM-IV-TR, 2000, p. 34).

While the GAF scores appear to be inclusive they are troubled by subjectivity as they are written through middle to upper class lens and the associated norms of those strata. This subjective lens values many friends, strong social networks with high stability in housing and employment (which are normative in middle to upper-class strata as referenced in the study by Wells & Zinn).

These features can often be absent as a normative feature in lower class SES systems where instability both in employment, housing and geographical locations make it difficult to invest the time necessary to create strong social networks and to develop a middle to upper class normed sense of social and work place propriety. William Cockerman discusses in *Sociology of Mental Disorders*, that "Class consciousness (an awareness of common interests with others in the same socio-economic circumstances) is viewed by Marx as the key element in how a person interprets reality and organizes his or her behavior" (Cockerman, 2003, p. 162). This reality he further explains is conducive to deviant behavior as defined by society, which further puts the individual at a disadvantage.

According to Routh and King citing a study by S.D. Lee 1968, the phenomenon exists within the clinical setting. Lee's study focused on psychiatrists and their diagnosis of 'clients' who were perceived to be from a lower SES. It was noted that, "These physicians, Lee found tended to ascribe more severe psychopathology to the man when they thought his background was a lower-class one" (as cited in Routh & King, 1972, p.202).

To investigate this phenomenon further Routh and King interviewed 47 subjects, 15 were clinical psychologists (all at a PhD level) and 32 (16 male and 16 female) were students enrolled in an introductory psychology class (whose participation in the experiment was a course requirement). Each of the 47 subjects was given a booklet containing 24 descriptive paragraphs about clients. Each of these paragraphs contained information on the client's age, occupation, description of current behavior and a mood statement.

The occupations chosen for each client was based on, "a listing of occupations by social class prepared by Hollingshead (1957)" (Routh & King, 1972, p. 203). The clients occupations were broken down into 12 lower-class jobs and 12 middle class jobs. The normal behaviors listed were drawn from the MMPI, the abnormal behaviors were drawn from a casebook and three abnormal psychology textbooks.

Each of the 24 booklets contained instructions for the subjects regarding the study. These instructed the subjects to read each paragraph and rate, "how likely it is that the person is in need of professional help for an emotional problem" (Routh & King, 1972, p. 203). Each page contained a rating *Likert* scale of 1-7. Each rating was attached to a descriptor; "1- extremely unlikely, 2-very unlikely, 3-somewhat unlikely, 4-neither

likely nor unlikely, 5-somewhat likely, 6-very likely, 7-extremly likely" (Routh & King, 1972, p. 203).

When the data was analyzed Routh and King (1972) found that the professional psychologists had a higher tendency to rate the client (all SES) as being in need of professional help with a mean rating of 5.24, where the students mean rating was 4.59. The class effect between clinicians and students showed "that class had a significant effect on ratings for both students…" (Routh & King, 1972, p. 204).

The study found that clinicians were more likely to diagnose the 'client' as being in need of professional help than the students were. Routh and King (1972), found that when the clinicians were presented with a 'normal' individual they were given a median rating of 2.5 when they were low SES and 3.34 when they were middle SES, 'neurotic' behavior was scored 5.02 for low SES and 5.67 for middle SES, with a mean rating of 5.92 for low SES and 6.33 for middle SES.

The current study agreed with Lee's (1968) finding that social class has an effect on clinical judgment, although the current study found the converse effect of Lee's study (as cited in Routh & King, 1972). The authors of this study however attribute this effect due to the 'clients' SES being conveyed to the subject only through the occupation. Whereas Lee's study (as cited in Routh & King, 1972) conveyed SES through multiple different statements given to his subjects, such as; "occupation…educational level, area of residence, source of income, amount of income, type of home, and religious preference" (Routh & King, 1972, p. 206). This was also indicated by Himmelfarb and Senn's study (as cited in Routh & King, 1972), which found that these variables tend to

sway subjects in their clinical judgment toward more severe diagnosis for the lower SES 'client'.

The interrelatedness of SES metal health and clinical bias towards members of our society's lower SES indicates a need to further emphasis social class bias in counseling and psychiatric programs to ensure the highest degree of ethical standards for treatment.

