2013

How Class Background Influences Negative Countertransference in Outreach Therapy

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DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Psychology in the Department of Clinical Psychology
of Antioch University New England, 2013

Keene, New Hampshire

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

HOW CLASS BACKGROUND INFLUENCES NEGATIVE
COUNTERTRANSFERENCE IN OUTREACH THERAPY

presented on July 25, 2013

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Dedication

This dissertation is dedicated to those who have helped me reach this pinnacle. To my parents for always being so proud of me, and never having any doubt that I would achieve my end goal. To my lifelong friends, Erin, Annette, Jocelyn, Melissa, and Sarah who have supported me, teased me, and begged me to stop talking about psychology. To the Griswold Inn, for allowing me to work on my dissertation between shifts in the Essex room (or anywhere there was an outlet), for asking me about my progress, and for always letting me know that I could write the book about them if I changed my mind. To Rob, for being my sounding board during my internship and dissertation years; your love and validating ways have been my comfort. And finally, to Dr. Bradley Waite for supporting me during my undergraduate years and encouraging me to apply to doctoral programs; you helped shape my path. I thank each of you, for without all of your support, I would not be here now.

Acknowledgements

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Abstract

This dissertation examines how the class background of social workers and doctoral level psychologists influences negative countertransference towards working with the poor in an outreach setting. A literature review explores countertransference from a psychoanalytic stance and showcases the development of the two disciplines, psychology and social work, and how class has directly or implicitly been a factor. Finally, the review discusses outreach therapy, its advantages and limitations, and how doing this work can impact clinicians. Participants for the study were master's level clinicians, current and former predoctoral psychology interns, postdoctoral fellows, and other doctoral level clinicians who were currently or formerly practicing outreach therapy. Participants completed two measures that were developed by the principal investigator. The first measure asked participants to identify with one of four possible social class descriptions. The second measure was a series of 10 vignettes portraying potential countertransference scenarios. Participants were to select from three possible "emotional blends" of negative countertransference and then rank the intensity (1-5) of that particular emotional blend. The study had 27 participants varying in age, gender and ethnicity. Chi-square analyses between education level and social class, education level and countertransference, and social class and countertransference, all were not significant. Descriptive statistics outlined the frequencies of emotional blend responses for each vignette, as well as levels of intensity for each emotional blend and respective vignette. Means and standard deviations indicated differences between social classes and the average level of intensity that was experienced. T-tests indicated that there were significant differences between master's and doctoral level clinicians regarding emotional blends. The research implies that there are relationships between education level and social class and its influence on negative countertransference in outreach therapy. Possible

explanations include that people from lower class backgrounds are better able to work with

people from lower class backgrounds. Further, those who go into social work versus psychology

are better able to work in an outreach setting as they receive focused training in working with an

underprivileged population.

Keywords: Social class, emotional blends, countertransference, psychology values,

social work values, outreach therapy

Chapter 1

How Class Background Influences Negative Countertransference in Outreach Therapy

"Both social class and mental illness may be compared to an iceberg; 90 percent of it is concealed below the surface." Hollingshead and Redlich (1958, p. 6)

Psychology was founded by European, Caucasian, and wealthy men. This foundation was then to include European, Caucasian, and wealthy women, with some obvious nepotism apparent. Anna Freud is the most obvious example. However, the field has grown significantly, and it would be unfair to say that psychology has kept with these traditions. While we can applaud the changes that have been made regarding the science, practitioners, and range of clients who receive services, it is evident that many constructs continue to be conspicuously absent from psychology. One of these is class and its impact on countertransference.

The purpose of this study was to explore the impact of class on doctoral level psychologists and master's level social workers and counselors when providing outreach therapy. This study's etiology was based on the author's experience as an intern providing outreach therapy. Throughout the internship there appeared to be a relationship between the class backgrounds of the clinician's working there and their overall attitude towards their jobs and clients. One important goal of this dissertation was to promote a better understanding of the potential for countertransference for the predoctoral interns that continue to attend that internship program and similar programs.

The intended benefits of this study are numerous. Firstly, as outreach therapy is a relatively new and growing field, additional research is valuable. Secondly, the stress and attrition associated with outreach therapy may be reduced if we can understand how class impacts the relationship between negative countertransference and clinician longevity at agencies where outreach therapy is the primary modality. Additionally, this research may be able to

provide insight into other disciplines where going into the home is common. Examples include

agencies such as the Department of Children and Families, social services, and home nursing.

Lastly, the issue of class, and how it impacts our attitudes as practitioners, has often been

neglected in the field of psychology. There continues to be a need for more research regarding

this topic.

The main hypothesis of this research was that those who come from working class

backgrounds will have less intense, or different negative countertransference reactions towards

working with the poor in outreach therapy than their middle or upper class counterparts. Level of

education, as a key component to social class, will be explored as one of the main factors in

comparing and understanding the type and intensity of the countertransference. The "type" of

countertransference is described as "an emotional blend" (Kagan, 2010; 2007).

The paper begins by discussing countertransference from a psychoanalytic perspective,

highlighting the utility and potential ramifications of positive and negative countertransference.

Next, countertransference towards working with the poor is discussed with a focus on common

countertransference reactions, particularly, hate and fear. A brief case example is provided to

illustrate some of the points mentioned in the literature.

A preliminary definition of social class is provided, which differentiates between social

class and socioeconomic status. The class backgrounds of psychologists and social workers were

explored as research has shown that class has impacted the development of both psychology and

social work, and has created a lineage of privilege and differing class values between the two

disciplines. The literature review includes an examination of social class values, and highlights

key differences between psychologists and social workers. The literature review concludes by

discussing outreach therapy, including the history, application, successes and potential

downfalls, and the impact of doing this work on clinicians.

Chapter 3 of the dissertation, Methodology, will provide an overview of the participants

and setting, a detailed description of the development and characteristics of the measures, how

the data was collected and recorded, and how the data was analyzed. Chapter 4 will present the

results of the statistical tests. Chapter 5 will interpret the results and provide possible

explanations for the results. Limitations of the research, recommendations and personal

reflections will be included. Attached to the dissertation is an informed consent form, a

demographic questionnaire, a measure to determine the participant's social class, a measure

consisting of 10 vignettes on countertransference, and a gatekeeper letter from the participating

site.

Chapter 2

Literature Review

This literature review discusses and elaborates upon three major areas: (a) countertransference and emotion, (b) the values of psychology and social work, and (c) outreach therapy. Specifically, countertransference as a construct will be discussed from a psychoanalytic perspective, with a focus on both positive and negative countertransference. How countertransference arises when working with the poor, as well as hate and fear as significant countertransference reactions, is discussed. A clinical example is provided to highlight various countertransference reactions.

A discussion of emotion and how people experience emotions is presented. This discussion is based on the work of Jerome Kagan (2010; 2007). Emotion as a construct, and the research behind understanding emotion from Kagan's point of view, will be incorporated in an effort to show the difficulty of being precise with emotion. Kagan's ideas on "emotional blends," or how one does not feel just a single emotion, will be the primary topic of the discussion. Finally, how emotion and countertransference are related is discussed.

The literature review then provides structure regarding the framework of both psychology and social work. People outside of the field often see the two disciplines as interchangeable; however, it becomes clear that psychology and social work while both helping professions, have distinct purposes with origins in differing class backgrounds. The review focuses on these differences and how they establish unconscious sounding boards for countertransference reactions.

The literature review concludes with a discussion on outreach therapy. A brief history of the growing field is provided, followed by a detailed discussion of the delivery of therapy, the

therapists who are involved, the advantages and disadvantages, as well as an in-depth look at the

impact that practicing outreach therapy has on the clinicians who provide it. The need for

specific supervision and skilled training, and the lack thereof of this training will be discussed.

Countertransference as a Construct

Throughout the course and development of psychology, there has been much discussion

regarding countertransference. Its definition and use in therapy have garnered both optimism and

hesitation. Alvarez (1983) and Gabbard (2001) quote Freud as saying, "(countertransference)

was an obstacle, a resistance, a symptom to be removed, decontaminated (1910/1957)."

However, current literature describes countertransference as being a positive construct, one that

teaches the therapist about the client, themselves, and the therapeutic relationship (Green, 2006;

Rossberg, Karterud, Pederson, & Friis, 2007).

For the purpose of this dissertation, a symposium of ideas on countertransference will be

the working definition, composed by a number of authors and theorists. The definition of

countertransference is based in psychoanalytic theory. As Gabbard (2001) notes:

"Countertransference has moved to the very heart of psychoanalytic and psychotherapeutic

technique" (p. 990). Alvarez (1983) opines that "Countertransference is any and all of the

feelings that the therapist has towards his patient. This might include his own analyzed

transference to the patient of a displacement on to the patient from outside, but it would also

include feelings put into him by the patient. It would not include a perception of something going

in the patient which is not accompanied by a similar or related feeling in the therapist" (p.11).

This unconscious emotional process is known as projective identification. Klein (as referenced in

Gabbard, 2001) proposed projective identification as a fantasy in which part of the patient's self

is split off and then unknowingly projected into the therapist, impacting how the therapist behaves.

Countertransference can occur when the client evokes feelings that the therapist finds to be unsettling in any number of ways (Gabbard, 2001), and is frequent with clients who have personality disorders. Clinicians who have worked with personality disordered clients, may easily recall losing their composure during a trying session. However, Gabbard argues that it is important to not ignore these sessions or reactions. Ignoring the countertransference, could be viewed as enacting the numerous objects in the client's life before this, and by doing nothing, it could bring up a variety of emotions such as abandonment (Gabbard, 2001). The literature review includes specific countertransference reactions incited by those with personality disorders.

McWilliams (2004) notes that when analyst and analysand are engaged in psychoanalysis, that both parties are intimately involved. According to McWilliams, "Countertransference is not seen as an occasional phenomenon but as a pervasive and unavoidable one; entry into the patient's subjective world tends to activate any compatible scripts from the therapist's life" (p. 18). Therefore, it behooves the therapist to accept that the client will impact their life in an unconscious and intimate way, and to be self-aware and reflective. Allowing oneself to notice changes in emotional presentation and considering them, will provide value to the work.

Heimann (1950) describes countertransference as the analyst's unconscious coming to a greater understanding of the patient. She views countertransference as integral to the production of good therapeutic work and the building of the alliance. The intensity of the countertransference also tells the analyst if the work is moving forward, or in contrast, has

reached a stalemate. Her brief, but groundbreaking work on countertransference has shaped the

way psychologists view the construct (Stein, 1991). Stein goes on to say that Heimann

"established the term countertransference to cover all the feelings which the analyst experiences

towards the patient" (p. 325). Heimann's work added to a growing current consensus that

whatever one is feeling can be considered countertransference, and should be acknowledged and

used as indicated.

Little (1950) also supports the strength and ferocity of countertransference citing that

"countertransference is no more to be feared or avoided than is transference; in fact, it cannot be

avoided, it can only be looked out for, controlled to some extent, and perhaps used" (p. 40).

Further, she notes that countertransference is observed in its aftereffects, not in action,

suggesting a commonality between countertransference and Klein's ideas of projective

identification. In terms of repressed countertransference, she describes it as, "a product of the

unconscious part of the analyst's ego, that part which is nearest and most closely belonging to

the id and least in contact with reality" (p. 33). She views countertransference as a compromise,

and compares it to a neurotic symptom. In other words, countertransference can be an emotional

dialogue one has with one self that is always based in internal conflict, whether the client incites

the countertransference or it is a product of one's own "secrets."

Wile (1972) discussed two types of countertransference : patient-induced

countertransference and therapist-related transference. He notes that these types of

countertransference become more obvious during an impasse, or a stop in the progression of

therapy. He offers the following suggestion in trying to understand one's countertransference, "I

am recommending that the therapist listen to his own reactions with the same free-floating

attention with which he listens to those of his patients—cautious, focused, and alert to the possibility of countertransference distortion, relaxed, unpressured, and self-tolerant" (p. 65).

In a thorough and informative dissertation on countertransference and working with children in a community clinic, Powell (2005) discusses the foundation of countertransference from many well known analysts including Bollas, Winnicott, Ogden, and Bion. Her use of theory collaborates points previously made that countertransference can be seen as an act that happens without being noticed at first glance, but recognized upon further inspection. As her work focused on transference and countertransference with children, she notes that countertransference is essential in working with children and that those responses are often the result of unanalyzed experiences from one's own childhood, both to the child and the child's caregiver. She elaborates by noting that working with children is especially difficult as one is experiencing the projected object relations of both the child and the child's caregivers.

Most clinical theorists consider countertransference to be a useful tool. Countertransference can stem from a variety of places including unresolved childhood conflicts and the evocation of emotions from a particular client. As we move forward in the literature review, a focus on positive and negative countertransference and how certain personalities can evoke different reactions will be provided.

Positive and negative countertransference. When we think of countertransference, there is a pull to think negatively about the construct and not surprisingly, there is a surplus of literature on negative countertransference that outweighs the research on positive countertransference. However, positive countertransference feelings can prove to be beneficial to the client, and ultimately further the work. The following section will focus on positive and

negative countertransference, common reactions, and diagnoses that often contribute to those reactions.

Positive countertransference can be feelings surrounding love, care, sympathy, concern, humor, and joy (Connolly & Cain, 2010; Fox, 1996). Love is a term that is used broadly, and one that can be off putting to some clinicians. Crespi (1986) notes that much attention has been on negative countertransference and that more attention needs to be paid to positive countertransference. He discusses intense positive countertransference as akin to "falling in love" in other settings. While he recognizes that that amount of intensity can be catastrophic, it can also be valuable to both the patient and analyst. If the patient and analyst can work through ruptures and identify the source of those ruptures, then improvement will ultimately be achieved. Of course, clients who improve are looked upon with positive countertransference (Rossberg et al., 2007), and may skew clinician's opinions.

Connolly and Cain (2010) explored how working with psychotic patients often created positive countertransference in the therapeutic relationship. Many therapists believe that working with psychotic patients is difficult and may presume that negative countertransference would be predominant. However, they found that the clinicians enjoyed the work and found these patients to be "more fun." Further, clinicians reported feeling a sense of connection, raw human emotion, and that they were needed by their patient. However, the study also found that there can be significant consequences in the positive transference. The authors note that psychotic patients are often responding to clinicians in a clear unconscious manner, or in other words are able to pick up on clinician's countertransference more readily than other patients. Thus, projective identification can result in clinicians experiencing their own increased inhibitions such as tardiness, lack of proper clothing, and sexual inhibitions.

Negative countertransference is researched more frequently than positive countertransference. This is likely not a surprise given the nature of psychology and a desire to figure out and explore the negative in our lives. Adrienne Harris notes in her article entitled, *Smile of a Serial Killer,* that "Sometimes, we want to traumatize our receptive audience, download into others what is so intolerable and frightening to us" (p. 87). Her contention is that if we are to understand some of our sickest clients, we need to not focus on being loving, but rather to see those destructive and primitive qualities in ourselves, to truly understand, in order for change to occur.

As previously mentioned, negative countertransference can often occur with clients who have a personality disorder. Davidson (2009) suggests that when a patient causes the analyst to feel impatience, anger, fear, and even loathing, that there is a degree of projection from the patient, or an unconscious understanding of the patient's unconscious. In a study by Rossberg et al., (2007), it was found that patients who believed their interpersonal problems could be described as being domineering, vindictive, and cold were correlated with less positive and stronger negative transference with their therapists. Further, they found that patients who saw themselves as more neurotic and open to experiences evoked fewer feelings of rejection in the therapists. They noted that neurotic patients were more likely to listen to their therapists, aimed to please, and saw their therapists as the experts in the room.

Schwartz (1978) suggests that countertransference can interfere with the work, however working through it can indeed make the work more productive. He notes that countertransference is often likely when working with clients who are depressed, hysterical, phobic, and sociopathic. Further, that adolescent, middle aged, couples, aging persons, and dying persons can cause

significant reactions as well. He points out that some clinicians can incite negative reactions as they provoke rejection in patients who are particularly vulnerable or defensive.

Countertransference and the poor. Psychological work with the poor has created many conversations regarding countertransference. Research by Hollingshead and Redlich (1958) found that that 78.3% of patients (or people with mental illness) in their study were in the impoverished and working class, despite only making up 66.2% of the general population in their study. The impoverished class had a significantly higher ratio of patients to general population than the working class. These findings indicate a substantial amount of mental illness within the "underclass," raising a discussion of cyclical implications for being impoverished and having a mental illness.

Research by Hollingshead and Stone (1960) further examined the relationship between social class and mental illness. They found that lower class patients were most likely to receive less than average treatment and were often subjugated to the attitudes and values of the middle and upper class. They state, "We believe that value differences between higher status psychiatrists and lower status patients are a serious obstacle in psychotherapy" (p. 15). It is unclear why they made this declaration; whether it was from personal experience or the group mentality of their peers. Regardless, the literature will show that for many this obstacle still exists.

Colson et al. (1986) conducted a study examining staff reactions to difficult hospital patients. They found that when working with a difficult population, described as hostile, violent, or aggressive, that a number of countertransference reactions were common. These reactions increased in intensity based on the behaviors or actions of the patient. Clinicians in their study could be quoted as saying that the clients were "hateful, obnoxious, a special problem, too sick,

help rejecting crocks, treatment failures and threatening" (p. 923). Other common reactions include intense, psychotic-like anxieties, fear, anger, hostility, disdain, and so on (Javier & Herron, 2002; Lion & Pasternak, 1973).

Living in poverty often means there are numerous hardships waiting to be dealt with in many different aspects of daily living. Borg (2005), a community psychologist, suggests that there is an underlying sense of powerlessness, chronic trauma, and conflict that has impacted the community's structure. He elaborates saying, "Residents see themselves as powerless and helpless, and come to rely on ritualistic defenses and routinized interactive patterns" (p. 6). Of course family history, lack of finances, poor health, poor nutrition, and other difficulties contribute to stress and other mental illness.

