Classism in Mental Healthcare

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According to Liu (2013), classism is a term used to refer to the marginalization of those who are perceived to be in a lower social class. This includes labeling, prejudice, discrimination, and stigmatization of others based on their class. Class, or social class, is commonly defined as “people who are in similar positions of valued resources within a society" (Koepke, 2007, p. 191). Individuals with many resources are regarded as being in the upper-class, individuals with a moderate number of resources are referred to as the middle-class, and those will little to no resources are deemed to be in the lower class. Ossowski (1963) held that class has four main properties: classes are ordered vertically, the interests of the classes are permanent, people within each class share a sense of class identity, and classes are relatively isolated from each other. From a different perspective, sociologists define class as "an analytical category that refers to the social relationships which derive from the ways in which material life is produced" (Katz, 1981, p. 583). This definition focuses on the social structures and social relationships between ranks of workers, as opposed to earned income or access to resources. It is this definition of class that is used to explain such social structures as the dichotomy between white-collar and blue-collar workers.

Socioeconomic status (SES) is also an important indicator of one's relative position to valued resources and position within the class system. Baker (2014) defines SES as a measure of one's combined economic and social status. SES differs from class in that SES is a more robust and subjective assessment of one's status and is primarily determined by examining income and poverty. Income is the amount of money someone earns through their occupation and provides access to basic resources such as food, shelter, and health care (Greene & Murdock, 2013). Sociologists define poverty as "…the extent to which an individual does without resources"

(Payne, 2005, p.7). With little to no income, individuals in a state of poverty are unable to access enough resources to meet their basic needs. SES is also directly related to one's position in the system of social stratification. Social stratification refers to "…the existence of a graded hierarchy of continuous social groups or collectivities" (Buckley, 1958, p. 372). SES is conceptualized as a gradient because individuals above the poverty line have more access to resources than those below them, and individuals at the highest levels have more access to resources than those below them in the hierarchy (Greene & Murdock, 2013, p. 227). One's level of education and occupational prestige also play a large role in determining SES. Additional subjective variables to assessing SES include accent, tastes, manners, style of dress, homeownership, and neighborhood prestige (Fisher et al., 2021; Baker, 2014). Combining the various definitions and concepts of class and SES, classism can be defined as the discrimination or oppression of a group or individual based on their perceived class or socioeconomic status.

Classism is a common and harmful source of oppression in the mental healthcare system. This paper critically investigates such classism in the mental healthcare industry. Specifically, this paper examines the historical context of class and socioeconomic status, how classism in the United States mental healthcare system sustains and perpetuates oppression, the impacts of this oppression on the individual and systemic level, and how clinical psychologists may act as an agent of oppression or remedy the unjust system. To understand classism in mental healthcare, we must first understand the historical context of social class in the United States.

Historical Review

Throughout history, social class in the United States has changed in response to various political, economic, cultural, and societal influences. For much of United States history belonging to an occupational class was a privilege allotted to those who were able to maintain

occupations, usually white men and their families. According to Schneider (2007), The Euro-American slave trade, beginning in the early 17th century, set the foundation for social class and economic development in the United States. African men, women, and children were imported to the United States and sold at auction to white plantation owners. Slaves were viewed as producers of labor or work equipment to generate capital for plantation owners. Slave labor was sold as a commodity and slaves themselves were viewed as capital; a slave-owner bought their slaves as they one bought a workhorse. The social and political impacts of slavery would have a longstanding and foundational impact on the United States' economic and class systems. Marx (1977) argues that the production of raw cotton by American slaves "…signalized the rosy dawn of the era of capitalist production" (p. 915).

In 1864, the Industrial Age led to large social, political, and economic changes. The use of new machinery and modern technology in factories allowed for the mass production of goods. New industrious technology and innovation benefited the United States economy and provided the opportunity for capitalism to thrive (Katz, 1981). According to Brayshay (2020), capitalism is defined as "a system where goods and services are produced for profitable exchange in a free market" (p. 23). Under the system of capitalism, the means of production are privately owned by independent competing companies, and goods are produced by laborers who work for wages. As capitalism became the dominant economic system, the space between classes began to grow. Sociologists hold that the United States began to divide into two distinct classes: a capital class and a labor class. Katz (1981) states that capitalist society is composed of two classes because most people share a commonality to both of its key aspects: the private ownership of capital and the sale of labor as a commodity. The distinct classes emerged because people who sold their labor did not own capital, and those who owned capital purchased labor.