Ethical Practices

Ethical Practices are set up for the guidance of the clinical relationship. The practices deal primarily with the legal aspects of the clinician client relationship such as confidentiality and duty to warn. The clinician is relied upon to seek supervision and therapy to deal with biases and issues that arise within them during counseling with the client.

The literature has shown that SES is an important factor of society and mental health. With this the presence of SES in the therapeutic relationship is far too important to simply overlook or at worst ignore in the therapeutic setting. Yet this aspect of the being is often overlooked in the therapeutic setting. When working with clients from a lower SES the clinician must ensure that he or she takes into account the clients SES. As the clinician most likely will be approaching therapy from the middle/ upper class view; the client may react negatively or try to appease the clinician based on the notion of authority and superiority.

This issue is repeated in the Ross article, one working class individual stated, "People of a higher class have a power to judge… because they seem internally more

developed human beings…" Ross (1995, p. 339). Clinicians are bound by a code of

ethics, while each major mental health organization has their own code they are often

very similar. Ethical codes are set as guidelines versus concrete laws to be followed.

According to Corey, Corey, and Callaham (2003), "Ethics codes do not provide specific

answers to ethical dilemmas you will encounter, but they do offer general guidance"

(Corey et al., 2003, p. 6)

   The American Counseling Association code of ethics covers eight main topics for

counselor guidance. As stated before these are guidelines not laws, they require

interpretation by the counselor. The counselor must utilize their moral and ethical

compass to interpret and follow the guidelines. The eight sections are listed below:

- Section A: The Counseling Relationship
- Section B: Confidentiality, Privileged Communication, and Privacy
- Section C: Professional Responsibility
- Section D: Relationships With Other Professionals
- Section E: Evaluation, Assessment, and Interpretation
- Section F: Supervision, Training, and Teaching
- Section G: Research and Publication
- Section H: Resolving Ethical Issues

             (American Counseling Association, 2005, p. 3)

   Each section contained within the ACA code of ethics includes subsections further

dealing with the counselor's responsibilities. The sections that are primary concern and

deal with the subject at hand are;

- A.1.a. Primary Responsibility
- A.2.c. Developmental and Cultural Sensitivity

- A.4.a. Avoiding Harm

- A.4.b. Personal Values

(American Counseling Association, 2005, p. 4)

All sections within the code are all equally important for the counselor to know, internalize and incorporate into their practice. The ethics code as it pertains to biases and this study is dealt with primarily in section A. Each subsection of A relates with protecting the dignity and welfare of the client, preventing harm or as the medical community states "*Do no harm*", and protecting the client by not imparting the counselor's biases or belief systems upon them (American Counseling Association, 2005).

Counselors have a great responsibility to society as they are the keepers of mans darkest memories, fantasies, thoughts and desires. It is their realm alone to bring these issues to light in the healthiest most coherent manner, all the while being cognizant of their inner-most biases and problematic issues. Yet by bringing their biases to light through supervision, peer review, continuing education and workshops; counselors can assure the highest quality of ethical care for their clients.

Ross closes her article with this summary,

Upward or downward mobility of individual family members can be the basis for many tensions within the individual and the family… By making social class issues manifest, we can help our patients and their families cope with the changes in their lives as well as the mixed blessing that comes from leaving one's origins (Ross, 1995, p. 350).

This quote succinctly states what the counseling profession is charged with, helping the client cope with the issues that abound in their personal life.

Chapter Summary

The effect of class systems within the United States and its interaction on the clinician client relationship is the primary concern for this study. Clinicians strive hard to expose their biases and provide the best possible care to their clients. This is accomplished first in ethics courses in graduate counseling psychology programs, the ACA code of ethics and state regulatory agencies.

Social class in an inherent facet of all societies that produces biases ether conscious or subconscious to which we are not immune. Clinicians are most likely members of the middle to upper classes of society view the world through a different lens as discussed in the previous text.

With this effect and interaction so clearly acting within the individual, their family system it is only logical to presume that this also occurs within the system of the clinician client relationship. These inherent differences of world-view can cause dissonance within the clinician client therapeutic relationship. Only through exposure and education can clinicians be inoculated against social class bias and prevent the perpetuation within the counseling field.