Unlike the middle or upper classes where there is less need and more active education and protection, the lower classes are not shielded from violence, drugs, and lack of health care (Javier & Herron, 2002). Krupnick & Melnikoff (2012) note minorities are more likely to experience posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and anxiety disorders than non minorities. Additionally, this group is overwhelmingly comprised of single, young women. This poses a generational issue as many children living in poverty are raised by their young mother's alone. The cyclical issue of poverty becomes enhanced when viewing it from this perspective.

Working with trauma survivors who are living in poverty is a difficult and stressful aspect of psychotherapy. In many ways, the therapist works towards becoming that classic "blank slate" in order to take on, work through, or absolve the horrific memories of their clients. Burnout and vicarious traumatization have as a result become common in therapists working with the poor (Pearlman & Caringi, 2009). Wilson and Lindy (1994) state, "Clinical work with

trauma victims brings the clinician close to the "soul" of the pain and injury" (p. 6). This significant countertransference can cause "empathic strain" which leads to a rupture of empathy and a loss of the therapeutic role. In other words, the brevity of the client's trauma becomes so overwhelming that the therapist can no longer contain it and therefore, the relationship is ruptured and empathy is lost.

Each therapeutic relationship is unique, suggesting that the type and intensity of countertransference towards clients will vary greatly. Subtleties and nuances of class background will most likely influence the dynamic. A therapist from a lower class background will be able to ease into a style of language and interaction that someone from an upper class background may have difficulty with (Mitchell & Namenek, 1990; Nelson et al., 2006). Gabbard (2001) notes that some therapists will be a "better fit" than others. The insinuation is that those from lower classes have a natural benefit over those from upper classes when working with the poor.

Doing therapeutic work with the poor is likely going to incite intense emotional reactions from the clinician. There is an intrinsic, a seemingly unchangeable quality, to being poor and having a myriad of both physical and emotional hardships. Further, there is a resistance from many clinicians to work with the poor making the availability for training less likely. Therefore it becomes pertinent to address the specific countertransference reactions when working with this population in order to understand our selves better and move forward in our professional and intrapersonal development.

Hate and fear. Some clinicians may be afraid to say that they have hate and fear towards their clients, believing themselves to be less empathetic or skilled than their professional counterparts (Haldipur, Dewan, & Beal, 1982; Heimann, 1950). Despite this sentiment, Winnicott (1949/1994) relished the idea of hate in the countertransference. Schoenewolf (1990)

notes that Winnicott's idea of hate in the countertransference changed the way psychoanalysis

viewed the subject. Winnicott suggests "However much he loves his patients he cannot avoid

hating them, and fearing them, and the better he knows this the less will hate and fear be the

motive determining what he does to his patients" (p. 350). Winnicott is suggesting that an

acceptance of the hate will allow one to move past the emotion, and focus more on the work,

rather than allowing the hate to impact the work. This becomes important when working with

psychotics who are expecting hate and should not be smothered with love as the patient will

believe it to be a "coincident love-hate" (Schoenewolf, 1990, p. 3).

Hate in the countertransference is possible in any alliance, at any time. When working

with the poor, hate can derive from a number of situations. People who are impoverished have

many obstacles such as lack of transportation, lack of child care, and often have cultural

differences with their therapists (Kim & Cardemil, 2012; Maxfield & Segal, 2008). These

obstacles can result in poor attendance which creates a disconnect in the alliance. It is easy for a

therapist to begin to feel unappreciated and as if they are wasting their time when they are

consistently stood up during a weekly scheduled appointment time (Lorion, 1974; Smith, 2005).

Green (2006) asserts that therapists feel frustration, rage, and despair, especially when

clients seem to be rejecting their help. He describes hate as developmental, something that builds

over time, whereas rage is an "unmet narcissistic need," or the need for recognition and not

getting it. He suggests that therapists too, are in search of a holding environment, and when

clients cannot engage in the holding environment it can illicit rage and anger. Like Winnicott,

Green suggests that hate is a powerful and relative tool. He notes that one needs to hate, and that

it is a useful way to work through negative transference.

Fear in the countertransference can be another common reaction when working with lower class clients. As the underlying hypothesis of this dissertation, the unknown and class biases of working with the poor is what causes the fear. However, there are times when fear is a rational emotion to be experiencing. Fear can happen with any patient, but psychotic clients are able to invoke fear of being attacked, and are able to sense the fear within the therapist (Haldipur, Dewan, & Beal, 1982). As mentioned previously, psychotic clients are able to communicate with clinicians on a clearer unconscious level than other clients making clinicians more susceptible to implicit exchanges.

When it's not simply countertransference. It is important to distinguish countertransference from other emotional reactions common in psychotherapy. Pearlman and Caringi (2009) differentiate between countertransference, vicarious trauma, and burnout. They note that countertransference is how the therapist is involved in the emotional process, similar to other theorists described above. However, they describe vicarious trauma, often confused with countertransference, as negative changes that occur in the therapist over time, across a broad spectrum of trauma work, rather than one individual therapeutic relationship.

Gibbons, Murphy, and Joseph (2011) contend that vicarious traumatization involves countertransference, but on a larger and more involved basis, such as working with a group of traumatized patients. One begins to take on many of their client's trauma histories and exhibits symptoms akin to PTSD. Burnout, while often in simpatico with vicarious traumatization, is the empty space between what the therapist should be doing, and what the therapist can be doing as a result of their work (Pearlman & Caringi, 2009). A belief in wanting to help everyone, always being appreciated, challenging organizations, and a desire to move forward in one's career can

also lead to burnout (Gibbons et al., 2011). All three of these experiences are possible in any psychotherapeutic discipline, but is more common in trauma work.

Whether the countertransference is positive or negative, it is most important to be cognizant that there will always be some form of countertransference. Positive and negative countertransference can cause treatment to come to a halt or allow the therapist to begin to hyperfocus on one emotion. However by working through these emotions great progress can be made. As pointed out in the discussion, lack of acknowledgement or avoidance of these emotions can result in long term emotional setbacks including burnout and vicarious traumatization.

Clinical example. The following is an example to illustrate the use of fear in the countertransference. This author had been working with an adult male in his fifties for approximately three months. Though the work seemed to be progressing, the author had a sense of worry and fear when working with this client. Perhaps it was a fear based on assumptions of working alone with a psychotic adult male, or in conjunction with these assumptions based on previous experiences of working with aggressive males in general. Lion and Pasternak (1973) note that clinicians can project unrealistic feelings onto patients, and that some clinicians need to address those issues more explicitly in supervision.

One day in session, at a different time than usual, the client made threatening statements towards this author, and once he realized that he had invoked fear, he kept the harmful dialogue going. What was later realized as a psychotic break, the client made abstract comparisons between this clinician's life and a box of tissues. His feelings of anger and rage were a result of an interaction he had on the bus before coming to therapy. This dialogue made the clinician worried that the client would not only harm her, but in fact, be capable of harming many others. This is a common fear for clinicians who work with psychotic clients (Lion & Pasternak, 1973).

Lion and Pasternak (1973) describe psychotic patients as invoking anxiety when they describe the urge of wanting to kill someone, perhaps a different anxiety than a neurotic or antisocial client would produce with a similar dialogue. This example was provided to highlight how clients can illicit strong countertransference reactions. This author felt "psychotic-like" symptoms including paranoia, repetition of words, and flat affect. While supervision with three psychologists provided insight into the client's actions as well as the author's own countertransference reactions, therapy did not continue with this clinician and the client was reassigned. Reassignment occurred for two reasons; primarily, this author's fear of working with the client had surpassed any probability of being able to do "good" work with the client. Further, it was unclear if a psychotic male client with violent and sexualizing tendencies should be doing individual therapy with a female therapist.

Hate and fear are powerful emotions that can become focal points in both clinician's and client's lives. An appropriate comparison can be made between these emotions and paranoid thinking. Once one begins on the trajectory of hate and anger, they find more reasons to be angry. There is a desire to feel validated which is often pursued until something unfortunate happens. In the next section, emotions and how we understand emotions will be addressed and then integrated with how we view countertransference.

Emotions

To make an exact pronouncement on how one is feeling is nearly impossible, according to Jerome Kagan. Kagan, a leading psychologist in the imprecise field of emotions, has published hundreds of articles and books on emotion in an effort to enlighten not only professionals of psychology, but society. The focus of his work includes what an emotion is,

emotional blends, and the problem with naming emotions, all of which will be discussed. Countertransference as an emotion or emotion state will also be included in the discussion.

What is emotion? Emotions are akin to a black hole, they cannot be seen, but have enough force and energy to even trap in light. How we define emotion has become a much studied and debated area. Kagan (2007; 2010) insists that there are four linked domains in which scientists have tried to understand and contain emotion; (a) motivation to change and changes in brain state, (b) changes in brain state and feelings with or without involuntary motor responses, (c) presumptions as to how one feels and interpretations that are made (i.e., emotional response after a divorce), and (d) interpreted feelings and behaviors. While these four factors have been proven to influence perceptions of emotion, a definition seems distant.

Like many other constructs emotions can be viewed on a continuum, in this example, valence and salience. Valence is defined as the experience of pleasant to unpleasant (Kagan, 2007). For example, smelling a bed of roses may be pleasant whereas the scent of driving past a horse farm may be unpleasant. Salience is the experience of emotional intensity from low to high (Kagan, 2007). For example, intense joy or moderate fear. The use of language in general has struggled with defining exact words for each occasion, and therefore the need for the emotional continuum presents itself (Kagan, 2007).

Emotional blends. On a bride's wedding day you will likely hear her say, "I'm so happy." But Kagan would hardly believe her. Kagan believes that there are emotional blends or a "combination of states." He notes that many people, including scientists who try and measure emotion, force people to choose from seemingly distinct categories. However, due to the ever changing use of language and the definitions we create, there is virtually no end result in having one word define the valence and salience of an emotion at a specific time.

Kagan (2007) states, "The existence of other equally complex blends highlights the inadequacy of most languages to capture the range of intensity and quality of frequent human experiences. Blends are coherent states, and not additive combinations of elementary states." (Chapter 1, Section 2, para. 11). Kagan presents examples of specific moments such as college graduation where a word does not encapsulate the spectrum of emotions that a person would be feeling in that moment. Rather, he believes that most of our emotions are forced into compact boxes labeled angry, sad, or joyous.

This predicament of the unknown becomes more pronounced in unfamiliar and unexpected events. Kagan (2007) describes an unexpected event as one that a person does not anticipate. An unfamiliar event is one that a person cannot comprehend in terms of already existing experiences. For example, going to a client's home and seeing drugs on the table would be unexpected. Overhearing a violent argument would be both unexpected and unfamiliar, depending on the person who is listening. Unexpected and unfamiliar events are unique to the study of emotion because there will be a heightened and different emotional reaction every time. The mind and body is not prepared to react in a specific way and therefore, emotions are often high in salience.

Anger and anxiety. Anger is one of the most discussed emotions states. Kagan (2010) notes that while there can be no "basic" emotion states, but rather, a socially constructed view on naming emotions, that anger is one of the most readily identified. This is likely because anger presents in different frames such as irritation, malevolence, and rage depending on the context of the situation. Kagan (2007) notes that context is an essential factor in understanding emotion, and that without context, the emotion is seemingly meaningless. He goes on to note that anger can be the result of frustration, mistakes, and a sense of violation. All three of these contexts

present a different form of anger, but, they are all still called anger; proving the problem of labeling emotion with one word, and the need to consider emotional blends.

Anxiety as an emotion is highly tangible. Anxiety can be nervousness, worry, fear, excitement, or perhaps an unidentified sense. Kagan (2007) notes that as psychologists we have a tendency to pathologize emotion; panic disorder, generalized anxiety disorder, social anxiety, and social phobias are all common examples. It is clear that as a group we are trying to understand the origin of our fears and anxiety despite knowing that anxiety is going to look different in each context.

Countertransference is an unconscious, sometimes made conscious, emotional blend. As Kagan (2010; 2007) discusses, the valence, salience, and the context of the situation will produce a blend of emotions that a word may not exist to define. Despite scientists best efforts to understand where emotion comes from exactly, emotion may be something one believes in, rather than what one can see. An aspect of this study is to understand the context, valence, and salience of emotions that clinicians feel in a specific environment. Further, to understand how clinicians react to unexpected and unfamiliar events that often provoke strong countertransference. Blends will hopefully be able to provide a platform for clinicians to gauge their emotional reaction.

Class and its Influence on Psychology and Social Work

Social class is understudied (Blustein et al., 2011). Whether it be an inherent dislike of working with the poor or a sense that helping the poor will be a waste of time; social class is understudied. However, when people do work with the poor, social class is a pivotal piece of the equation for not only members of the lower class, but for the people providing services. The following discussion will focus briefly on the definition of social class, how social class impacts

working with the poor, and the differences and values between social work and psychology as disciplines in regards to working with the poor.

     Social class vs. socioeconomic status. Attempts to pin down an accurate definition for social class have been difficult for many. Social class and socioeconomic status (SES) are often intertwined. However, for the sake of this discussion we will view the two separately, with a focus on social class. Blustein et al. (2011) defines socioeconomic status as a monetary figure, purely based on inherited wealth and income or other objective identifier. They go on to say, "Social class is someone's position in a hierarchy that is determined by income, educational level and occupation…this economic position in conjunction with the individual's awareness creates social class" (p. 215). Thus while one can usually infer socioeconomic status from one's income, social class is a culmination of other cultural factors that often result in an income that relate to class status.

     Hollingshead and Redlich (1958) are pioneers in the study of social class and mental illness. Their monumental book, *Social Class and Mental Illness: A Community Study,* is cited in much of the research that followed, and that has been reviewed in this dissertation. Interestingly, Hollingshead was a professor of Sociology at Yale, while Redlich was a professor of psychiatry at Yale, adding a unique dynamic to this dissertation in terms of academic backgrounds and inherent perspectives associated with the two disciplines. In the introduction of their book they note that Americans choose to "ignore" the idea of social class as it would be un-American to assume that there were such things as classes.

     Despite this un-American sentiment, Hollingshead and Redlich (1958) moved forward to develop the index of social position. The index was developed by interviewing people from over 552 households with a 200 point questionnaire detailing ethnic, religious, economic, educational,

social and residential backgrounds of the participants in the New Haven community (p. 388).

Ultimately, residence, occupation, and education would be the three scales developed from the

questionnaire. These scaled scores were given based on the responses and resulted in placement

of one of five classes. They described the following classes as such:

Class I: Families where wealth was inherited, business leaders and professionals, lived in

the best neighborhoods, college graduates from Ivy League schools, social life included

functions, usually at private clubs.

Class II: Almost all are college graduates, management jobs, families do well on merit

based income, social life revolves around family.

Class III: small proprietors, white collar and sales associates, high school graduates or

associate level degrees, social life is family and attending lodges. Class IV: Semiskilled

factory workers, adults under 35 have graduated high school, social life includes family,

neighborhood, and labor unions.

Class V: semiskilled and unskilled laborers, many have not completed grade school. Live

in tenements. Social life takes place in their homes, streets, or neighborhood social

agencies.

While this research is over 50 years old, if you incorporate inflation, it appears that not much has

changed in terms of how we describe the social classes. Additionally, the percentage of people in

those classes has not changed dramatically either.

    In today's terms, class one on the index of social position represented the elite class

(2.7% of families), class II, upper middle class (9.8%), class III, middle to upper middle class

(18.9), class IV, lower to middle class (48.4%), and class V, lower class (20.2%). As we progress

through our discussion, it is important to understand how social class has been determined

throughout much of the preceding research, therefore, the above description of social class has been provided. Details of what Hollingshead and Redlich found will be provided throughout the following literature review.

　　　　The "Underclass." As implied throughout the dissertation thus far, working with the poor has not been the career objective of many therapists. Therapists worry that time commitments, dependence, emotional strains, and an overall difference in lifestyles will greatly impact the work between a therapist and a lower class client (Karon & Vandenboos, 1977). In the Hollingshead and Redlich (1958) study, it was found that there were a significantly greater percentage of impoverished people with psychotic diagnoses, whereas in the upper classes the primary diagnoses were neurotic.

　　　　Interestingly, the number of psychotic diagnoses v. neurotic diagnoses for class III, middle class, were 291 vs. 237 respectively, which considering that number in terms of 100,000, those numbers are fairly balanced and indicate a more general distribution in the middle class than the upper class or lower class. Neuroses typically seen in classes IV and V were phobic anxiety-reactions and in class V antisocial reactions. Prevalent psychotic diagnoses within classes IV and V were organic psychosis and schizophrenic psychosis. In all categories of psychoses that the lower class endorsed, the number of psychotic diagnoses increased.

　　　　 Early research (Bonner, 1953; Graff, Kenig, & Radoff, 1971) proposed that working with the poor is a purposeless feat and that medications or alternative therapies such as group therapy should be provided to the poor in lieu of insight therapy which was once believed to be ineffective with the impoverished (Hollingshead & Stone, 1960). However, in a study by Goin (1965) it was found that 52% of patients were interested in insight-oriented therapy, 14% wanted medications, and 34% wanted advice. Smith (2005) seconds this notion stating that recent

research has found that impoverished people are just as interested in and benefit from therapy as other people.

The research shows us that despite having numerous hardships, the impoverished class is seeking guidance, insight, and perhaps most bluntly, they are looking for help. As indicated up until this point and what will be illustrated throughout the dissertation, much of the problem can lie with the clinicians and their hesitancy to work with this population. While we like to view ourselves as an evolving and unconditionally positively regarding group, we also know that there are unconscious thoughts that prevent us from doing the best work.

The class of psychology. The term psychologist is privileged to those who strive and attain its denotation (Smith, 2005). There are significant differences between counselor, therapist, life coach, case manager, and social worker. But perhaps the biggest difference to be seen in this dissertation is the class background associated to these individual titles.