Income & Wealth Inequality

The divide between classes has continued to grow in the United States. One of the reasons for this is the income gap. As of 2009, the poorest quantile earned only 3.4% of the nation's income, while the richest quantile held 50.3% of the nation's income. (DeNavas-Walt et al., 2010). Additionally, the richest 20% of the population earned as much income as the remaining 80% of the population (DeNavas-Walt et al., 2010). The degree of income inequality in the United States exceeds that of all other industrialized nations (Mishel et al., 2009). Rising rates of income inequality can be linked to mechanisms of financial oppression in taxation and income distribution policies. Such policies favor the upper class at the expense of the middle and lower classes (Barlett & Steele, 2002). From 1979 to 2005, post-tax income grew by 80% for the nation's wealthiest fifth, but only 6% for the nation's poorest fifth; during the same period families in the top 1% of the nation's wealth saw their income increase by 288% (Mishel et al., 2009). Taxation and income distribution policies perpetuate classism within the United States by hindering upward mobility for the middle and lower classes.

While the income gap undoubtedly perpetuates class inequality, the correlation between income and wealth ownership is weak, suggesting that measuring income alone does not allow for a comprehensive determination of financial well-being. Instead, Kiester & Moller (2000) argue that family wealth is a more critical component of class well-being. Wealth, or net worth, is the difference between total assets and total liabilities or debt. When wealth is considered, the inequality between classes appears to be even greater due to the advantages associated with wealth ownership that income alone cannot provide. Wealth provides short and long-term financial-security social prestige, political power, and can be used to produce more wealth (Kiester & Moller, 2000). Between 1922 and 1950, the top 1% of wealth owners possessed an

average of 30% of the wealth (Wolff, 2012). Wealth inequality began to rise exponentially after 1979 and by 2012 the top 1% of wealth owners held 42% of the nation's wealth. This exponential growth in wealth inequality was largely facilitated by the top 0.1%, whose proportion of total national wealth increased from just 7% in 1978 to 22% in 2012 (Saez & Zucman, 2016). Wealth inequality perpetuates long-standing socioeconomic injustice and inequality among middle and lower-class families and contributes to poverty. Continually rising inflation, classist political policy, and increasing income and wealth gaps mean that middle and lower class individuals are increasingly unable to receive a formal education, which is regarded as one of the few consistent opportunities to escape generational poverty (Levine & Nidiffer, 1996). With a lack of opportunities for low SES individuals and groups, the longstanding impacts of historical class inequalities continue for historically marginalized individuals.

Researchers view race as an antecedent and determinant of SES, showing that SES differences between racial groups in the United States are produced by long-standing societal structures and processes (Yu & Williams, 1999). Classism is not an isolated form of discrimination. Racism contributes to and perpetuates classism in the United States through the unequal distribution of income and wealth. The complex intersectionality of SES and race is salient wealth disparities, particularly at the lowest levels of income. Previous research has shown that for United States citizens among the lowest income quintile, white individuals held a median wealth of $10,257, compared to $645 for Hispanic individuals and $1 for African Americans (Yu & Williams, 1999). African American and Hispanic individuals also receive significantly lower levels of income in proportion to their level of education when compared to white individuals. Additionally, College-educated African Americans are four times more likely to experience unemployment than college-educated white individuals (Willhelm, 1987). This

research shows that historical oppression is perpetuated today in the disproportionally low SES of non-white groups. The impacts of racism are closely linked to SES and classism at a systemic level.

Socioeconomic Mental Health Disparities

The impacts of classism as oppression are systemic and are visible today in various contexts. One such context is individuals' health status. Classism facilitates health disparities between classes. According to research by Chetty et al. (2016), there exists a positive relationship between income and overall life expectancy. As a direct result of income inequality, the gap in life expectancy between the richest 1% and poorest 1% was 14.6 years for men and 10.1 years for women. Such inequality in life expectancy has increased over time. From 2001 to 2014, life expectancy increased by 2.34 years for men and 2.91 years for women in the top 5% of income. However, those in the bottom 5% of income saw increases of only 0.32 for men and 0.04 years for women. Income inequality can have lethal consequences on the oppressed, while the non-oppressed, or high SES individuals and groups, are privileged to not experience classism's dangerous effects.