Chapter 3

METHODS

The purpose of this project is to develop curriculum for an educational presentation aimed at clinicians in training and clinicians in practice to expose internal biases, social class bias in particular. Social class bias will be addressed via a mock diagnosis based on two case histories, which through professional consultation have been designed to only allow enough information for a rule-out diagnosis, GAF (Global Assessment of Functioning) score, and social class assumption. The mock diagnosis phase will be followed by the disclosure of the true GAF, diagnosis and social class by the facilitator. This will be followed up with the presentation of relevant literature regarding the effects biases on clinical relationships and society and ending with an exit survey to determine the efficacy of the presentation.

Procedures

The procedures for this project are designed to expose the clinician/ clinician in training to their own internalized social class biases, review current literature and expand their personal understanding and knowledge on the subject. This presentation currently is design for small groups of fewer than 25 participants and for a minimum of two hours in its duration. The main components of the presentation are: identifying social class bias within the clinician, presenting literature on the effects of social class bias on the therapeutic relationship in addition to impairment of clinical judgment with discussion,

and finally administering an exit survey to find any deficiencies in the presentation and to rate the helpfulness of it. Each feature is explained in greater detail under their own title further in the text.

The mock diagnostic session will consist of reading a case study that includes enough relevant information on the client for a diagnosis, GAF score and social class perception, this information is based off of diagnostic criterion from the DSM-IV-TR. The participants will be instructed to read the case histories and present a preliminary multiaxial diagnosis with severity and prognosis with the inclusion of a social class perception. They will be given 10-15 minutes to complete this task.

At the completion of the mock diagnosis session the participants will be asked to give their rationale for each diagnosis and their assumptions on social class. This session will be followed by a break-out group event where members will be asked to come up with a list of adjectives to describe the three major classes including positive and negative attributes of each, as well as stereotypes. The participants will then be given the accurate diagnosis and social class for each client they had read about. Upon receiving the accurate diagnosis each participant will be asked if their diagnosis differed from the real diagnosis, was the clients prognosis and severity influenced by their perception of the client's social class. Do they believe that these perceptions have any effect on their clinical judgment? This is designed to elicit a new understanding within the clinician regarding their biases.

The lecture portion of the project will entail reviewing literature from chapter two that builds a foundation for social stratification, biases, and hostility between the classes and the clinician's role in this. Each clinician will be given a packet consisting of chapter

two for future reference. Following the literature review participants will be able to ask questions to clarify and expound on the ideas presented or those elicited by the material. The culmination of the presentation will be the exit survey to identify deficiencies in the execution of the presentation as well as what they have learned.

<div align="center">Identifying Social Class Bias within the Clinician</div>

Through training, exposure and inherent self-awareness clinicians understand that biases exist within the human psyche. Awareness of one's own biases is an ethical mandate that is monitored solely through supervision. It is highly recommended not mandated. The clinicians own cognitive abilities, and possibly with the addition of the clinicians own personal psychotherapy is also highly recommended, but also not mandated). In other words, it is dependant upon the clinicians' own ability to witness, address, and prevents these biases from entering the therapeutic relationship.

Class bias is an inherent facet of social structure, yet it is rarely addressed. Social class bias is a veiled part of American society. That even with the highly developed sense of self-awareness that most clinician's possess, they are not socialized to be aware of this underlying bias. When the clinician is unaware that they incorporate class bias into their worldview, it will categorically color the lens through which they view the client and the therapeutic relationship. Unveiling this bias and exposing the clinician or the clinician in training to this hidden component of American society and their internal beliefs is primary.

The exposure of social class bias within the clinician/ clinician in training would be accomplished through a diagnostic evaluation of a case study. This evaluation would

be based off of a one given by Donald Routh and Kenneth King. In their study Routh

and King utilized a diagnostic evaluation consisting of "an initial, an age, an occupation,

a behavioral description, and finally an ascribed mood adjective" (Routh & King, 1972,

p. 203). In this study, clinicians were given a brief mental health history of the client as

well as a minor descriptor of their social class. King and Routh found that they did not

provide enough social class descriptors to accurately describe the client's history. They

also used descriptors for the mental health history derived from abnormal psychology

textbooks.