As psychologists, we are taught to believe that we can work with anyone. Yet, we all seem to have one diagnosis or area that seems challenging, for example working with criminals or sex offenders. It has been the experience of this author, however, that we are never taught how to work with the poor, instead focusing on factors such as gender, sexuality, culturally diverse backgrounds, and now, a concentration on the aging. Psychologists may feel that they cannot work with the poor because of their own class bias (Smith, 2005). There are two schools of thought concerning problems working with the poor: either they will become overly dependent on the therapist, or they will not stay in therapy long enough to see its benefits (Karon & Vandenboos, 1977). Further, therapists have their own ideas of what constitutes "good therapy" (Kim & Cardemil, 2012).

Research has shown therapists from lower class backgrounds have more lower class clients, and do better work with lower class clients than therapists from upper classes (del Gaudio, Stein, Ansley, & Carpenter, 1975; Mitchell & Atkinson, 1983). However, therapists who do well with lower class clients do just as well with upper class clients (Lorion, 1974; Mitchell & Namenek, 1970). Lorion notes that when working with poor clients, personal characteristics versus years of experience takes precedence. The ability to connect with lower class clients is a connection between both the therapists and client's background, however, the therapist may change their demeanor and speech unconsciously when working with lower class clients (Mitchell & Namenek, 1970).

Discussions as to why psychologists become psychologists have often been focused on their own neuroses rather than class background. The literature shows that the field of psychology originates from middle and upper class white therapists (Liu, Pickett, & Ivey, 2007). Karen and Vandenboos (1977) note, **"**There are, after all, only therapists who come from two kinds of backgrounds: those from lower class backgrounds who were socially upwardly mobile, and those who came from at least upper-middle class backgrounds" (p. 171). As a college education has become more attainable and necessary in the United States, more people from all social classes are attending college. However, doctoral level students are still primarily from middle to upper middle class backgrounds (Graff, Kenig, & Radoff, 1971).

While the search for any research that said explicitly that doctoral level students were from upper class backgrounds proved futile, there were some statistics that offered insight. In a July, 2011, news article by Ryan Brown chronicling the use of financial aid for graduate education based on the Department of Education's most recent report, it was found that there has been a 57% increase in graduate school attendance since 1988. Further, it was found that

master's level students in comparison to doctoral level students did not enroll in their programs full time, whereas 60% of doctoral students, 79% of law students, and 89% of medical students were enrolled full time. Seventy percent of master's level students continued to work full time while in school, whereas only 43% of Ph.D. students, 10% of medical students, and 19% of law students continued to work. While social class may be a factor in certain students not working, doctoral, medical, and law programs are historically rigorous and time consuming and may not afford students the opportunity to work.

The study from the Department of Education also found that Ph.D. students were the least likely group to be dependent on loans, whereas 80% of law students and 82% of medical students took out loans. This is likely due to the insurmountable costs of medical and law programs versus Ph.D. programs. More than 75% of master's level students took out loans, 42% of Ed.D. students, and 20% of students in other fields. In 2010, the APA found that of 289 doctoral level programs in clinical and counseling psychology that 77.30% were women, 22.68% were men; and that 68.48% of all students were Caucasian, 7.01% African American, 10.23% Hispanic, and 7.61% identified as Asian (APA, Annual Report Online, 2010).

In terms of the actual cost of doctoral level psychology programs, the numbers can be staggering. The American Psychological Association notes that most graduate students have an average of $78,360 in student loan debt, noting that 77% of students carry that significant amount of debt. Further, they note that the average debt of a student in a research oriented program is $46,743 and around fifty percent of students in those programs have no debt at all. This line between research and clinically oriented psychologists, often seen as Ph.D. vs. Psy.D., thickens as the APA notes that Psy.D. graduates have significantly more debt than Ph.D.

graduates. They conclude by noting that some Psy.D. students have up to $120,000 in student

loan debt (DeAngelis, 2010).

Based on these studies and reports, it can be speculated that the reason why doctoral level

students are not working during their graduate studies is because they do not have to, or in other

words, have support from family and significant others. Further, the cost of a Ph.D. program is

substantially less than medical or law school and they do not have to take out loans, however, the

Ph.D. program is still more costly than a master's level program. In terms of ethnic backgrounds

within a doctoral level program, it is clear that minorities are not being equally represented.

If a student attends the right program, they can learn the multiple roles available as a

psychologist. However, those focused on becoming therapists know there are many different

routes to practice therapy other than a doctorate in psychology which would be more cost

effective and less time consuming, such as a master's degree in marriage and family therapy or

counseling. Despite these alternative routes there is prestige in becoming a doctor. Bonner

(1953), referring to medical doctors states, "The doctor is held in high esteem for several

reasons. He impresses people by his long educational and technical training—a training in which

he himself takes much pride and which gives him a feeling of self-assurance and competence.

Being highly conscious of his profession and its esteem in the eyes of others, he acquires an

exaggerated dignity and reserve" (p. 302).

"Dignity" and "reserve" however, come with a price that only certain groups can afford.

Thus, it is not surprising that the science of psychotherapy grew out of middle and upper class

white therapists (Graff et al., 1971). A legacy has been developed and Lott (2002, as cited in Liu

et. al, 2007) states, "Some have suggested that all counselors, because of their privileged status,

are potentially classist given the theories used in therapy and the training for many counselors" (p. 197).

In an article by Smith (2005), she reviews and discusses how class influences psychotherapy with the poor. She notes that psychologists are uninterested in working with the poor due to their unexamined class bias. Further, she references Bernice Lott, a leader in class based research, as saying, "Psychology as a field has distanced themselves from the poor" (p.691). Smith notes that a common attitudinal barrier amongst psychologists is that poor people are forced to contend with so many overwhelming daily problems that what they really need is someone to assist them with those barriers.

The discussion thus far has focused on the upper-class background of psychologists. However, it would be unrealistic if a few working class psychologists did not enter the field. In a study by Nelson, Englar-Carlson, Tierney, and Hau (2006), they explored how people from the lower class were able to move into academia or have professorships within a university. They believe that some children who are from lower class backgrounds were able to move up socially due to their performance in education. Additionally, they found that this group were "voracious learners," hard workers, and knew from an early age that they were highly intelligent or gifted. But despite these attributes, this qualitative study found that many of the participants found it difficult to relate to their peers noting that even while they could communicate academically, they felt that there was a noticeable difference in pedigree and upbringing.

A similar feeling of being in an inferior class might be felt by doctoral candidates of clinical psychology during the internship match process. The internship process requires students to rank internship sites where they receive interviews and vice aversely the internship sites rank potential candidates and are then "matched for best fit." While most of us in the field of

psychology are familiar with this process, we know that this can be an uplifting and also

discouraging time for so many applicants. This can be especially true for interns who match at a

site working with the lower class and who are then required to drive to their clients. An

unconscious and often conscious sense of being a lower class intern is common and can

contribute to potential negative countertransference.

The profession of psychology has created some noticeable barriers between itself and the

poor. However, given the current cost of a psychology education, it is plausible that many

psychologists cannot afford to work with the poor because working in a community center pays

very differently than a private practice. Further, as noted above, psychologists who come from

working class backgrounds have an interest in moving up the social class ladder, again

distancing themselves from working with the poor. This general attitude is one of the defining

differences between psychology and social work.

Social work and its working class background. Social work is rooted in the concept of

class. It started as a "moral obligation" to help the poor despite its founders being from the

middle class (Strier, 2009). Poverty and social exclusion are the center focus in social work

(Weiss & Gal, 2007). The goal or mission of social workers was, and still is, to help the

impoverished receive resources and be afforded the best opportunities that are available to them

by working with the poor and underserved (Strier, 2009; Weiss & Gal, 2007). Thus social

workers recognized they were dedicating one's life to a charitable cause, an understanding that

one would never "get rich" off serving the poor.

Many social workers come from working or middle class origins (Ochoa, 2004). In a

study by Huppatz (2009), she found that lower and middle class women were likely to pursue a

caring profession as working class women found there was financial mobility in that line of

work. Most social workers however, described themselves as coming from middle class backgrounds and as Reay (1997, as cited in Huppatz, 2009) states, "To own an identity as "working class" is, among other things, to accept one's social inferiority" (p. 119). In a study by Hodge (2003), he found that 75% of social workers were women and 90% of them came from working or middle class backgrounds.

One of the defining differences between social work and psychology is working with the poor, with a focus on case management, or helping clients with their immediate situation (Ginsburg, 1963). However, many social workers have gravitated towards practicing therapy. Perry (2003) believes that social work, and its mission, are under debate. She notes that many social workers are no longer interested in helping the impoverished but, are interested in the "prestige of private practice." In a study by Perry (2009), she found that neither class, nor any other demographic variables, influenced a student's desire to be a clinician; they all wanted to be clinicians as opposed to social workers. Strier (2009) states, "The current rush of social workers into the role of therapists has disempowered them to deal with welfare cutbacks and global changes" (p. 239). These statements leave many providers wondering who will provide the case management services that are so needed. And who's job is it, anyway?

There is a pretense that those who go into social work will be working with the poor. Ginsburg (1963) notes that the social worker needs to be aware of their class background, not only in terms of how it will impact her interaction with her clients but also to understand how class influenced her choice in becoming a social worker. Further, "One element in the choice of an occupation derives from the need to find one's work the satisfaction of instinctual need in a job that conforms to one's interests and goals and satisfies one's sense of values and purpose" (p.

639). Thus, it would seem that a social worker must understand their own background, like psychologists, as to why they chose this line of work, both consciously and unconsciously.

As social workers are trained to work with the disenfranchised, they view poverty from a structural viewpoint. In other words, poverty is something that people are a part of rather than individual characteristics such as being lazy or unmotivated; a viewpoint that is not always shared within other professions or personal opinions (Weiss & Gal, 2007). It is likely this viewpoint that instills a responsibility on social workers to care for and advocate for their clients (Hodge, 2003). An integrated sense from both the social worker's priorities, motivations, and background that does not place responsibility or blame on the individual, but rather, their contextualized role within society.

As the discussion moves forward, these values and training may be what allow social workers to excel in outreach therapy, and what hold psychologists back from pursuing this line of work. The literature has shown that a great majority of social workers are women coming from working class backgrounds. An interest in practicing therapy rather than case management, or providing immediate help, will likely greatly impact the direction of social work causing both positive and negative results for the people in need of social work services.

Outreach Therapy

Outreach therapy, while having been a possibility for a few decades, is just now starting to take more of a presence in the delivery of therapy. There has been an emergence towards providing mental health services to the poor in a nontraditional way. The community mental health centers that typically provide services to the poor are no longer sufficient as so many people have difficulty reaching those centers. The goal of this section is to provide a clear

description of outreach therapy including its advantages and limitations. The phrase "outreach therapy" will be used interchangeably with "in-home therapy" or "in-home family therapy."

History. It is not entirely clear where outreach therapy has its beginnings. However, it does appear that due to health care reform and budget cuts in the early 1980s or what became known as managed care (Chambliss, Pinto, & McGuigan, 1997), that there was a movement to begin to see clients in their homes. Christenson (1995) cites the passing of Public Law 96-272 as integral to the movement. The law demanded that great efforts be made to keep children in their natural homes in lieu of foster placements. This led to the development of home-based programs which focused on the notion of the family changing in an effort to have the child change. Additionally, Newton (2000) cites a variety of reasons including reaching people who normally would not be seen in traditional settings, as a cost-effective alternative to inpatient care, and to provide a comprehensive treatment option to those with multidimensional needs and issues.

Outreach therapy, or what is commonly found in the literature as "in-home" therapy has become a positive and cost effective way to provide services (Barth et al., 2007a), often to the disadvantaged (Huston & Armstrong, 1999; Mattek, Jorgenson, & Fox, 2010; Zarski, Aponte, Bixenstine, & Cibik, 1992; Zarski, Sand-Pringle, Greenbank & Cibik, 1991). Additionally, the growing field has proved beneficial to some of the most difficult cases (Glebova et al., 2012). McAndrews (1981) notes that the expectations of success for outreach therapy are high, citing the need to provide quality clinical work and to work with other organizations that try to impede therapy.

The delivery. The delivery of services in outreach therapy is one of the defining points of working in this nontraditional setting. In a review of the literature on home-based family therapy, Cortes (2004) defines this type of therapy as the family system being the focus of treatment,

therapeutic functions are delivered in the home rather than the office, and therapy is delivered by

qualified professionals. Therapists drive to their client's homes and try to provide a quality of

therapy to their clients that they would provide in the office. However, working in these settings

has proved that there can be significant differences between the two environments and that

training needs to be specific to the task (Zarski et al., 1991).

In-home therapy is typically brief in the number of sessions, but depending on the setting

(and insurance company) therapists will make appointments as often as two times a week for up

to four hours (McWey, 2008). Newton (2000) notes that intensive or once a week appointments

will make vast improvements compared to the once a month visits that were typically seen in

some social work settings. Therapy usually takes place in a quiet setting in the home; however,

as will be pointed out later, this can be a challenge.

The therapists. Therapists who conduct in-home therapy are typically master's level

clinicians, with degrees either in social work, psychology, or counseling (Clark, Zalis, & Sacco,

1982; Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012). Further, this work is often

carried out by those with little clinical training and by unlicensed providers (Newton, 2000).

Outreach therapists should recognize that they will not be "getting rich" by providing outreach

therapy. To elaborate, it has been postulated that outreach therapists have no room for

advancement or salary increases (Clark et al., 1982). As fee for service clinicians, it is difficult to

find other avenues for advancement unless one has moved into an administrative position, which

is often held for the clinician with years of experience and higher levels of education.

In their original book on outreach therapy, Clark et al., (1982) describe the personality

traits needed in an outreach therapist in order to manage the stress of working in the field. They

go on to describe seven necessary components of the outreach therapist, (a) a capacity to cope

with high levels of stress, (b) patience, (c) a minimal need for emotional support (as the clinician

works alone and is not allowed to discuss cases due to confidentiality), (d) to be resourceful (by

reading and attending workshops even at one's own expense), (e) be capable and accepting of

failure (as failure will occur every day), (f) to be narcissistic (to maintain the strength of one's

ego), and (g) to obtain a missing characteristic that is undefined but apparent in most outreach

clinicians. They note that education plays no significant role in the skill of the outreach clinician

and that the experience learned while providing outreach therapy will make the clinician the

"expert" on matters of family dynamics and therapy.

The aforementioned description shows that Clark et al. are forthright regarding the more

negative aspects of the job. They note that even though they have warned the therapists of the

harsh demands of the job, there is really no way to prepare for the stress. They state "One

individual decompensated to the point of becoming actively schizophrenic. Several became

depressed" (p. 112). However, they do acknowledge some of the positive aspects including the

opportunity for self-development and expertise.

Advantages. Perhaps the number one advantage of outreach therapy is accessibility for

the clients. The literature suggests that the biggest reason for clients not being able to make or

keep their appointments is lack of transportation (Cortes, 2004; Mattek, Jorgenson, & Fox, 2010;

Mattek, Huston, & Armstrong, 1999; Maxfield & Segal, 2008). Thus, being able to bring

therapy to the client's has been the most obvious advantage. However, other advantages such as

reducing a stigma (Boyd-Franklin & Hafer Bry, 2000; Maxfield & Segal, 2008) and making the

client feel more comfortable in their own home (Cortes, 2004) have been recognized as pivotal

changes for positive outcome in providing therapy to an underserved population.

Outreach therapy has been shown to have positive and significant results. In a study by Barth et al., (2007b), it was found that in-home therapy produced better results than residential treatment facilities. The study noted that the consistent treatment in the client's home provided less restrictions and more opportunity to grow than a residential treatment program. Further, they noted that residential treatment programs lacked the appropriate level of after care, or skills building while the client was placed in residential treatment.

When utilized with children at risk, outreach therapy has been shown to be very effective. The in vivo nature of working in the home allows the therapist to teach the parents efficacious ways to modify their children's behavior (McWey, 2008). Further, therapists working in the home have noted that they are able to understand the family dynamics and have a unique perspective on the issues in the home (Christenson, 1995). Anecdotally, there are many clinicians who second this idea, stating "there are things that I learned about my clients that I would never have known if I had not been in their homes."

The client's appreciation for therapy is also increased when a therapist comes to the home. Clients report that in-home therapy allows them a more comfortable place to talk, reduces the need for a babysitter, allows other family members to participate in session, and provided a "friend" like figure in the home (Whittington, 1985). Many clients have noted that they are lonely throughout the day and having someone stop by felt like a "visitor" (Maxfield & Segal, 2008). McWey (2008) conducted a qualitative study and found that many of her participants felt similarly noting, "having someone available to me was very helpful" (p. 52). Despite the client's views on the benefits of in-home therapy, there are like any modality, drawbacks to working in the home.

Disadvantages. There are some inherent and even blatant issues when providing therapy in the home. Boundary violations, confidentiality, and therapist discomfort are at the top of the list. Knapp and Slattery (2004) note that psychologists working in these settings will face a variety of challenges and that maintaining ethical boundaries are a major concern. Further, they go on to say, "It could be argued that the very act of delivering services within the client's homes is a boundary crossing" (p. 554). While this view is not widespread throughout the literature, there are related concerns.

Confidentiality becomes a controversial subject when working in a client's home. With many people walking in and out of rooms, or perhaps even listening in the next room, the therapist can become uncertain in how to deal with these challenges (Mattek et al., 2010). Safety can become an issue as Christenson (1995) found that clinicians would be worried about their safety in the home as well as for their clients. She reported that some of the clinicians in the study worried about their client's safety when they left the home, as a number of emotions had arisen during the session. They noted that this would not be the case if the session had been conducted in the office as the client would not be vulnerable to other people listening to the conversation or commenting on the emotional state of the client after a session.

Further, the role of the therapist can become blurred for both the provider and the client. Being in the client's home offers a more familiar tone and thus, a therapist can become more engaged in social or small talk. Boyd-Franklin and Hafer-Bry (2000) suggest however, that clients may be more comfortable with small talk in the beginning of the therapeutic relationship. They note that some clinicians feel compelled to "dive in" whereas a slower pace may be warranted. However, it would be easy for a therapeutic relationship to become lost in that type of

dialogue and the client may feel hesitant to engage in more in depth issues after a relationship

that was based in "small talk."