Beyond overall life expectancy, classism perpetuates mental health disparities for low SES individuals and groups. Sociologists have long acknowledged the relationship between SES and mental health status, particularly the inverse relationship between SES and psychiatric morbidity (Yu & Williams, 1999). According to The Epidemiologic Catchment Area Study (ECA; Robins & Regier, 1991), one of the largest community mental health surveys conducted in the United States, there exists a consistent negative relationship between SES and diagnosis of psychiatric disorders. However, the strength of the relationship varies by the type of psychiatric disorder examined. Results of the ECA indicated that individuals in the two lowest SES quartiles

were almost twice as likely to meet diagnostic criteria for major depression when compared to those in the highest SES quartile. The lowest SES group also had a rate of alcohol abuse and dependence almost four times that of the highest SES group. Schizophrenia occurred almost eight times more frequently among adults in the lowest SES group, compared to adults in the highest SES group. Additionally, the ECA found that about 60% of respondents with a history of at least one psychiatric disorder currently met the diagnostic criteria for two or more psychiatric disorders. Among the low SES group, meeting criteria for three or more psychiatric disorders was triple that of the high SES group (Robins & Regier, 1991). Results from the ECA show that low SES individuals are significantly more at risk of developing a psychiatric disorder when compared to high SES individuals.

It has been established that low SES individuals face increased mental health disparities when compared to high SES individuals. However, the causes of such mental health disparities may vary by individual and circumstance. According to Yu & Williams (1999), two main hypotheses exist to explain the association between SES and mental illness. The social selection hypothesis is the view that mental illness prevents individuals from obtaining or keeping the employment needed to become upwardly mobile. Thus, "…mental illness causes individuals to drift into lower SES groups or fail to climb out of financially insecure positions at rates comparable to that of healthy adults" (Yu & Williams, 1999, p. 158). It is believed that lack of employment and mental illness creates a positive feedback loop causing individuals to continually drift into lower social classes. In contrast, the social causation hypothesis argues that higher rates of mental illness in low SES individuals and groups can be attributed to systemic socioeconomic adversities. This hypothesis holds that high rates of mental illness among low SES individuals can be attributed to a lack of resources in low SES environments that

foundationally prevent individuals from becoming upwardly mobile. Much of the research into the social selection and social causation hypotheses have examined longitudinal and cross-sectional and longitudinal methods with mixed results. Results largely suggest that social selection and social causation may be involved differentially for certain psychiatric disorders and operating simultaneously for others (Dohrenwend et al., 1992). Both hypotheses show that aggravating factors in the development of mental illness are caused by multiple manifestations of systemic socioeconomic injustice that result from a life in poverty, supporting the notion of poverty and classism as a potential etiology of mental illness.

Access to Quality Mental Health Care

While low SES individuals and groups often demonstrate a high need for mental health care, institutional classism presents specific barriers to receiving quality care. Differences in access to health-promoting resources and differences in access to high-quality treatment based on social class have been shown to have a large impact on one's health status. (Lott, 2002). Therefore, gaining access to mental health care does not guarantee one will receive quality care. Carrillo et al. (2001) explain that access to quality health care exists on a continuum and consists of primary, secondary, and tertiary access. Primary access is defined as having health insurance and is the main health care access mechanism in the United States. Individuals without health insurance face primary barriers to quality care. However, even with primary access, insured individuals in marginalized socioeconomic, cultural, or linguistic groups face additional barriers that are less tangible than insurance possession alone. Secondary access barriers are institutional, organizational, and structural barriers to receiving high-quality health care. Examples of secondary access barriers include difficulty getting appointments, lack of access to after-hours care, or long wait times for referrals to specialists (Carrillo et al., 2001). Similarly, tertiary access

barriers occur for individuals who have overcome primary and secondary access barriers but face cultural and linguistic barriers that inhibit patients from forming effective relationships with their health care providers.