This researcher plans to address these deficiencies by utilizing the DSM-IV-TR

for the mental health history descriptors, including the GAF scale with more detailed

descriptors of the 'client's' social class. The mental health history will consist of two

'client's' male and female. The female will be middle to upper class with a GAF of 31

with a diagnosis of depression; the male will be lower class with a GAF of 71 and a

diagnosis of panic attacks. The case studies are listed in Appendix A.

These descriptors contain enough information for a trained clinician to at least be

able to formulate a diagnosis for 'rule-out' purposes. Clinicians use this when they are

not sure a diagnosis is entirely accurate and it is usually a preliminary diagnosis). These

descriptors go beyond Routh and King's version with symptomology taken from the

DSM-IV-TR. This writer uses social cues such as neighborhood of residence, occupation,

marital status, and childhood experience to indicate social class. Another tool used is the

GAF indicator; while it is subtle it should be able to be observed and noted by the

clinician. The clinicians will be asked to complete as much of a multiaxial diagnosis, as

possible from the information provided by the case studies. They will then be asked to

provide how severe they perceive the client's diagnosis to be, and to provide the clients perceived social class as either high, middle or low with a rationale as to why they assigned this particular class.

<center>Presenting Literature and Discussion</center>

Once the clinicians finish their evaluations the true nature of the study will be revealed. That in fact it is to determine how social class bias may have affected their clinical judgment. Each clinician will be asked to look at their diagnosis and evaluate whether social class clouded their judgment. As this is designed to be a self –awareness exercise, each clinician will keep their diagnostic evaluation for use in the discussion portion of the presentation. The presentation of literature will serve as a reinforcing function after the diagnostic evaluations are completed. The literature to be explored will be centered on studies done by Hollingshead and Redlich 1958, Lenski 1966 and others referenced in the literature review section of this project. Social stratification theory will be utilized as well as a brief history of social class and mental illness. This presentation of literature would necessitate about an hour to complete.

Following the review of literature the floor would be open to discuss the value and limitations of the literature as well as the case studies. This open discussion allows for ideas to surface in addition to solutions on how social class bias can be excluded from the therapeutic relationship. Clinicians can speak regarding how they cope with such issues and what strategies they found lacking to prevent them. This portion of the project would take another hour depending on group dynamic, years of experience and professionalism.

Administering Exit Survey

At the conclusion of the discussion portion each clinician would be given a survey to complete prior to their departure. The survey will consist of seven questions in a Likert scale of one to five, with a comment area at the end for personalized comments. These scales would be;

1. Highly disagree

2. Disagree

3. Neither disagree or agree

4. Agree

5. Highly agree

The survey questions are designed to be brief to maintain the clinician's attention after sitting through a two-hour presentation. The questions are as follows;

1. The presentation was thorough enough regarding social class bias

2. The presenter was knowledgeable in this area

3. The material was relevant to my practice or current occupation

4. Social class bias is a relevant topic in therapy

5. My graduate program taught me about social class bias

6. I was aware of social class bias prior to this presentation

7. Social class bias is an ethical dilemma faced by clinicians in our society

The clinicians should be able to answer the questions: how can this presentation be more relevant to psychology, how can the presenter improve upon this presentation?

These comments and answers will then be analyzed to determine the efficacy of the presentation.

Chapter Summary

This chapter deals with the methodology of presenting on social class bias in the clinical relationship. Clinicians will be presented with two case studies that include mental health issues and social class cues embedded. The clinicians will then be introduced to social class bias as interpreted by current literature on the subject. The participants will then be able to discuss their diagnoses of the case studies, their rationale for the diagnosis, and whether they felt social class bias clouded their judgment.

This presentation is not intended to treat or diagnose any deficiency within the clinician rather it is intended to raise their self-awareness. The attempt to expose the clinician to their internalized norm of social class bias is the paramount objective. This is an educational seminar designed for the professional clinician/ clinician in training to enhance their professional efficacy, client advocacy and increase the quality of overall client care.