McWey (2008) noted that some clients enjoyed the disclosures of the therapist making

them feel validated. This example illustrates the blurred boundaries that are intangible in doing

outreach therapy. Perhaps the clinician was right in disclosing, but it is also possible that the

clinician was in an unfamiliar environment and was not as "on guard" as they would normally be

in a clinic setting? This could also be a result of the unstructured environment and the level of

ego strength that is necessary to work in that setting (Lawson & Foster, 2005). This implies that

the amount of stress caused by working in these settings is pushing the limits of the clinician's

training and resources.

Lack of training has been a frequently mentioned point in the literature regarding in-

home therapy. As previously mentioned, in-home therapy is a developing and growing field, one

that is being carried out by inexperienced or untrained master's level clinicians (Zarski et al.,

1991). This is not a limitation of the clinician's ability to practice, but rather a reference point for

the need for more rigorous training regarding outreach therapy. Clinicians practicing outreach

therapy have noted that the training they have received thus far has focused on work in a clinic

setting (Mattek et al., 2010). Cortes (2004) and Christenson (1995) note that training programs

in addition to not educating clinicians on in-home therapy, also do not train clinicians in working

with both children and adults, often a key component in working in the home.

In a review of the literature Mattek et al. (2010) found that there were four common

themes regarding the training of therapists doing in-home therapy: (a) doing in-home-therapy

was particularly challenging and demanding, (b) clinicians felt ineffective and unprepared to do

in-home therapy, (c) rigorous training was recommended, and (d) supervision was necessary

when practicing in-home therapy. Of course a recommendation for specialized training as well as intensive and focused supervision was given. Zarski et al. (1991) also recommend that supervision be a key component in the training of clinicians in this field. They note that supervising this type of work requires a specialized and focused knowledge base.

 Impact on clinicians. Clinicians working in this environment can feel significant emotional strain, and understandably so. In conjunction with traveling to client's homes, being in uncomfortable situations, worrying about safety and confidentiality, and an overall lack of training, it is not the most desirable setting. Cortes (2004) notes that being in the home with generations of problems may cause the clinician to "prematurely burnout." Many academics have noted that clinicians feel compelled to do "whatever it takes" (Sprengle, 2000). This can lead to ethical boundary crossings, blurred roles, and a drain on the clinician's energy.

 Feeling safe and at least moderately comfortable in the client's home also greatly impacts the clinicians and the therapy they are providing. Glebova et al. (2012) note that working with the poor in their homes is a unique experience that many individuals are not prepared for. Feeling safe will impact the alliance and the type of work that is done resulting in an obvious sense of discomfort in the therapists.

 In a study by Thomas, Snyder, and McCollum (1999) they found that interns working in this environment had a heightened sense of anxiety, a decrease in confidence, and a difficult time in transferring or disassembling their views on how to deliver therapy in the home. This sense of having to change one's therapeutic style and standards to meet the needs of in-home therapy can be highly disconcerting to a therapist of conviction. Further, these changes in style can cause the clinician to feel as though they are doing something wrong, causing increased stress and anxiety.

Issues such as smoking, pets, and cleanliness can also impact the clinician. As the clinicians are in the client's home, many find it difficult to bring up issues such as unruly pets jumping on you. One clinician who had previously allowed a client to smoke during sessions found herself in a difficult situation when she learned that she was pregnant. The clinician did not want to disclose that she was pregnant, but had trouble finding a reason to ask the client to stop smoking. These added stressors are unique to working in the home and can impact the clinician on both a physical and mental health level.

Outreach therapy is a new and growing field that has many advantages in helping reach an underserved population. Conversely, there are disadvantages that may make outreach therapy not for all clinicians. The dedication of time, resources, and patience can easily explain why so many clinicians decide to pursue other career paths. This is consistent with thoughts that the level of training for outreach clinicians needs to increase and become more specialized. Outreach therapy requires a unique person with a dedicated mindset to learn a completely different style of providing therapy. Supervision needs to focus on how this type of work impacts the clinician and ways to improve this growing field.

Chapter 3

Methodology

To demonstrate the relationship between class background and its influence on the countertransference of master's and doctoral level clinicians, quantitative research was carried out. The methodology section will highlight the hypotheses, participants and setting of the study, the types of methods that were utilized to measure data, how the data was collected and recorded, and the specific statistical analyses that were conducted in order to interpret the data (Locke, 2007). Appropriate appendices including the informed consent (See Appendix A), demographic questionnaire (See Appendix B), and the complete measures are included in the appendix section.

Hypotheses

The main hypothesis of this study is that clinicians who come from lower or working class backgrounds will have less intense or different countertransference towards their clients in outreach therapy than clinicians from middle or upper class backgrounds. Further, it is estimated that there will be a relationship between class background, education level and academic discipline, as well as the type or emotional blend and intensity of countertransference.

Participants and Setting

Participants in the study were master's level and doctoral level clinicians who have practiced outreach therapy. The doctoral level clinicians included predoctoral interns, postdoctoral fellows, and other doctoral level clinicians who are currently or who have worked in outreach therapy. The clinicians were recruited from two separate offices in urban locations in New England. The two offices are part of one agency that is a small, for profit agency funded through federal and state grants.

Measures

To measure social class and countertransference is a challenging task. The literature has found that measuring social class cannot be formulaic and trying to pinpoint an emotion can be a rigorous task. Therefore the author has developed two measures; one to measure social class and the other to measure countertransference. The following section will focus on the development of these two measures and how they were implemented.

Measuring social class. Rossiter (2012) suggests that there is a need for a new measure of social class. While his interest in social class is based on consumer behaviors rather than sociological ideas, Rossiter corroborates the idea that social class is primarily based on occupational status, education level, and income level. He further contends that there are six different social classes, the upper-upper, lower-upper, upper-middle, lower-middle, upper-lower, and lower-lower. However, he does further suggest that there is another class known as the X class. The X class is based on how people want to live, rather than how they are predicted to live based on their social class. These people are often considered "people of the world" and base much of their lives on receiving a broad education.

In an effort to develop a better measure of social class, Rossiter (2012) formulated the Social Class Values Index (SCVI), a 34-item measure that included the new X class in addition to the six other primary class categories. Some sample items are: Can speak or understand several languages (X class); Inherited most of my income (upper-upper class); My job requires me to wear durable clothes or a uniform (upper-lower class). For the purpose of this study, some of the ideas or statements from the SCVI will be combined with the more traditional rating of social class in an effort to reach a new generation where social class has begun to change.

To measure the participants' social class, descriptive characteristics portraying four different social classes were provided (See Appendix C). The literature typically breaks social class into five or six groups; however, given the small sample size of this study the principal investigator has elected to develop four social classes that all participants could fit in. The social class descriptions with their appropriate social class group are listed below:

1. Your parents are both college educated, one or both of them may have graduate degrees. When growing up, you went on family vacations annually. You and/or your parents drive a luxury vehicle. You did not need to take out student loans for your degree. Your parents are able to help you out financially. Your parents believed that you should pursue a graduate degree in whatever field made you happy. You spend your spare time attending events, reading, and furthering your knowledge base.

(Upper class to wealthy)

2. One of your parents attended college, they may have graduated. You often read newspapers, or watch a national news show. You have concerns regarding the welfare of others across the world. You and your family go out to eat frequently, at nice restaurants. You did not have to work while you were receiving your education. If you did work, it was part-time or perhaps doing skill related jobs such as teaching tennis or being a lifeguard. Your parents believed that you should graduate from college and were thrilled that you pursued a graduate degree. You spend your time with friends, reading, and engaging in physical activities, such as working out.

(Middle class to upper middle class)

3. Your parents did not attend college, but they did graduate high school. They may have specific trade professions, such as a plumber or electrician. The neighborhood you grew

up could be categorized as decent, not great, but not horrible either. You started working at a young age in order to buy things that you may have wanted. You went out to eat on special occasions, but primarily your parents cooked at home. You went on a few vacations with your family. Your parents believed that you would have a better life than them if you went to college, however, they did not save money for you to attend. You spend your time watching television, going to the movies, or going out to eat at American restaurants such as Chili's.

(Working class to middle class)

4. Your parents may or may not have graduated high school. Your parents have jobs may have included waitressing, retail, or other jobs that require less training or specific skill sets. There may have been times when your parents were unemployed. You began working at a young age in order to buy things you needed, or to help the family out. This may include working in a family business. Your parents are proud you went to college, but would have been just as happy if you had a steady job with decent income. You spend your time watching reality shows, at home with the family, and frequently eat fast food.

(Lower class to working class)

The participant chose a vignette that sounded *most* like them. The actual form the participants filled out had the vignettes scattered as to detract from any perceived order. The vignettes are based on Rossiter's (2012) research as well as Hollingshead and Redlich original research on social class. Recent research has shown that there is a movement for social class to be redefined as the means to which people can attain their social class standing have moved beyond inherited wealth or what one's parents did as an occupation (Weeden & Grusky, 2005). Thus, the descriptions have some modern qualifiers.

Measuring negative countertransference. The second measure that was developed for this study is a series of 10 vignettes describing various situations with the potential for negative countertransference (See Appendix D). The participant chose between three emotional blends: anger/irritation, fear/anxiety, and ambivalence/indifference. The participants were guided to choose only one of the emotional blends in order to limit the potential for participants to express all potential emotions. In other words, the most predominant blend is the one that was chosen. These three emotional blends were chosen as the three most likely blends that a clinician would experience while doing outreach therapy. This judgment is based on the principal investigator's personal experience practicing outreach therapy and based on conversations with peers who have practiced outreach therapy. Further, as mentioned in the literature review, burnout and vicarious traumatization are common with clinicians working in impoverished areas. Therefore, ambivalence and indifference were included as an emotional blend.

The participants then rated the intensity of these countertransference reactions on a likert scale (1 to 5), one being least intense, three, moderately intense, and five, extremely intense. Intensity is to be defined as the level or severity of emotion that the participants feel. For example, one would likely be less fearful of a sharp pencil on a table, but extremely fearful of a knife. The following vignettes are direct examples from the countertransference measure that the participants will be asked to rank. In an effort to be concise, the blends and intensity scale is only listed after the first vignette.

1. It is your fourth session with a new client in their home. You arrive at the front door and ring the door bell. While you can't see your client, you can hear them moving around inside. You wait patiently, and even call the client on your personal cell phone. While you can hear the phone ring, no one answers. You get back in your car and leave.

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference

Intensity: 1   2   3   4   5

2. You are at your client's home and in the middle of the session, her teenage daughter joins

   your session at the kitchen table. The seventeen year old begins talking about her

   problems and is dominating the session. Despite your best efforts to refer the client's

   daughter to her own therapist (who she decided she no longer wanted to see), the teenager

   insists on sitting at the table. The parent joins in on the conversation. This has become a

   recurring issue.

3. As you arrive for your first session and knock on the door, you hear a large dog barking

   and trying to get towards the door. Your client puts the dog in the crate and tells you not

   to worry about it. Months later, the dog is in the basement, barking loudly at your arrival.

   Your client says, "He's going to come and get you, ha-ha."

4. You are working with your adult client when their small child interrupts the session.

   Initially, the parent asks the child to leave, sternly but calmly. However, when the child

   interrupts the session again, your client begins swearing at the child and yelling. The

   child becomes visibly upset.

5. You are working with your client, an eight year old girl. Your co-worker, Kelly, sees her

   11 year old sister, Tina. One session, your client says to you, "When are we going to do

   cool stuff like Tina does with Kelly?"

6. You've been *working* with a client for three months. However, every two weeks the

   client calls and says there is an emergency, or someone is sick, or that they missed the

   bus. You genuinely like this client. Despite this sentiment, you have decided to issue an

   attendance contract. Your client starts attending regularly for three weeks, but then on the

fourth week does not show. When you call to address this issue, they report that they did not have any money for the bus and they no longer have any minutes on their phone.

7. Your long standing client calls you in crisis. They tell you that their home has been broken into and that their boyfriend has been involved in some neighborhood criminal activity or violence. They report that they are worried and don't know how much longer they can take living in their home. You ask the client if they believe it is safe for you to continue seeing them in the home and they say yes.

8. You and a few other co-workers are treating four different members of a family. You learn that one of the clinician's has been attacked by the family cat, Twix. The clinician has been taken to the hospital to receive a round of rabies shots. Meanwhile, the family members are saying that the cat has been kicked out of the home, and is wandering the streets. However, they cannot provide proof. They do not believe that any of the clinicians are at risk, and would like the clinician's to return to the home.

9. You are working in a home where you see both of the children and are doing a joint session with them. While you are playing, you hear the mother's boyfriend come home, intoxicated. He and the mother begin to engage in a fight, and suddenly, you hear a large thud to the ground. You know from previous talks that this happens often, and that the kids are never harmed.

10. You are working with your adult male client who works "under the table" for a cleaning company. Despite having minimal bills, and an income, your client would like to sign up for federal and state benefits such as welfare, health insurance, and food stamps. Your client would not be eligible for disability. Your client goes on to say, "Hey, why shouldn't I get mine?"

In these vignettes, the three emotional blends are often all a possibility. A clinician could become angered or irritated by the client's apparent disregard for their therapy session. Further, a clinician could become fearful or anxious that something underlying is occurring with their client and perhaps this is why the client continually misses sessions. Finally, a clinician may have little feeling at all towards the exchange, often a result of experiencing many situations like this. These vignettes were developed by the author and some are based on actual events that occurred. Any possible identifying information has been changed to protect people (and pets) that were involved. Participants were informed that the study should take no more than ten minutes to complete.

As the literature has shown, the type of countertransference someone feels can be both a highly unique experience and also applicable to many clinicians and their specific patient population. Therefore, the second rating, intensity, will provide a more in depth view of the participants overall countertransference. For example, the results may show that while half of the clinicians have a feeling of being angry and irritated, or ambivalent and indifferent, that all of them found these feelings to be moderately intense.

Reliability and validity. As the measures were both developed by the principal investigator for this pilot study, no studies or statistical measures have occurred to test the reliability and validity of the measures. Further replications of this study would be needed in order to validate these measures and will be included in the recommendations.

Data Collection

Data collection occurred in two ways. First, the principal investigator attended a staff meeting at the office where the clinicians work in order to explain the survey and its purpose in person as well as to collect data immediately (See Appendices E and F for gatekeeper letters).

The second approach, online data collection, was for participants that could only be reached electronically (including participants that work in an office that is far from the principal investigator), or for those who chose that option. The informed consent form, demographic background questionnaire, class background descriptions, as well as the vignettes were made accessible via *Psychdata.com*. Minor language changes were made to the online version of the measures. For example, instead of the informed consent stating that by signing the form they agree to participate, the form was signed electronically by clicking on agreeing to participate. The online option was also made available as some participants only had an electronic option as they were no longer working for the agency. These people were contacted via email with a link to the study.

Data Analysis

The participants were divided into two groups based on level of education, master's and doctoral level. Between those two groups, class background was determined based on the participants' selection on the class background descriptions. Social class was coded into a numerical value: 1: upper class to wealthy, 2: middle to upper class, 3: working to middle class, and 4: lower to working class.

To determine a relationship between social class and education level, a chi-square analysis was conducted. Chi-square analyses were conducted between education levels and negative countertransference (emotional blends) as well as social class and negative countertransference. Frequencies are completed for the emotional blends and intensity for each vignette. Descriptive statistics are presented to examine social class and the intensity of countertransference experienced by participants. T-tests are conducted to determine if there are any significant differences between education level and emotional blends.

Chapter 4

Results

Participant Demographics

Demographic data of the participants are presented in Table 1. The sample group consisted of 30 current and former outreach clinicians. Three people (10%) of the participants did not fully complete the surveys and were excluded from the data analyses ($N = 27$). The age ranges of participants were well distributed. Surprisingly, the 50+ group had the largest number of responders (26%). The second largest group was the 26-30 age range (19%). The majority of responders were Caucasian (70%) and women (74%).

Hypothesis Question One

Is there a relationship between education level and social class amongst outreach clinicians?

A chi-square correlation could not be conducted to determine a relationship between education level and social class background due to insufficient frequencies (88%) of the factors. It is worth noting that none of the participants in the doctoral level group identified as lower to working class. Table 2 shows the counts for education level and social class.

Hypothesis Question Two

What are the relationships between education level, social class, and overall negative countertransference reactions?

Two chi-square analyses were conducted to determine if there was a relationship between education level and negative countertransference reactions, and social class and negative countertransference reactions. Both analyses did not produce significant results regarding any of the vignettes.

Table 1

Participant Demographics.