Secondary and tertiary access barriers perpetuate classism at the institutional and systemic levels. Specifically, access to mental health care is often restricted by institutional distancing, the act of exclusion, separation, devaluation, or discrimination against low-income groups by creating barriers to full participation in the institution or system (Lott, 2002). Institutional distancing within the healthcare system based on social class can be overt or subtle and is a dominant response to the poor by non-poor individuals within the mental health care industry. The impacts of institutional distancing have severe consequences for those affected. Low-income individuals are often denied access to quality mental health care due to the bias and discrimination associated with institutional distancing (Lott, 2002). Davis & Proctor (1996) found that mental health workers do not feel comfortable working with low-income patients and find it difficult to empathize with them. It was also discovered that many mental health workers find low-income clients to be inarticulate, suspicious, resistant, apathetic, and passive. Adults also tend to believe that low-income individuals lack morals and are personally responsible for their suffering (Chafel, 1997). Low-income clients are also more likely to receive brief and pharmaceutically focused therapy compared to high-income clients (Leeder, 1996). Additionally, while federally funded student loan forgiveness programs exist to encourage doctors to work in high-need areas, only 9.5% of eligible health care professionals choose to participate. Institutional distancing within the United States mental healthcare system is one of the largest classist barriers to attaining quality mental health care for low SES individuals and groups.

Insurance

According to Hoffman & Paradise (2008) health insurance assists individuals in accessing health care by protecting them and their families from the high or unexpected costs of medical care and connects individuals to networks and systems of health care providers. Health care costs in the United States are the highest per capita in the world. Such continually escalating health care costs have made insurance nearly essential to ensure access to affordable care. The United States insurance system is pluralistic, meaning that it is made of both public and private sectors. However, the foundation of insurance in the United States is employer-paid plans for working families and Medicare for the disabled and elderly (Hoffman & Paradise, 2008). While insurance is available in private and public forms, a large reason why many low-income individuals lack health insurance is that their employers do not offer them coverage (Carrillo et al., 2001). Research by Hall et al. (1999) found that citizenship status, education status, and workforce characteristics were large determinants of access to health care. Notably, individuals without United States citizenship, with low levels of education, and those employed in blue-collar industries were less likely to be offered insurance by their employer. Such classist inequalities force members of the lower social classes to go without insurance or mental health care. This contributes to the development and furtherance of mental illness (Yu & Williams, 1999). Research has found that poverty, insurance, and health are interconnected. Those with low incomes make up 66% of the nation's uninsured and it is estimated that racial and ethnic minorities disproportionately account for over half of the nation's uninsured. Without employer aid, health insurance is unaffordable for many low-income individuals and often competes with the most basic needs, such as food and housing (Hoffman & Paradise, 2008).

According to research by Druss & Rosenheck. (1998) while multiple options for insurance coverage are available, individuals with mental disorders have historically faced

substantial barriers to maintaining health insurance and acquiring necessary mental health care. Mentally ill individuals with employer-based insurance were more likely to have difficulties gaining insurance due to denial for a preexisting condition compared to those with no mental illness. While 45 states prohibited the denial of coverage for preexisting conditions, enrollees of fee-for-service plans and preferred provider organizations continually faced limitations and restrictions in their benefits as a result of having a preexisting condition. Due to such restrictions, individuals with mental illness were twice as likely to be unable to obtain medical and mental health care when compared to individuals without a mental illness. Individuals with mental illness are also more likely to stay at non-preferred places of employment due to increased fears about losing their employer-based health benefits.

In response to these growing concerns, the United States government enacted The Health Insurance Portability and Accountability Act (HIPAA) of 1996, which was regarded as the most significant federal healthcare reform in a generation. Atchinson & Fox (1997) explain that HIPAA enacted many changes aimed at increasing the availability and portability of health insurance for all Americans. This included setting various anti-discrimination and exclusion policies pertaining to availability and portability standards in health insurance coverage. Under HIPAA, group health insurers became limited in their ability to deny coverage due to preexisting conditions, including mental health conditions. Insurance providers and employers could also no longer cancel coverage, deny renewals, or charge higher premiums based on their health status or medical history. Notably, HIPAA also required insurance to be portable if an employee changes jobs or an employer changes their sponsored health plan (Atchinson & Fox, 1997). While HIPAA was enacted to improve individuals' access to health insurance and make healthcare more affordable, researchers have found that the benefits of HIPAA are largely unfulfilled. Kuttner

(1997) argues that HIPAA does little to address foundational inequalities in the United States healthcare system. High regulation costs of HIPAA encourage employers to drop or dilute their coverage. Kuttner likens HIPAA, and other regulatory healthcare legislation, to a patchwork that overlays a dysfunctional system. HIPAA has also been shown to increase regulatory burdens in a system already hindered by both public and private bureaucracies. Maintaining a public-private health insurance system aimed at limiting the reach of government regulation creates additional complexities to compensate for the fundamental inadequacies of the system. Even with a patchwork of healthcare regulations, Kuttner (1997) argues that the system is fundamentally flawed and needs to be rebuilt from the ground up.