Chapter 4

RESULTS

The results section is comprised of three sections. These components engender the

crux of this project. The first section looks at the mock diagnosis aspect of the

presentation; this includes the GAF score and social class assumption in addition to a

presumed diagnosis. The second section addresses the information presented and the third

section addresses the post- presentation survey regarding the efficacy of the presentation

regarding the exposure of social class bias as it occurs in the therapeutic setting.

Mock diagnostic interview

Clinicians are trained to begin the diagnostic session with the minimum of

information and then be able to extrapolate and delve deeper through dialogue to find

meaning. This project utilizes this skill set by offering the minimum amount of

information needed to start the therapeutic process. The case histories for the mock

clinical diagnostic session are located in appendix A. There were two separate

presentations given to an audience of clinicians. The clinician's were presented with two

case histories for a mock diagnosis exercise. This was designed to have them start

exploring the notion of bias within themselves. The diagnosis was looked at for proximity

to the accurate diagnosis, GAF score, and social class assumption.

It should be noted that six of the clinicians had four or less years of practice which

includes a year of practicum and internships in graduate school. The remaining clinicians

had seven years between them. Each clinician received graduate instruction in Abnormal Psychology, Ethics, and cultural diversity. Each clinician stated that they felt confident in their ability to recognize and remove their biases from the clinical environment in order to preclude diagnostic interference.

The diagnosis, GAF score and social class assumptions were looked at and discussed during the beginning of the presentation. Each clinician was given case histories for two clients, one male the other female. The appropriate diagnosis, GAF score and social class for each client had been determined prior to the workshop through professional consultation. The appropriate diagnosis, GAF, and social class are: the male client has a diagnosis of panic attacks, a current GAF score of 71 and is from the lower socio-economic class. The female client has a diagnosis of depression, a current GAF score of 31 and is from the middle to upper socio-economic class.

The information that was uncovered during the discussion was looked at for patterns, as this project was designed as an informative seminar to expose social class bias and enhance personal and professional growth. After identifying each clinician's diagnosis, GAF score, and social class assumption, it became apparent there was discord between the appropriate diagnosis and the diagnosis given by the clinicians. Of the clinicians that were presented with the information for Carl the male subject 60% diagnosed him with a more severe diagnosis than he "has". 40% of the clinicians diagnosed him with PTSD, 20% diagnosed him with Acute Stress Disorder and 20% diagnosed Carl with Agoraphobia. Only 20% of the clinicians diagnosed Carl with Panic Attacks, conversely 100% of the clinician's accurately identified Carl as hailing from the Low SES. Another interesting event was the GAF scoring 90% of the clinician's scored

Carl below his current GAF score. The average GAF was 54, 17 points below his current

score of 71. The range of scores was from 41-70, with only one clinician assigning this

score.

Cynthia, the female client showed a converse effect on her diagnosis and GAF

score. Of the 10 clinicians that were presented with the information for Cynthia the

female subject 60% diagnosed her correctly with a diagnosis of depression. 40%

diagnosed her with a less severe diagnosis than she has. 30% of the clinicians diagnosed

her with Mood Disorder Not Otherwise Specified (NOS), 10% diagnosed her with

Seasonal Affective Disorder (SAD, a seasonal depression). 100% of the clinician's

accurately identified Cynthia as hailing from the middle to high SES. As with Carl the

GAF scoring was inaccurate, for Cynthia she was rated higher than her current GAF

should be. 100% of the clinician's scored her GAF above 31. The lowest GAF assigned

was 40, nine points above with the highest score (occurred four times) of 71 being 40

points higher than her official score. The average GAF assigned to Cynthia was 63, 32

points above her current score of 31. The range of scores was from 40-71, with only two

clinician's assigning a score close to the 31; the assigned scores were 40 and 45.

Information Presentation

Once the clinicians finished their mock evaluations they were presented with

information regarding the official diagnosis, SES and GAF scores of the clients. As this

project was run as an educational workshop the audience was aware of the purpose of the

project from the beginning. As the clinician's were presented with the accurate

information they were not surprised at their accuracy of identifying SES, yet they were

surprised by their inaccuracy with the GAF scores. The participants were asked if they

believed that their perception of the clients functioning could have been influenced by

social class perception a majority of both groups concluded that it was. The clinician's

were then presented with current literature regarding social class bias and its impact on

clinical judgment and objectivity.