	N	%
Age		
20-25	3	11.1
26-30	5	18.5
31-35	4	14.8
36-40	4	14.8
41-45	2	7.4
46-50	2	7.4
50+	7	25.9
Gender		
Male	7	25.9
Female	20	74.1
Ethnicity		
Caucasian	19	70.4
African American	4	14.8
Asian	1	3.7
Multiethnic	2	7.4
Pacific Islander	1	3.7

Frequencies for each emotional blend were completed for all vignettes. The following figures display the percentages of each emotional blend for the corresponding vignette. Box-and-whisker plots will directly follow each pie chart to show the range of intensity for each emotional blend on each vignette as well as point out any outliers.
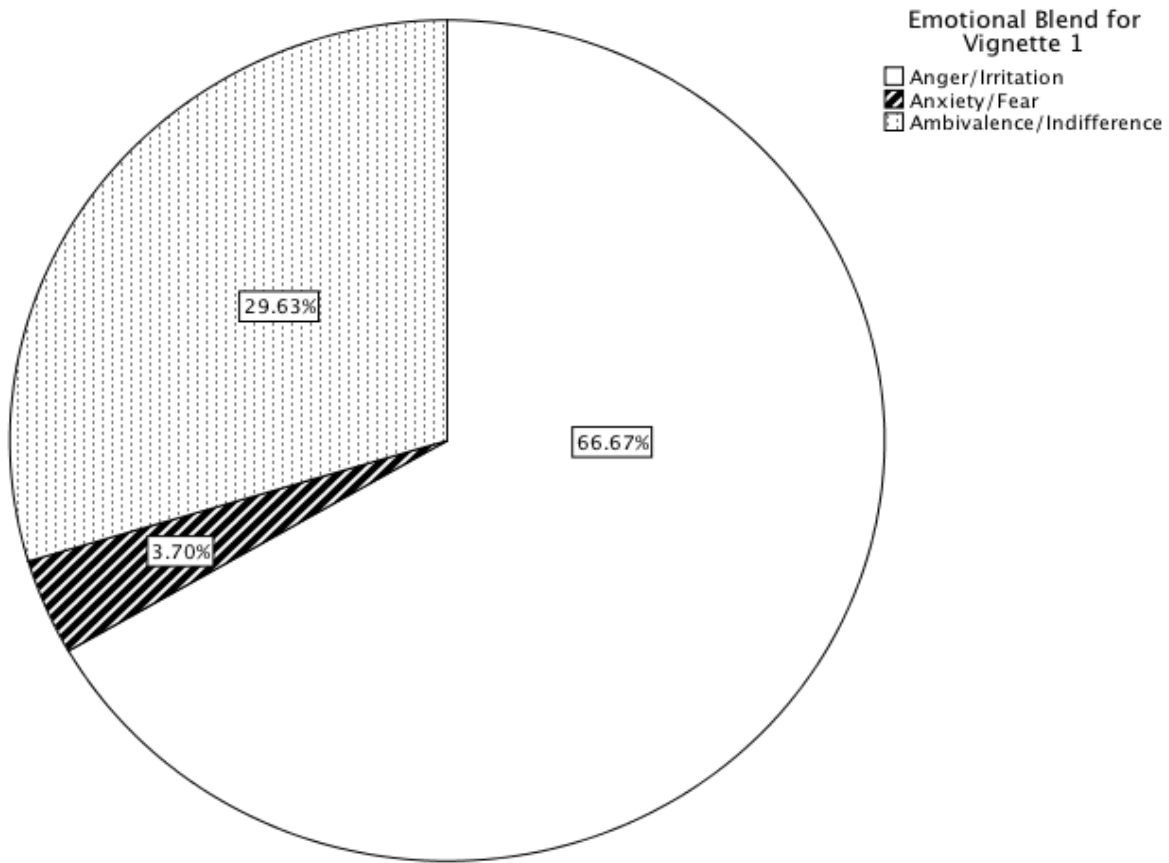
Figure 1. Emotional blend percentages for Vignette 1: It is your fourth session with a new client in their home. You arrive at the front door and ring the door bell. While you can't see your client, you can hear them moving around inside. You wait patiently, and even call the client on your personal cell phone. While you can hear the phone ring, no one answers. You get back in your car and leave.

Figure 2. Intensity levels for each emotional blend on Vignette 1: It is your fourth session with a new client in their home. You arrive at the front door and ring the door bell. While you can't see your client, you can hear them moving around inside. You wait patiently, and even call the client on your personal cell phone. While you can hear the phone ring, no one answers. You get back in your car and leave.
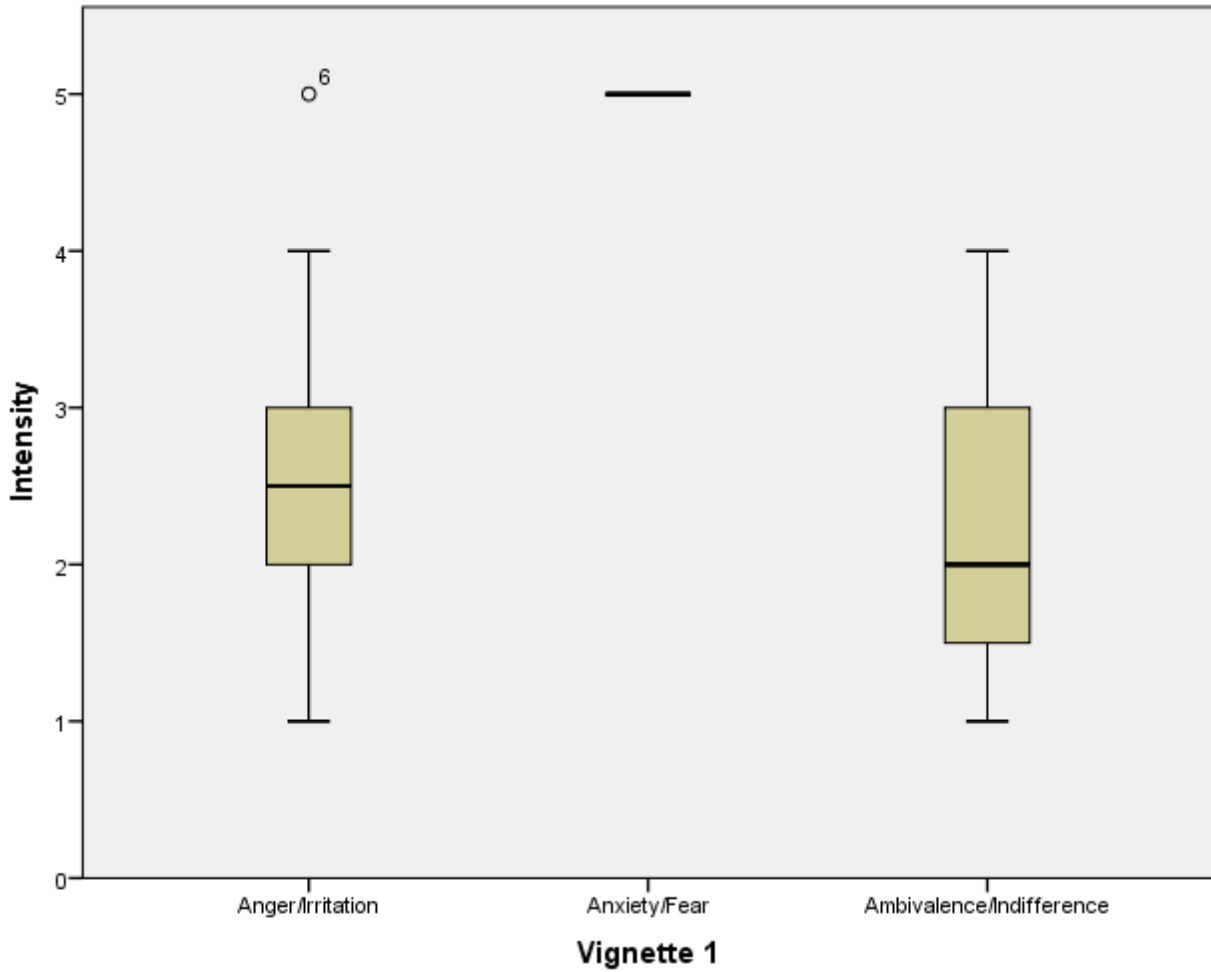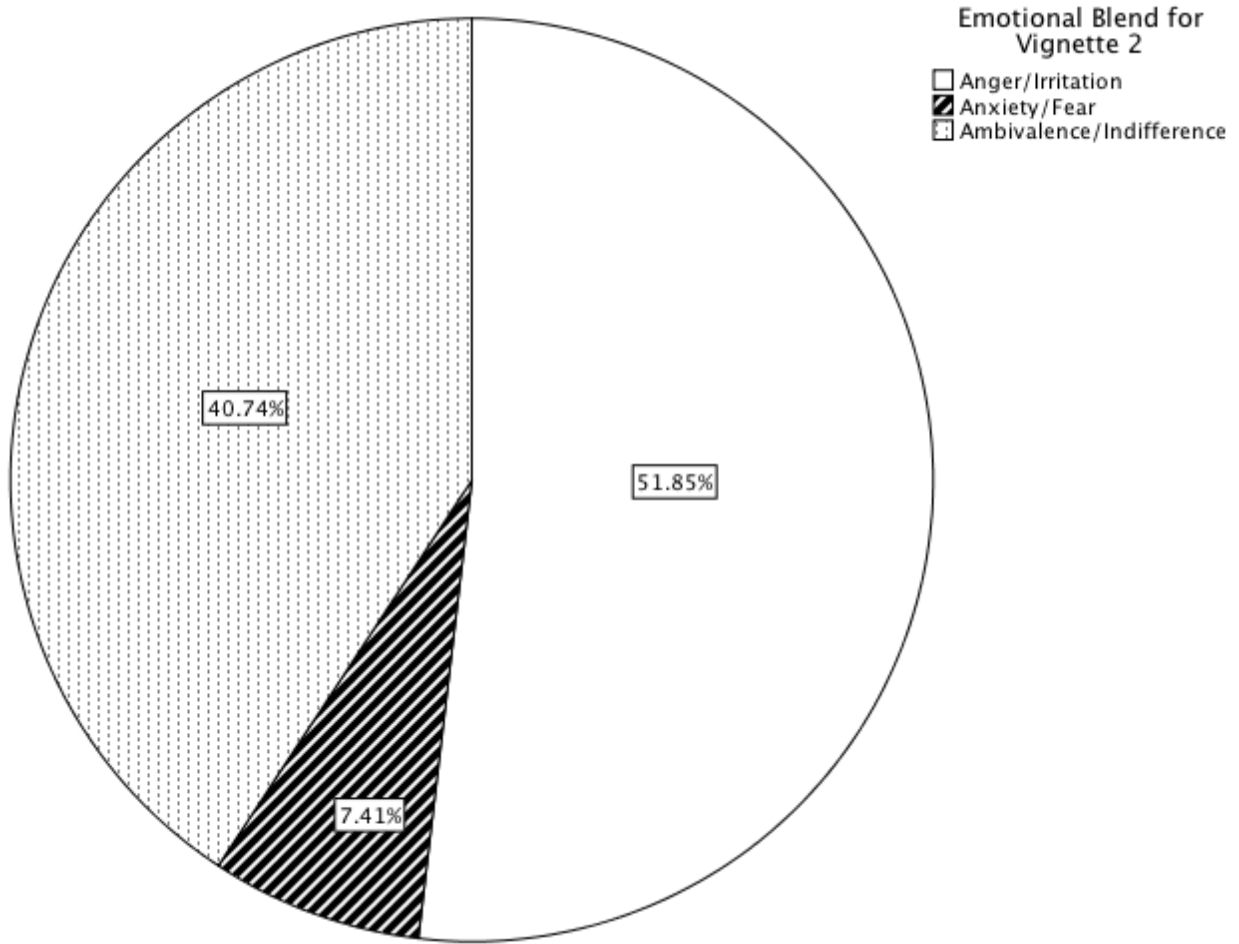
Figure 3. Emotional blend percentages for Vignette 2: You are at your client's home and in the middle of the session, her teenage daughter joins your session at the kitchen table. The seventeen year old begins talking about her problems and is dominating the session. Despite your best efforts to refer the client's daughter to her own therapist (who she decided she no longer wanted to see), the teenager insists on sitting at the table. The parent joins in on the conversation. This has become a recurring issue.