Psychologists within the System

As mental health care providers, psychologists have a professional and ethical duty to deliver meaningful assistance to those afflicted by oppression. However, research has shown that some psychologists may act as agents of oppression within the mental healthcare system. Specifically, classism among clinical psychologists is perpetuated through attitudinal barriers toward low-income individuals. Smith (2005) identified four common manifestations of classist attitudinal barriers among clinical psychologists: poor clients need assistance with basic resources as opposed to psychotherapy, psychotherapy will be less effective due to the many problems extraneous problems faced by poor clients, working with poor clients takes away the comfort of not knowing how poor people live, and conventional psychological services are not familiar or widely accepted in the cultures of many poor and working class. Such attitudinal barriers hinder the funding and development of psychological services for low-income individuals and compromise the efficacy of such psychological services. When a psychologist's subconscious bias or held stereotypes are left unexamined, it results in evasion of a client's

underlying issues and manifests in classism (Smith, 2005). Additionally, research by Chalifoux (1996) found that therapists may have difficulty incorporating a low-income client's financial circumstances into a therapeutic context. This research revealed that low-income clients felt misunderstood and believed that their therapists were unaware of the countertransference resulting from their own class values.

While psychologists may serve as agents of oppression, they can also foster a more just mental healthcare system. Smith (2008) argues that psychologists should work to advance an anti-classist social justice agenda within the field of psychology. For psychologists, the process begins by understanding and identifying the social mechanisms and obstacles in place that perpetuate classism and acknowledging their potential classist biases. To tackle the issues of classism in clinical practice, anti-classist and social justice training must be present within the psychology curriculum and continuing education. Smith (2008) adds that anti-classist training should focus on acknowledging one's social positionality, gaining knowledge about the circumstances and experiences of low-income people, questioning assumptions about poverty and social class, and decoding everyday experiences of class. Anti-classist and social justice training results in psychologists acquiring the tools and awareness needed to act on injustices and provide meaningful and effective anti-classist mental health care to low-income clients.

Conclusion

Classism is present in the United States mental healthcare system at a fundamental and systemic level. The history of classism described above shows that many of the foundational aspects of social class in the United States were shaped by historical, social, and political events. The complex history of class in the United States has facilitated the intersectionality of class, race, and socioeconomic status (Yu & Williams, 1999). As a capitalistic society grew, income

and wealth inequality increased. Rising income and wealth inequality are antecedents to classism, as they further the divide between classes. Classism is particularly salient for marginalized individuals and groups, who are more likely to face barriers to escaping generational poverty (Mishel et al., 2009).

The impacts of classism also perpetuate socioeconomic mental health disparities. This includes higher rates of major depression, substance use disorders, and schizophrenia among low SES groups when compared to high SES groups (Robins & Regier, 1991). While low SES individuals and groups demonstrate a high need for mental health services, institutional classism erects barriers that decrease access to quality mental health care. Institutional distancing facilitates differences in the quality of mental health care based on social class (Lott, 2002). Additionally, the pluralistic foundation of the United States health insurance system means that many low-income individuals cannot afford high-quality insurance and are forced to go without mental health care (Carrillo et al., 2001). Individuals with mental disorders face additional primary access barriers such as denial of coverage or limitations on coverage for having a preexisting mental health condition (Druss & Rosenheck, 1998). While public policy has been enacted to remedy access barriers and health discrimination, regulatory policies such as HIPAA do not adequately address the classist inequities that comprise the United States employer-based insurance system (Kuttner, 1997). Furthermore, psychologists and other mental health professionals may act as classist agents of oppression when they fall victim to their own biases, reinforce stereotypes, or project their class values onto their clients' circumstances (Smith, 2008). Psychologists can also act as forces of liberation for their clients by engaging in anti-classist and social justice training, acknowledging their social locations, and questioning assumptions about poverty (Smith, 2008).

Classism in the United States is systemic and longstanding. Therefore, fundamental change in the United States mental healthcare system is needed to ensure that all people can receive access to high-quality mental health care (Kuttner, 1997). Government and healthcare professionals need to work together to foster a more just system by engaging in anti-classist training, passing anti-classist policies, and fulfilling their professional and ethical obligations to remove barriers and "serve, not colonize" (Aponte, 1994, p. 11). Until the many systemic and classist barriers are demolished, low-income individuals will be unable to receive the mental health care that all human beings deserve.

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