Administration of the Exit Survey

At the conclusion of the presentation, each clinician was asked to complete a

survey. All of the clinician's who attended the workshop completed the exit survey. The

average scores given for each question asked are listed following the questions.

1. The presentation was thorough enough regarding social class bias

2. The presenter was knowledgeable in this area

3. The material was relevant to my practice or current occupation

4. Social class bias is a relevant topic in therapy

5. My graduate program taught me about social class bias

6. I was aware of social class bias prior to this presentation

7. Social class bias is an ethical dilemma faced by clinicians in our society

The average score for the entire presentation was 4.2 on a five point Likert scale,

which rated just above "Agree". The individual scores were similar across the survey, the

seven questions obtained these average scores respectively; question one a 4.4 average,

question two a 4.4 average, question three a 4.5 average, question four a 5 average,

question five a 3.2 average (the lowest average recorded), question six a 4 average, and

question seven a 3.8 average. The lowest score recorded with an average of 3.2 pertained

to question number four which stated, "My graduate program taught me about social class bias".

Chapter Summary

This chapter deals with the results of the presentation on social class bias in the clinical relationship. The clinicians were presented with two case histories for a mock diagnosis and asked to complete a post-presentation survey to determine whether or not this presentation was of value. The clinician's GAF scores presented the largest divergence among the three areas (diagnosis, GAF score and SES) that were discussed. The GAF scores for "Carl" had a range of 41-70 with an average of 54, which rates17 points below his current score of 71, whereas "Cynthia" the female client had a range of 40-71 with an average score of 63, 32 points above her current score of 31. This disparity of scores added to the increased severity in diagnosis for "Carl" and the decreased severity in diagnosis for "Cynthia" shows causal evidence of a social class bias existed in this group.

The post-presentation survey indicated through its average score of 4.2 that the 10 clinicians given the presentation agreed to its usefulness for their profession. The average score of 3.2 (the lowest average recorded) on question five indicated that the clinicians felt that there was a need for improvement in training future clinician's regarding social class bias in therapy. Overall, the information gathered during this presentation indicated that clinician's need to be made aware of social class bias.

Chapter 5

DISCUSSION

The chapter consists of three sections that address the mock diagnosis, information presentation and the post- presentation survey that was administered to the presentation participants. The discussion will consist of an overview of the sections, readdressing the results as discussed in chapter 4, the limitations that exist within each of the three main components, and additional research opportunities exposed through this project.

Mock Diagnosis

It was decided that the most effective manner to begin a presentation of biases was to include a mock diagnosis portion where the clients SES was blatantly obvious. This was done to elicit a conscious and subconscious reaction from the workshop participants. As social class is an inherent part of society, the bias operates on both levels within the human psyche. The mock diagnostic portion allows the clinician an opportunity to make quick diagnosis based upon little information with an obvious social class presence. The mock diagnostic also afforded the clinician the opportunity to analyze and reflect on the impetus behind their diagnosis. This exposure allows for dialogue to begin openly and internally, and additional positive effect is allowing for an openness of new ideas as presented in the literature regarding social class bias.

Information Presentation

The information presented during this workshop pertained directly to the effects of social class on interpersonal relationships including the therapeutic relationship. This topic was chosen due to its relevancy to the counseling profession and the small amount of academic time, if any, that is utilized to address this particular bias, which occurs naturally within societies. The information is of an academic level suitable for professional clinicians or graduate level students. It was chosen for its relevancy to the field and for professional growth and development of the clinician or graduate student. The information was presented in a lecture format with an accompanying PowerPoint presentation to reinforce the material.

Post Presentation Survey

A post-presentation survey was utilized for this workshop/ presentation, the survey was designed to help the writer of this project improve and tailor the presentation for professional relevancy. The participants were given no time limit regarding the completion of the survey, they were only asked to complete it prior to departing from the presentation.