Figure 4. Intensity levels for each emotional blend on Vignette 2: You are at your client's home and in the middle of the session, her teenage daughter joins your session at the kitchen table. The seventeen year old begins talking about her problems and is dominating the session. Despite your best efforts to refer the client's daughter to her own therapist (who she decided she no longer wanted to see), the teenager insists on sitting at the table. The parent joins in on the conversation. This has become a recurring issue.
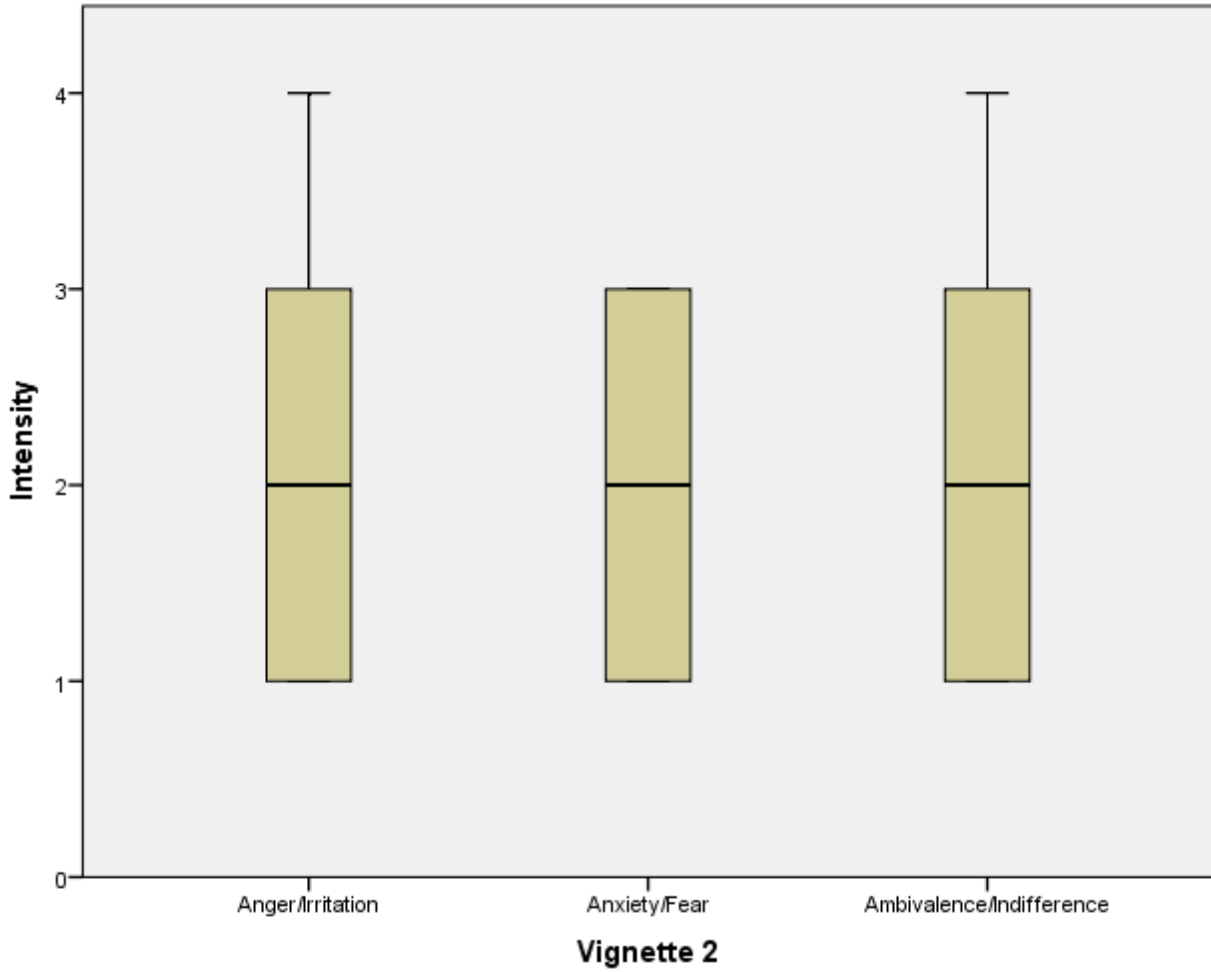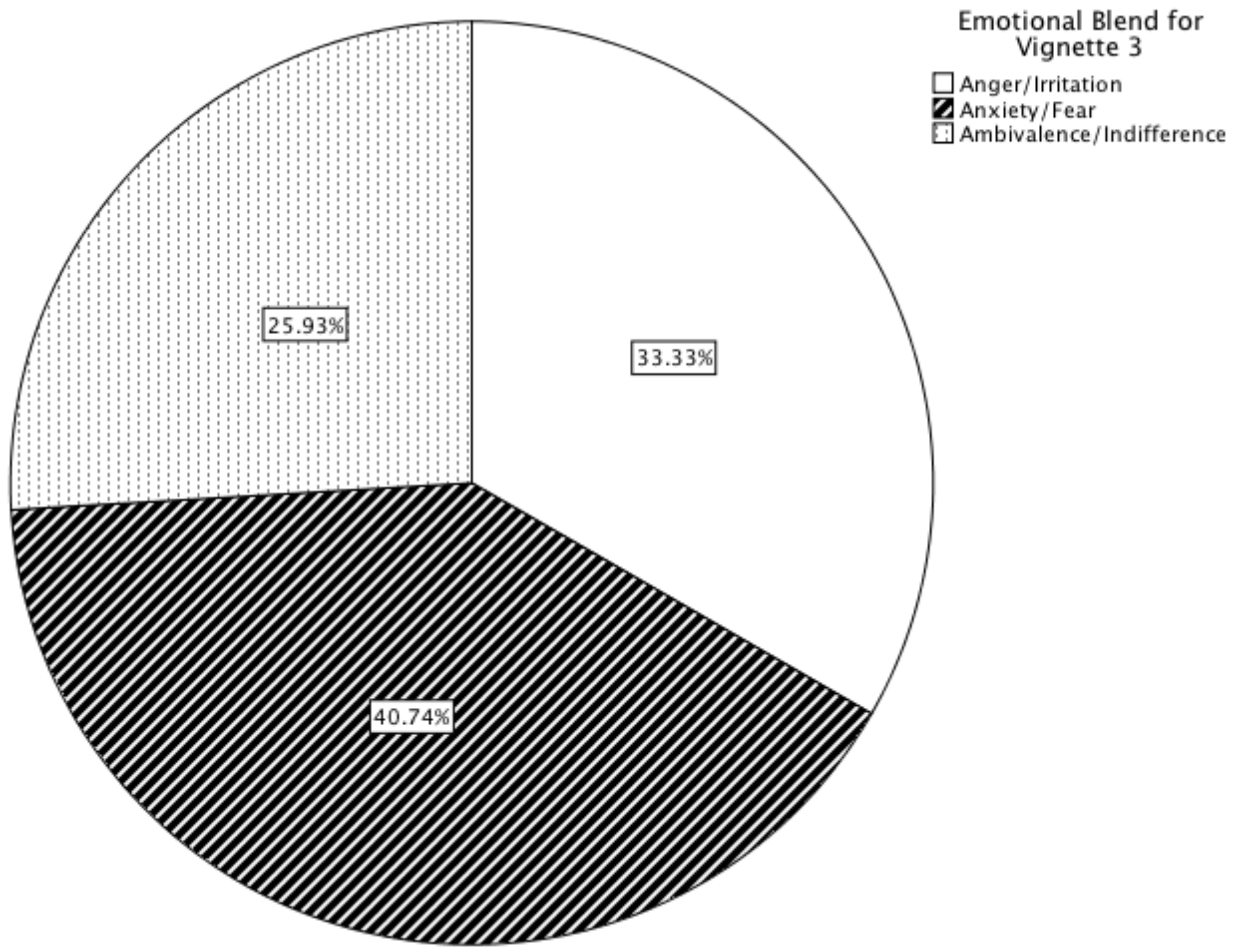
Figure 5. Emotional blend percentages for Vignette 3: As you arrive for your first session and knock on the door, you hear a large dog barking and trying to get towards the door. Your client puts the dog in the crate and tells you not to worry about it. Months later, the dog is in the basement, barking loudly at your arrival. Your client says, "He's going to come and get you, ha-ha."
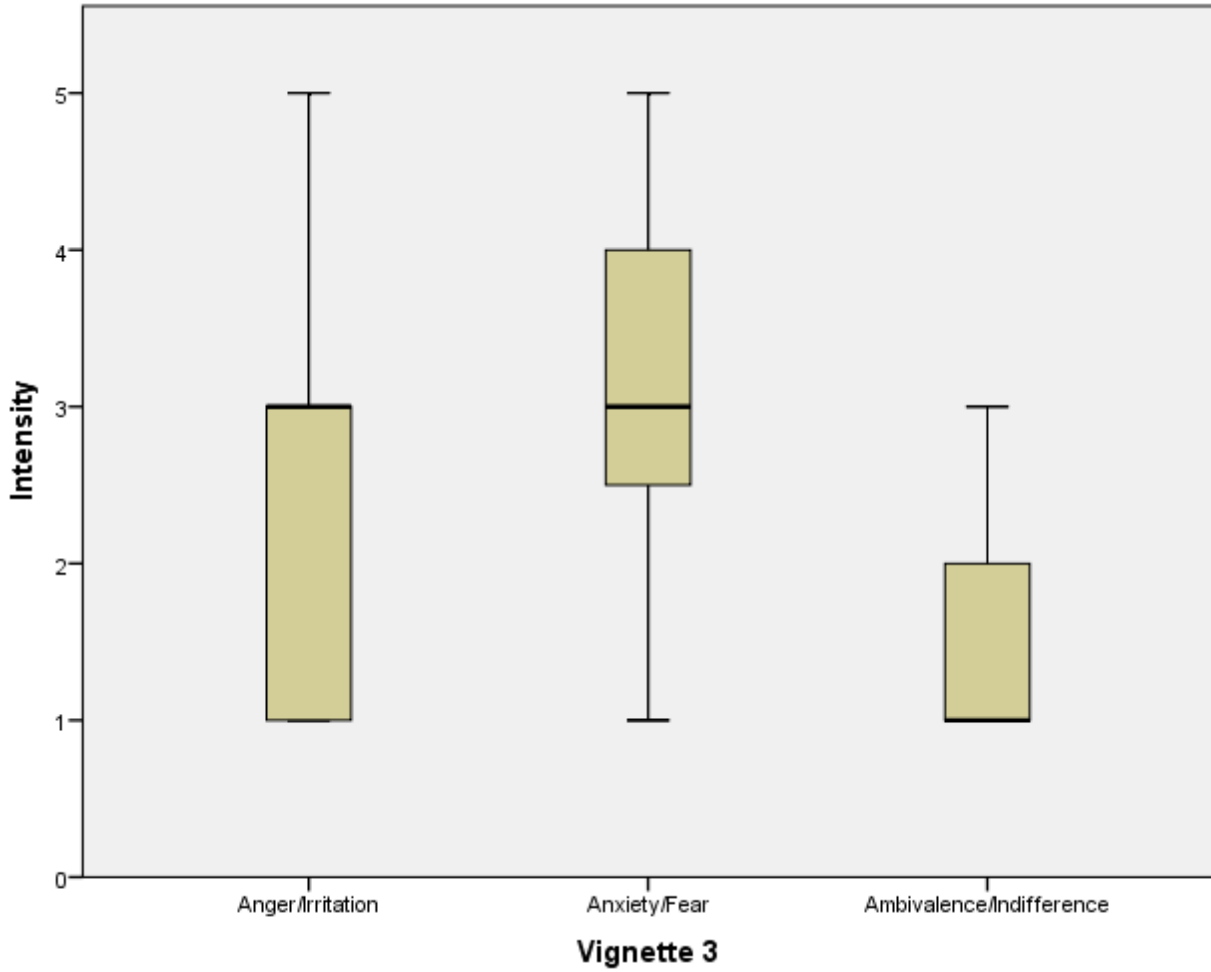
Figure 6. Intensity for each emotional blend for Vignette 3: As you arrive for your first session and knock on the door, you hear a large dog barking and trying to get towards the door. Your client puts the dog in the crate and tells you not to worry about it. Months later, the dog is in the basement, barking loudly at your arrival. Your client says, "He's going to come and get you, ha-ha."
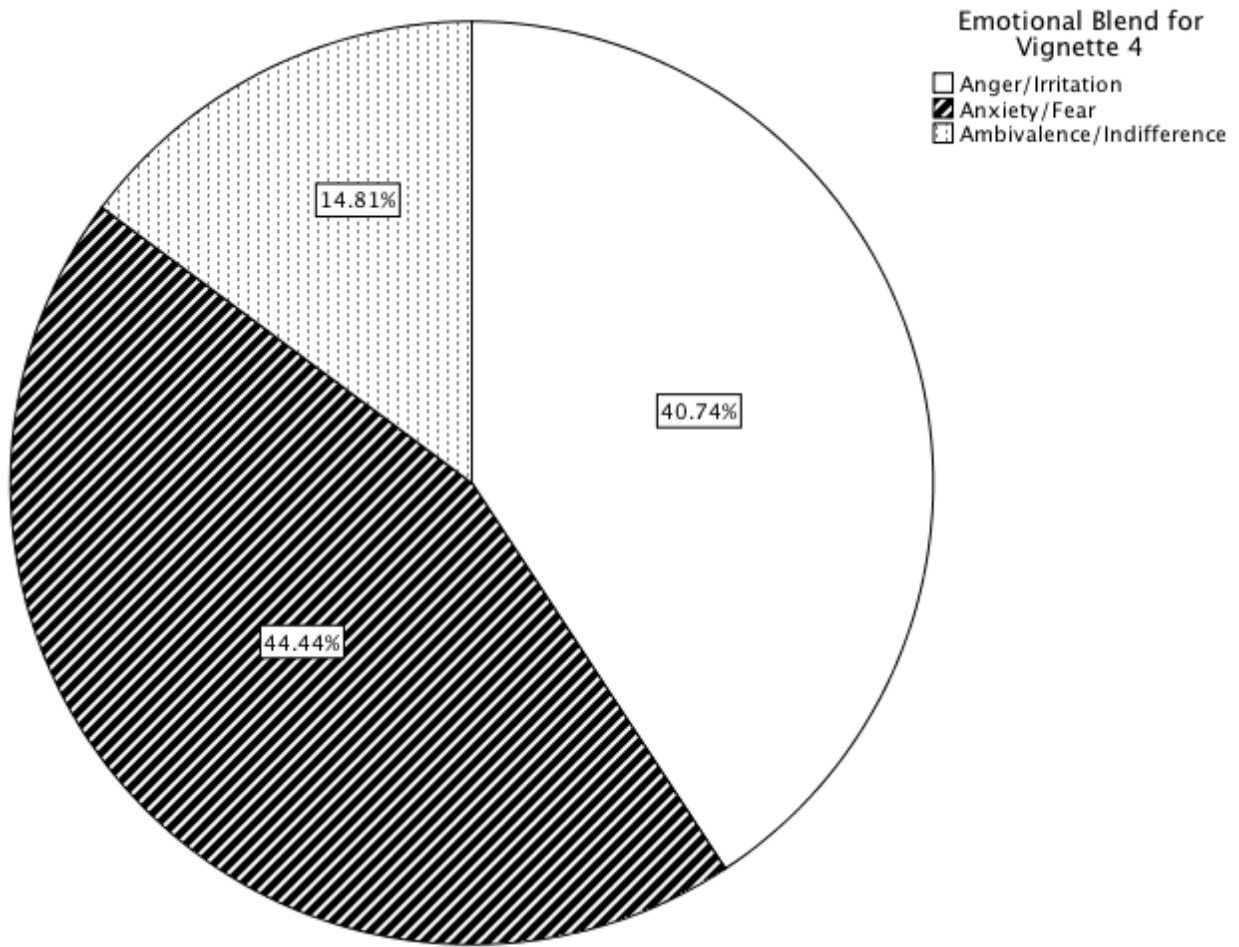
Figure 7. Emotional blend percentages for Vignette 4: You are working with your adult client when their small child interrupts the session. Initially, the parent asks the child to leave, sternly but calmly. However, when the child interrupts the session again, your client begins swearing at the child and yelling. The child becomes visibly upset.
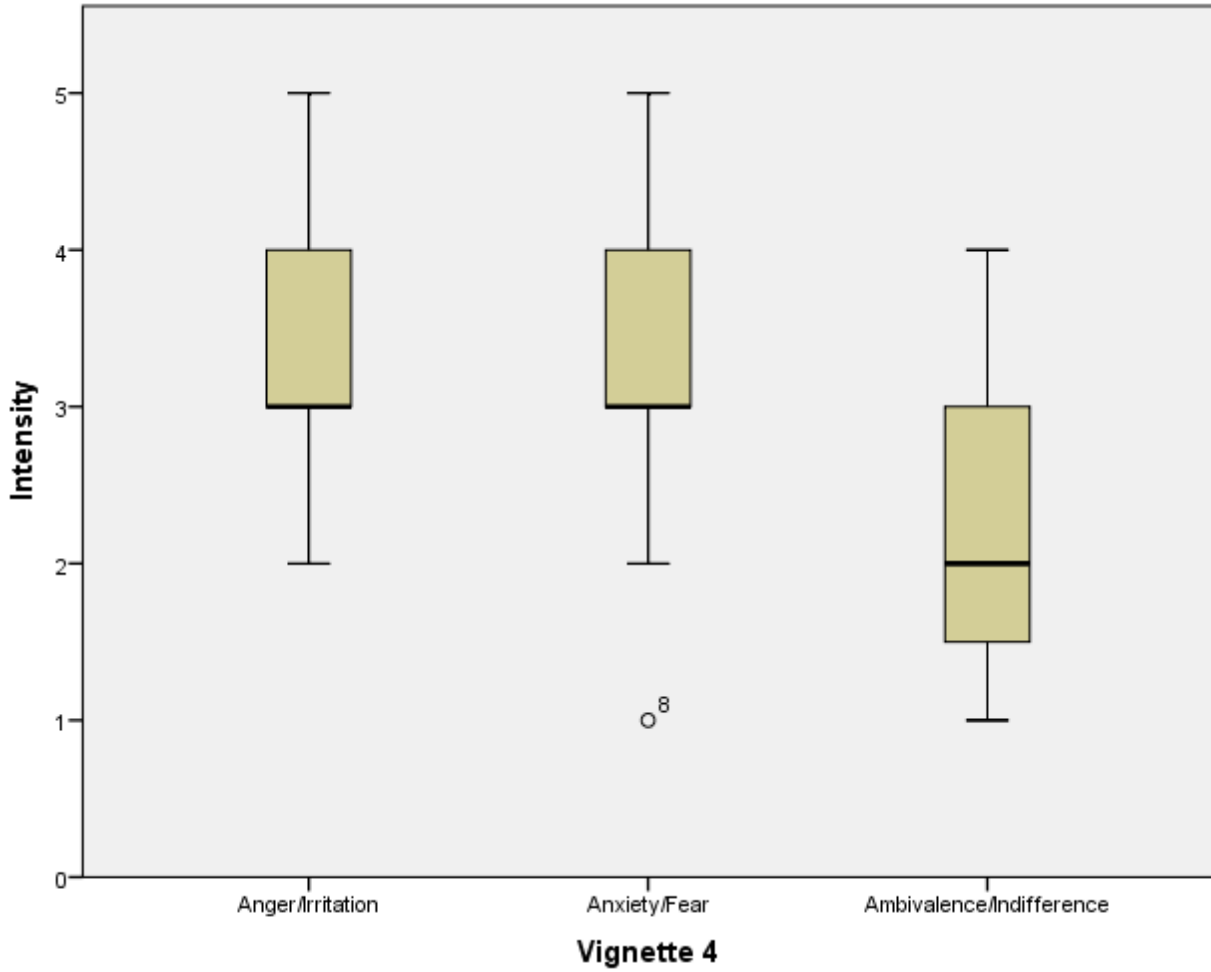
Figure 8. Intensity for each emotional blend for Vignette 4: You are working with your adult client when their small child interrupts the session. Initially, the parent asks the child to leave, sternly but calmly. However, when the child interrupts the session again, your client begins swearing at the child and yelling. The child becomes visibly upset.
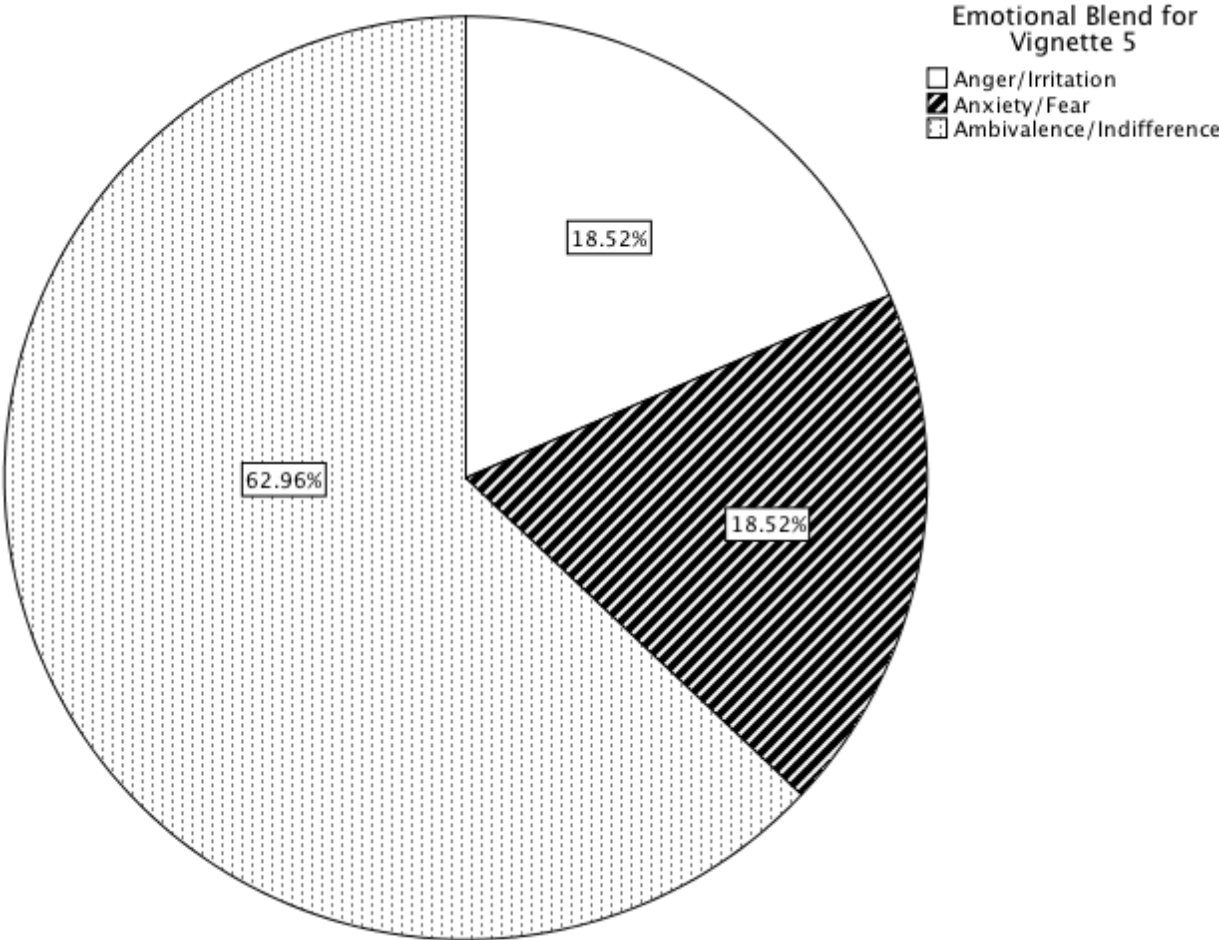
Figure 9. Emotional blend percentages for Vignette 5: You are working with your client, an eight year old girl. Your co-worker, Kelly, sees her 11 year old sister, Tina. One session, your client says to you, "When are we going to do cool stuff like Tina does with Kelly?"