Discussion of Results

The responses that were elicited from the clinicians during the mock diagnostic portion of the presentation were on par with the literature. They overestimated the higher class individuals GAF & underestimated severity of diagnosis, and conversely for the lower class individual. This effect inferred to the audience that as clinician's they may ascribe certain attributes to a client based upon their perceived social class. This is on par

with the literature regarding social class bias and its implications in the therapeutic relationship. The information that is available concerning this particular topic is compelling, in that it reinforces that social class bias does occur. When presented with the information and its relevancy, as well as the impact of bias on clinical relationships the workshop participants were receptive to this 'new' trend. This openness allowed for an informative and collegial exchange of ideas to occur.

It was not surprising when the question was posed of how many participants felt they were aware of all their biases, that nearly 100% of the participant's felt confident of this. After the mock diagnostic and discussion this percentage fell to approximately 50%. The paradigm shift that occurred during the beginning of the workshop reinforced the notion that more training both in academia and professional development should occur to prepare clinicians. The clinician's showed through their post-presentation survey that they felt that their graduate programs did not prepare them for this particular bias and that they felt it was useful information to have regarding their current practice/ occupation.

Limitations of Presentation

The main limitation of the mock diagnostic portion of the presentation is the confounding variables that occur. An important aspect to note is that the diagnoses were taken from the DSM-IV-TR almost verbatim; the GAF score is open to interpretation and generally takes into account the clients last year of functioning. Absent a year of information regarding a client's level of functioning, a GAF score can be assigned based upon their recent level of functioning. This could have influenced the clinician's assignment of GAF as 'Cynthia' appeared through the mock case history to have had a

high level of functioning until recently and conversely 'Carl' appeared to have a consistently low level of functioning.

Another variable that needed to be taken into consideration that was addressed as a limitation in the relevant literature, was years of practice in the clinical setting and going even further the clinician's exposure to severe diagnosis and awareness of how they present. These were not accounted for due to the logistical and time constraints present when producing this project

Some limitations that can be readily identified regarding the information presentation is the age of the largest studies regarding social class issues. The largest of the studies on this topic that was implemented in the United States was completed in 1958 by Hollingshead & Redlich, although this study is still relevant on this topic, it is nearly 50 years old. Even though there are fresh studies and data concerning this phenomenon, it does not occur in the amount that previous studies do. The need for more time sensitive data regarding this phenomenon is required.

The post-presentation survey has some limits, which must be addressed. Using a Likert scale generally ensures that one will have quantitative data to analyze, yet it can often remove the qualitative quotient. Fields such as Counseling Psychology utilize qualitative data more than quantitative. This may make the participant feel forced into an answer, and skew the data. Another limitation is human attention spans and the ability to ask enough questions without losing the audience. Due to the time constraints the writer of this project was unable to utilize different surveys to find the most effective and reliable measure to ensure validity regarding the post-presentation survey.

Additional Research Opportunities

The limitations of this project illuminate additional research opportunities to increase the effectiveness of the mock diagnostic interview portion of this workshop. Of these the need to clarify the clients last year of functioning in addition to taking into account the clinicians years of practice. Additionally by looking at the clinicians years of practice in conjunction with the type of practical experience they had would enhance the presentation. It is remiss to expect an accurate diagnosis of a 'client' when the clinician has little to no experience dealing with that diagnosis outside of their Abnormal Psychology class in graduate school. The mock diagnostic portion of this project speaks of the need for further academic research regarding the effects of social class bias on the therapeutic relationship.

The additional research opportunities that were shown in the limitations regarding this topic include, running a quantitative research project to supplement the information presented to ensure a time relevancy to the participants. In addition by replicating the study it can impart that this information is just as relevant in 2007 as it was in 1958. The inclusion of more economic, sociological and anthropological theories to fortify the underpinnings of the inherency of social class bias would make for a more effective professional presentation. With the inclusion of these fields of studies it would expose that economic bias in just as inherent and relevant as racism, ageism, gender and sexual orientation biases.