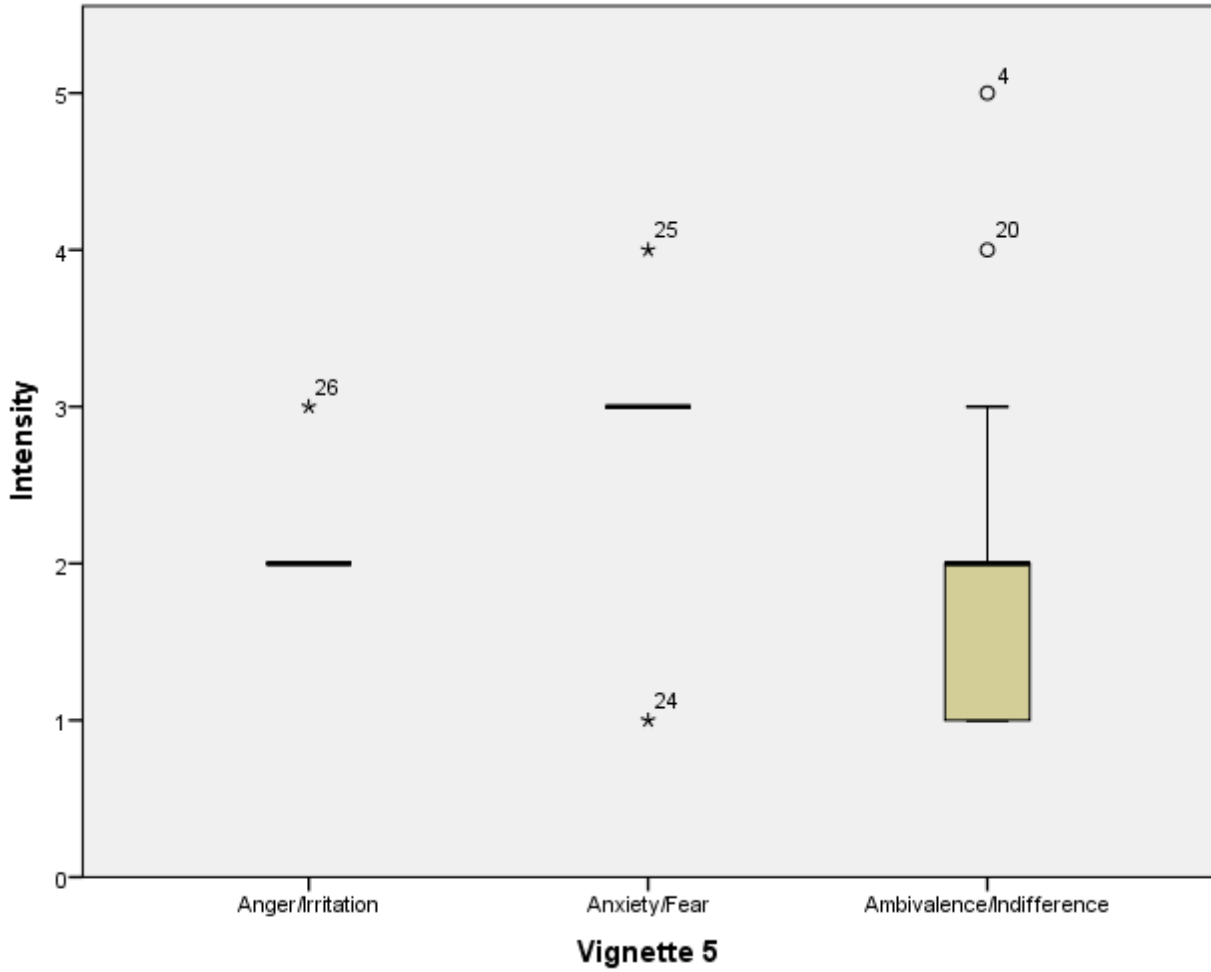
Figure 10. Intensity for each emotional blend for Vignette 5: You are working with your client, an eight year old girl. Your co-worker, Kelly, sees her 11 year old sister, Tina. One session, your client says to you, "When are we going to do cool stuff like Tina does with Kelly?"
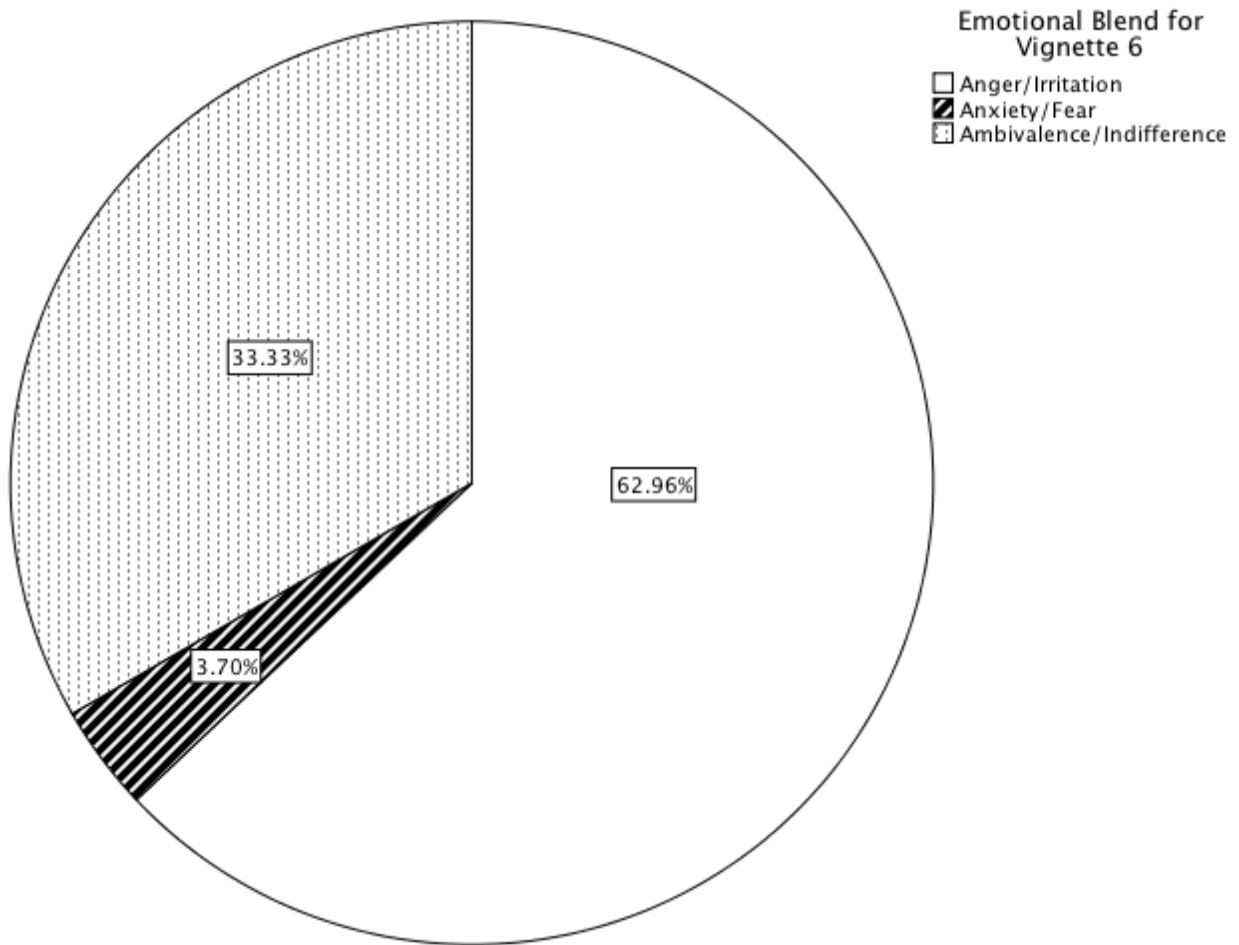
Figure 11. Emotional blend percentages for Vignette 6: You've been *working* with a client for three months. However, every two weeks the client calls and says there is an emergency, or someone is sick, or that they missed the bus. You genuinely like this client. Despite this sentiment, you have decided to issue an attendance contract. Your client starts attending regularly for three weeks, but then on the fourth week does not show. When you call to address this issue, they report that they did not have any money for the bus and they no longer have any minutes on their phone.
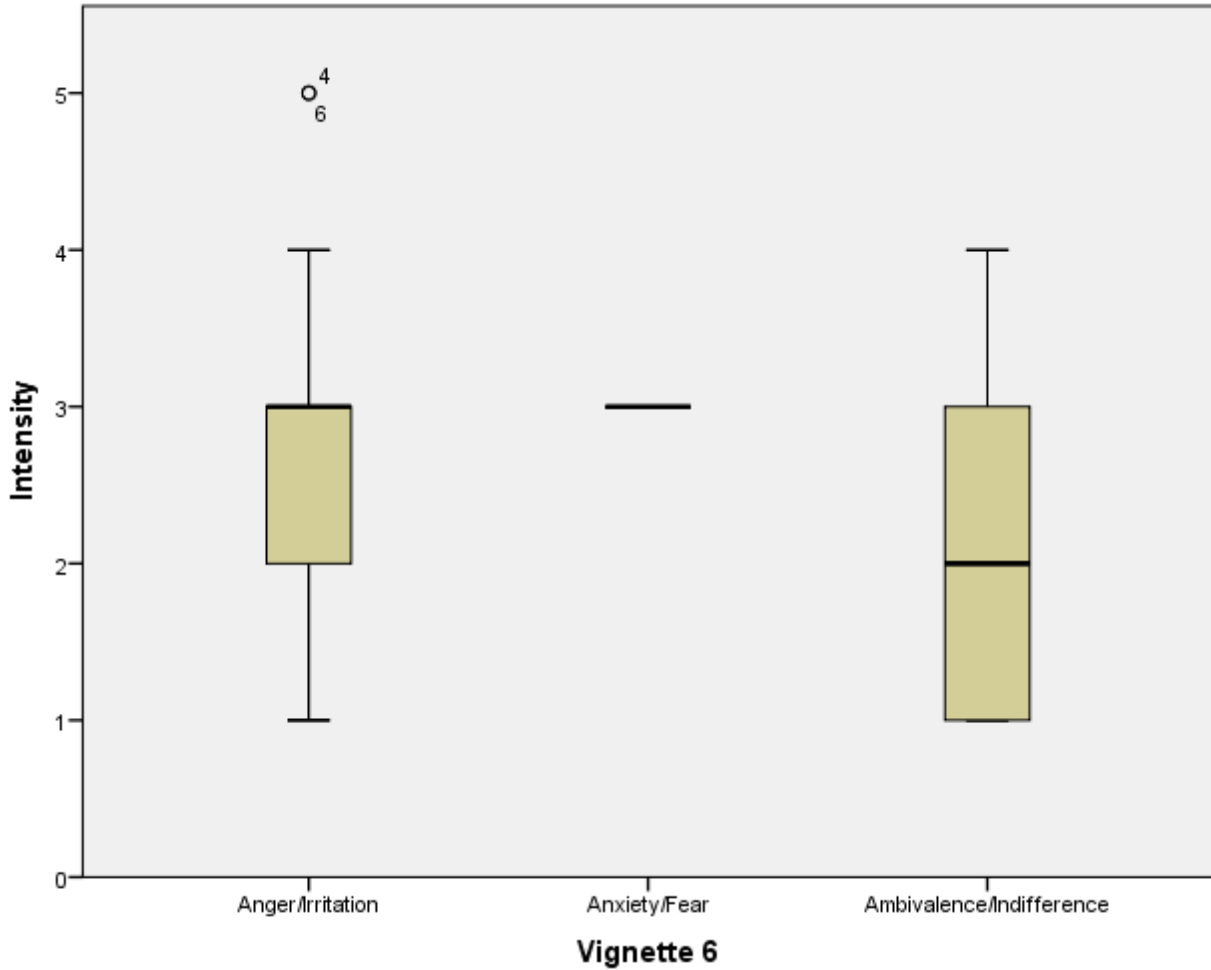
Figure 12. Intensity for each emotional blend for Vignette 6: You've been *working* with a client for three months. However, every two weeks the client calls and says there is an emergency, or someone is sick, or that they missed the bus. You genuinely like this client. Despite this sentiment, you have decided to issue an attendance contract. Your client starts attending regularly for three weeks, but then on the fourth week does not show. When you call to address this issue, they report that they did not have any money for the bus and they no longer have any minutes on their phone.
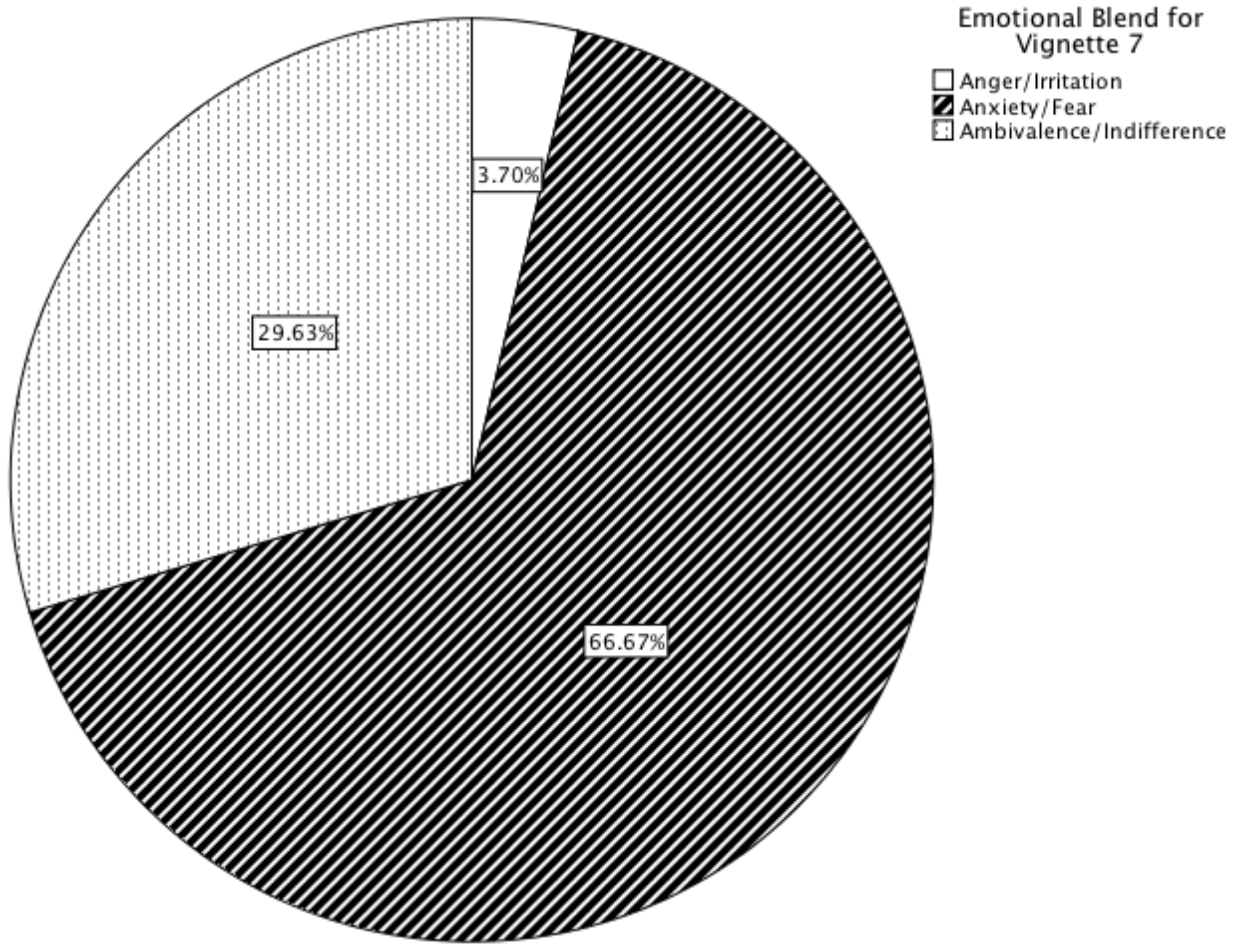
Figure 13. Emotional blend percentages for Vignette 7: Your long standing client calls you in crisis. They tell you that their home has been broken into and that their boyfriend has been involved in some neighborhood criminal activity or violence. They report that they are worried and don't know how much longer they can take living in their home. You ask the client if they believe it is safe for you to continue seeing them in the home and they say yes.
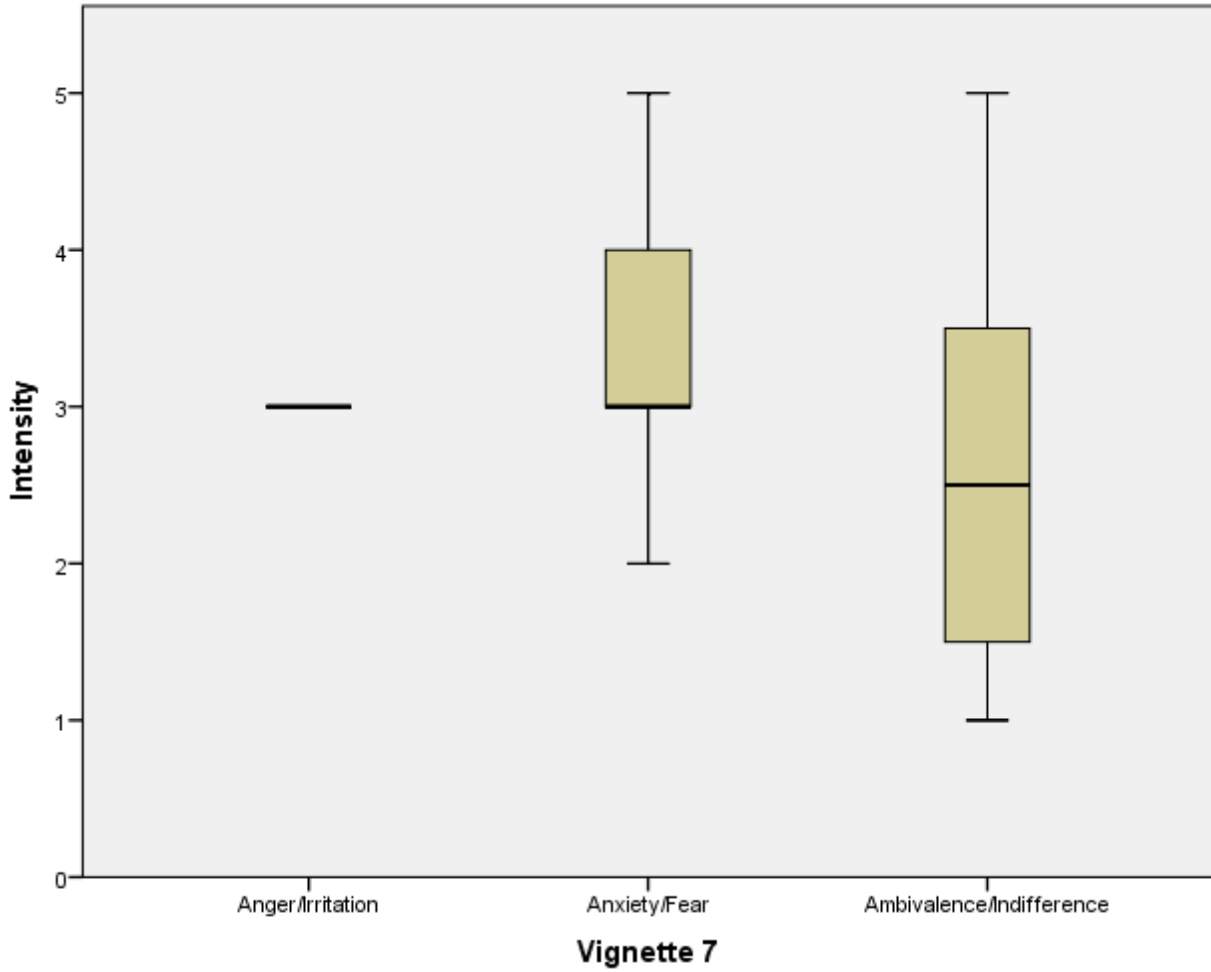