There are a few research opportunities exposed regarding the post-presentation survey. The first is to research and develop a valid measure that ensures reliability. This was not able to be done due to logistics prior to implementing the survey. Based upon the

participant's responses, it would behoove graduate programs to increase the time spent on identifying social class bias. Increased research by Therapist's and Clinical Psychologist's regarding social class bias would increase the ability to inoculate one's self from this inherent social bias.

Chapter Summary

This chapter pertains to the discussion, limitations, and additional research opportunities posed by this project. Each of the three main topics has its own unique differences as-well-as similarities. The limitations posed by all three sections included the inability due to logistics to test each measure for reliability and validity. This caused some difficulty in making concrete statements regarding the efficacy of the presentation.

The presentation did expose the need for further research by clinician's regarding social class bias and its impact on the therapeutic relationship. This was seen as a deficiency that is occurring in graduate programs. Although this cannot be stated concretely since the methodology was limited to an applied project, was not a quantitative study, and there was not a large enough test group, qualitatively this findings were ascribed by workshop participants. Social class overruns every aspect of society and every individual's interaction within in it.

As stated by Karl Marx, "Society does not consist of individuals but expresses the sum of interrelations, the relations within which these individuals stand". If individuals are perceived as being unequal they will be treated unequal through conscious or subconscious means. The greatest research opportunity that came from this project

reflects the opinion that research needs to focus on social class bias in the 21st century as much as it needed it in the 19th and 20th centuries.

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Appendix A

The case studies used for the diagnostic evaluation are listed below:

Please read over the following case histories making note of all relevant information. Once you have read the case histories please complete as much of a multiaxial diagnosis as possible from the information provided by the case studies. In addition please also note your perception of the client's social class (high, middle or low) with a rationale as to why you assigned this particular class.

Carl is a 53-year-old male who is at this time employed as a short-order cook; he currently resides in an inner city neighborhood of Denver with his girlfriend of 2 years. Carl reports that he has lived in this neighborhood for his entire life. He describes his current living situation as tough with there being 'hardly enough of anything to go around'. Carl did not graduate from high school instead he dropped out in the 10th grade to begin working.

Carl comes to therapy after being referred by the emergency department at Denver Health Medical center. Carl has visited the ED on several occasions complaining of a pounding heart, shortness of breath, dizziness, trembling and nausea. The doctors could not find any medical reason for these symptoms. Carl reports that when this occurs he feels as though he is dying and cannot control what is going on with him. These ED visits have kept him from work on occasion, which has lead to him being terminated from a previous job at a gas station. Carl reports that these feelings began after an erroneous SWAT team entry into his home.

Cynthia is a 32-year-old female who owns her own architecture firm with her husband of 8 years; she currently resides in the Cherry Creek area with her husband. Cynthia reports that she grew up in the Conifer area; she describes her life currently as

very comfortable. Cynthia was valedictorian of her high school class; she earned a Bachelor of Arts from CU Boulder in Architecture, in addition she earned a Masters of Urban Development from CU Denver.

Cynthia was referred to counseling by her private physician after a suicide attempt. Cynthia has described her mood as being "hopeless"; she reports that she is currently sleeping 12-16 hrs a day. She has stopped playing weekly tennis with her college roommate and going to charity events which she used to love. Cynthia reports that there may be some depression on her mother's side but that it was never talked about. Cynthia reports that her business is doing extremely well despite her current situation; she and her husband are adding an office in Vail this year.

Appendix B

Post-Presentation Survey

Please take a few moments of your time to complete this evaluation. This evaluation will

be used to improve the quality and efficacy of the presentation for future audiences.

Use the following scale to answer the questions.

1. Highly Disagree

2. Disagree

3. Neither Disagree or Agree

4. Agree

5. Highly Agree

1.The presentation was thorough enough regarding social class bias. _____

2. The presenter was knowledgeable in this area. _____

3.The material was relevant to my practice or current occupation. _____

4.Social class bias is a relevant topic in therapy. _____

5.My graduate program taught me about social class bias. _____

6.I was aware of social class bias prior to this presentation. _____

7.Social class bias is an ethical dilemma faced by clinicians in our society. _____

(*Please provide additional comments below and on the following page*)

Additional Comments:

_____

_____

_____

_____

_____

_____