Figure 14. Intensity for each emotional blend for Vignette 7: Your long standing client calls you in crisis. They tell you that their home has been broken into and that their boyfriend has been involved in some neighborhood criminal activity or violence. They report that they are worried and don't know how much longer they can take living in their home. You ask the client if they believe it is safe for you to continue seeing them in the home and they say yes.
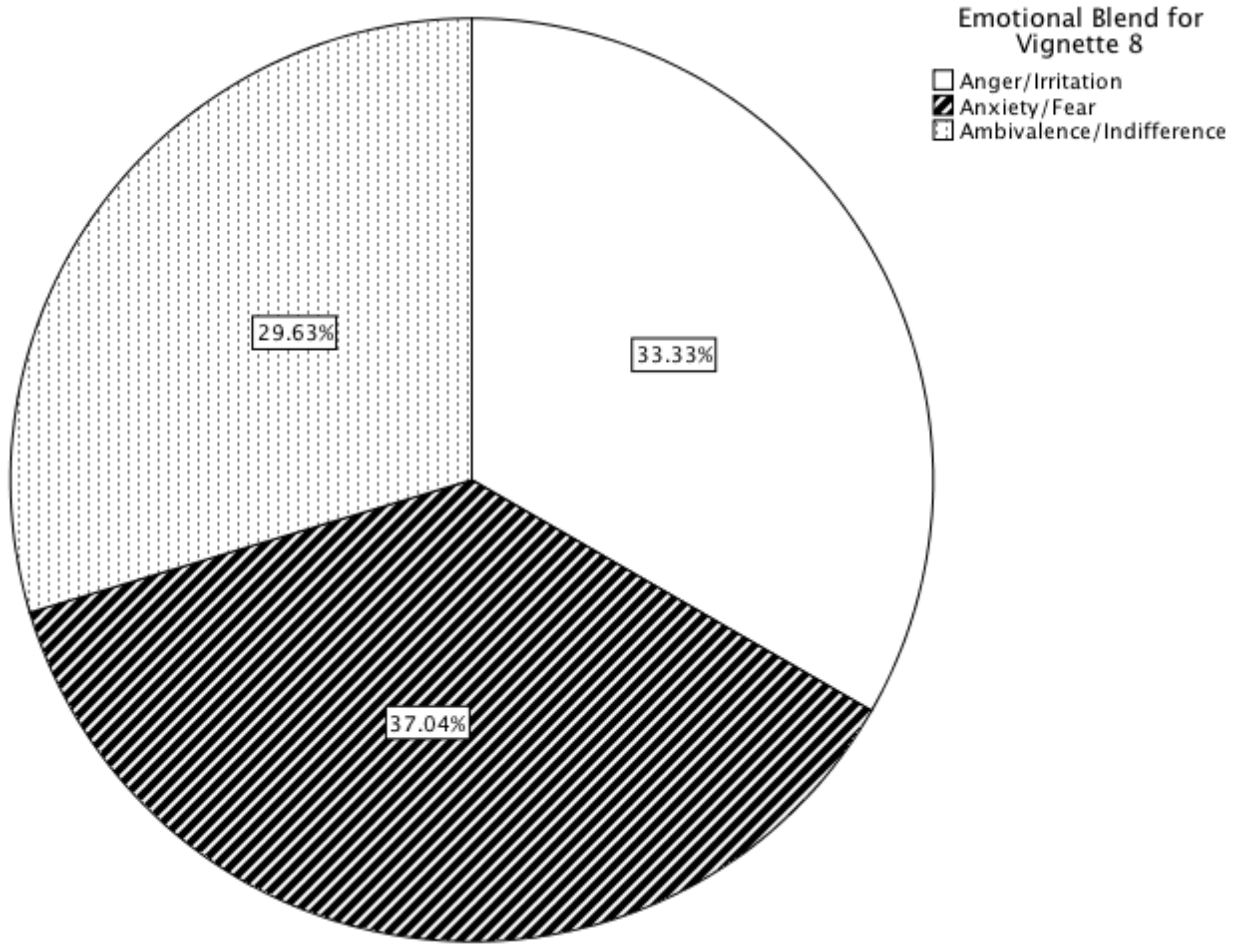
Figure 15. Emotional blend percentages for Vignette 8: You and a few other co-workers are treating four different members of a family. You learn that one of the clinician's has been attacked by the family cat, Twix. The clinician has been taken to the hospital to receive a round of rabies shots. Meanwhile, the family members are saying that the cat has been kicked out of the home, and is wandering the streets. However, they cannot provide proof. They do not believe that any of the clinicians are at risk, and would like the clinician's to return to the home.
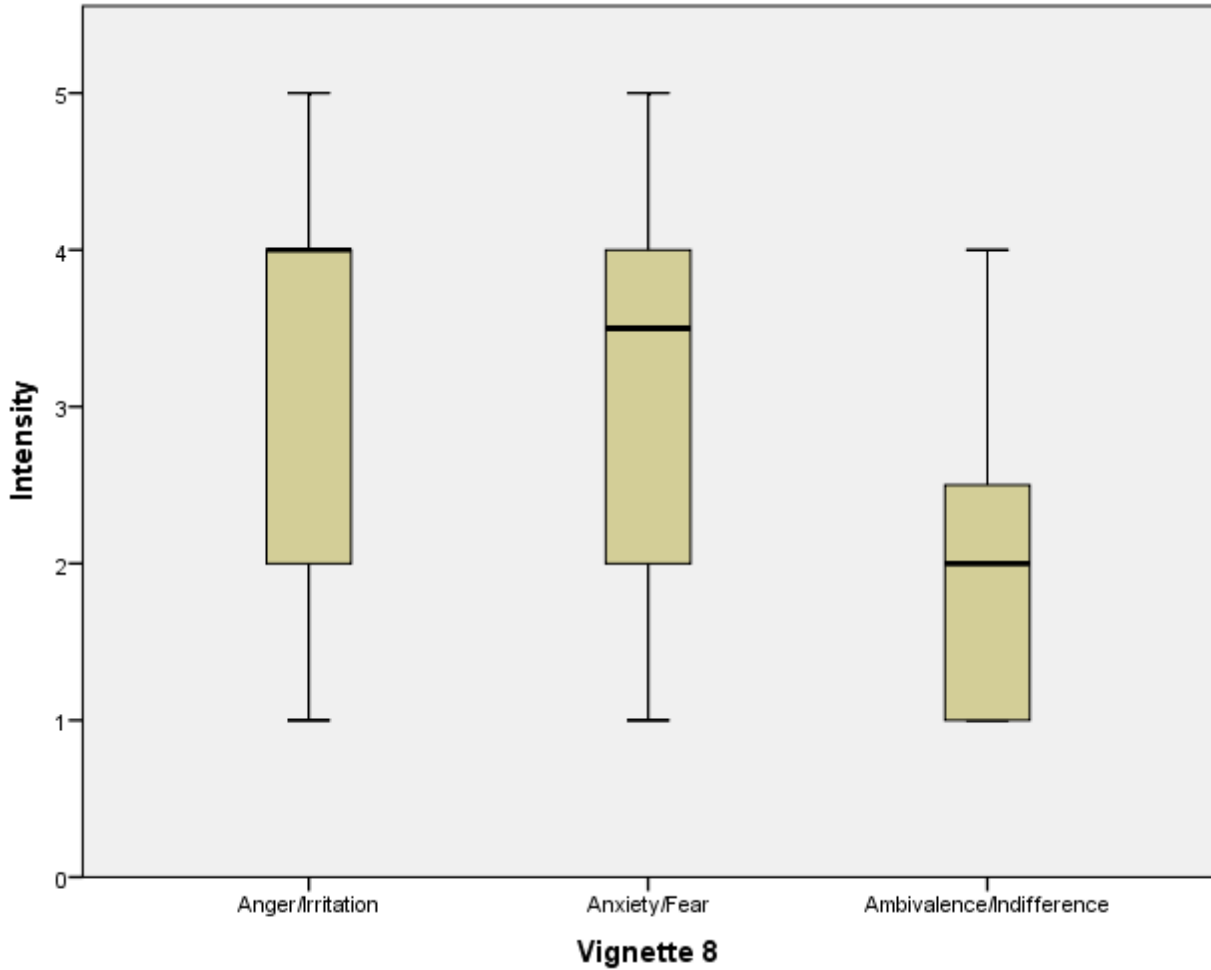
Figure 16. Intensity for each emotional for Vignette 8: You and a few other co-workers are treating four different members of a family. You learn that one of the clinician's has been attacked by the family cat, Twix. The clinician has been taken to the hospital to receive a round of rabies shots. Meanwhile, the family members are saying that the cat has been kicked out of the home, and is wandering the streets. However, they cannot provide proof. They do not believe that any of the clinicians are at risk, and would like the clinician's to return to the home.
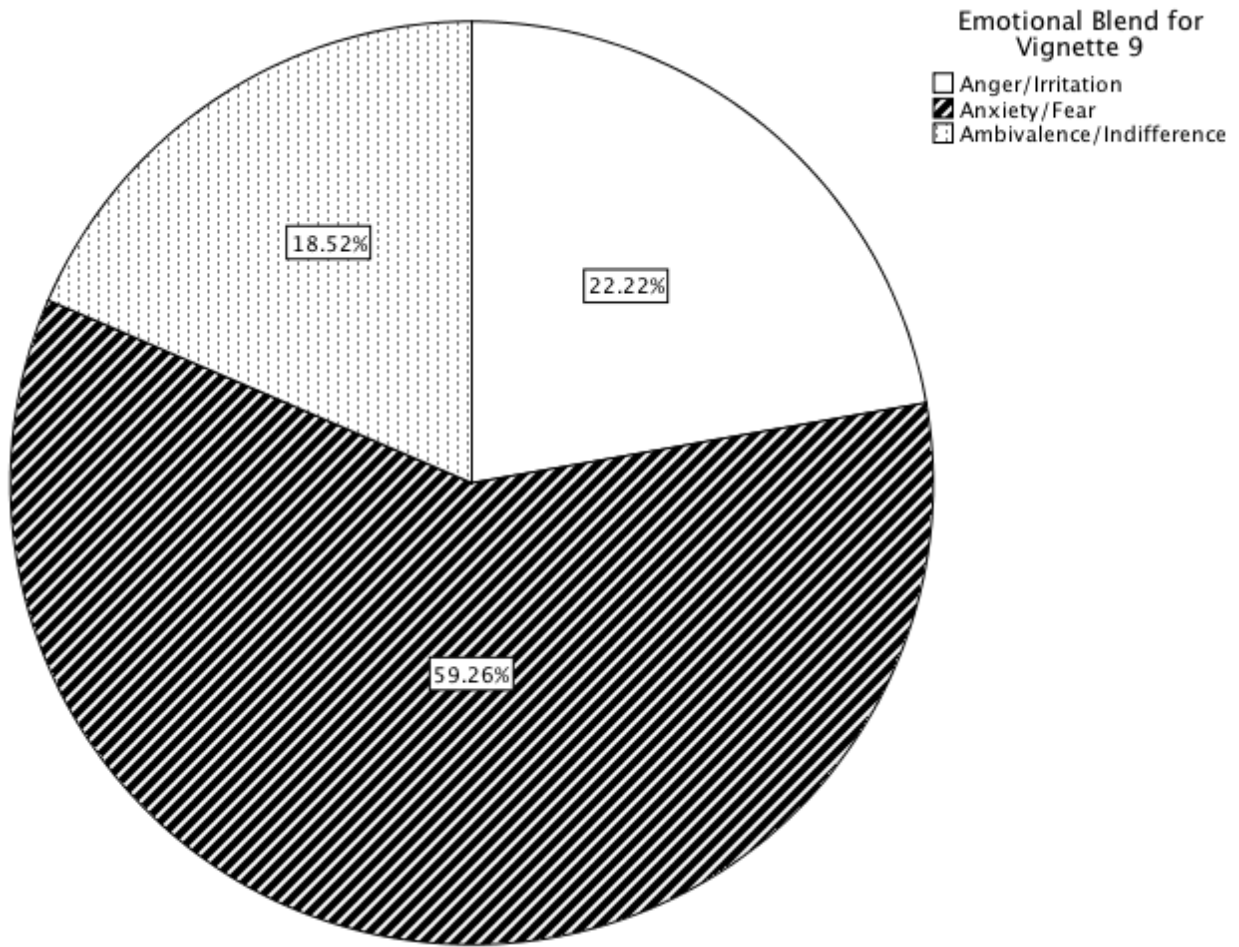
Figure 17. Emotional blend percentages for Vignette 9: You are working in a home where you see both of the children and are doing a joint session with them. While you are playing, you hear the mother's boyfriend come home, intoxicated. He and the mother begin to engage in a fight, and suddenly, you hear a large thud to the ground. You know from previous talks that this happens often, and that the kids are never harmed.
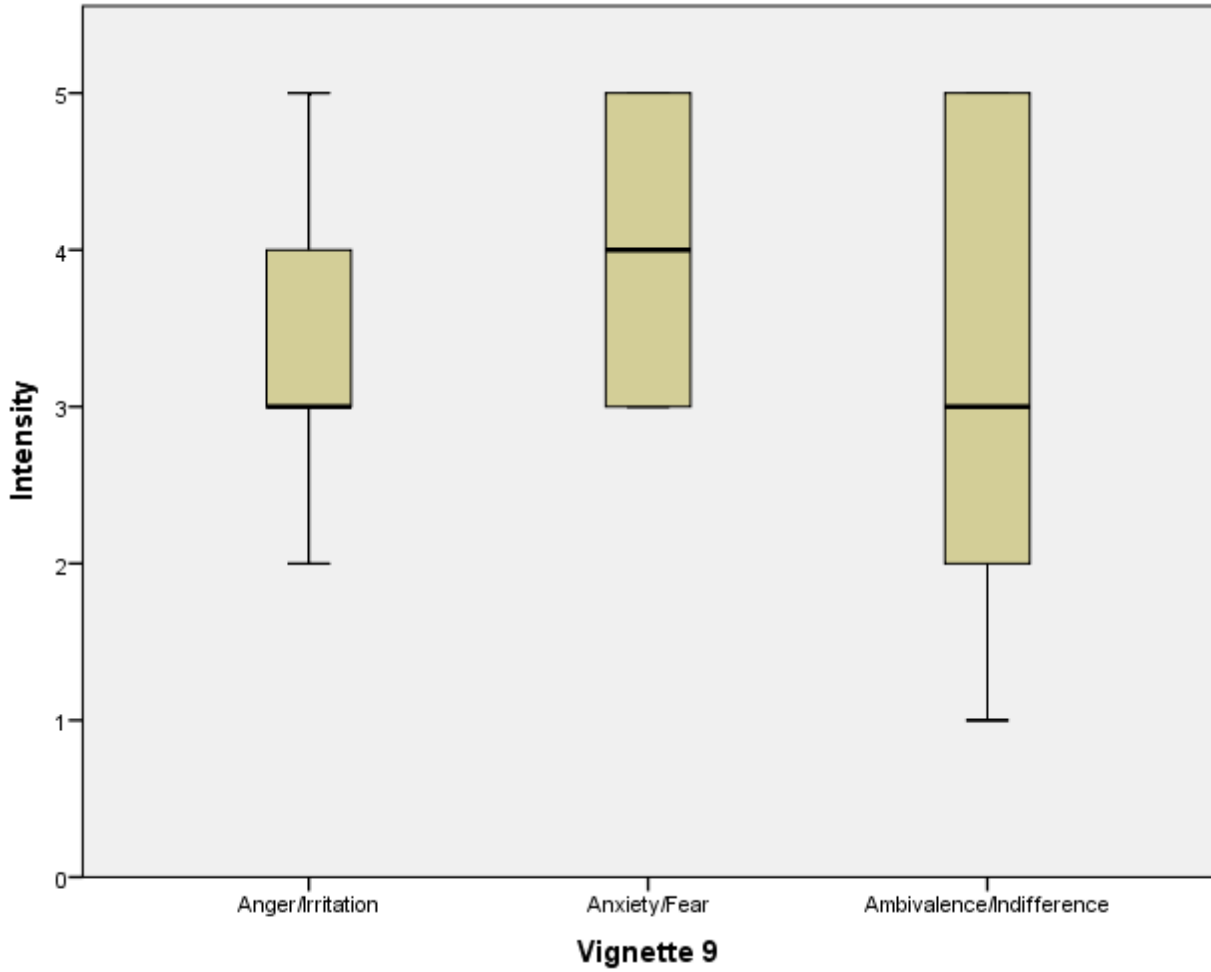
Figure 18. Intensity for each emotional blend for Vignette 9: You are working in a home where you see both of the children and are doing a joint session with them. While you are playing, you hear the mother's boyfriend come home, intoxicated. He and the mother begin to engage in a fight, and suddenly, you hear a large thud to the ground. You know from previous talks that this happens often, and that the kids are never harmed.
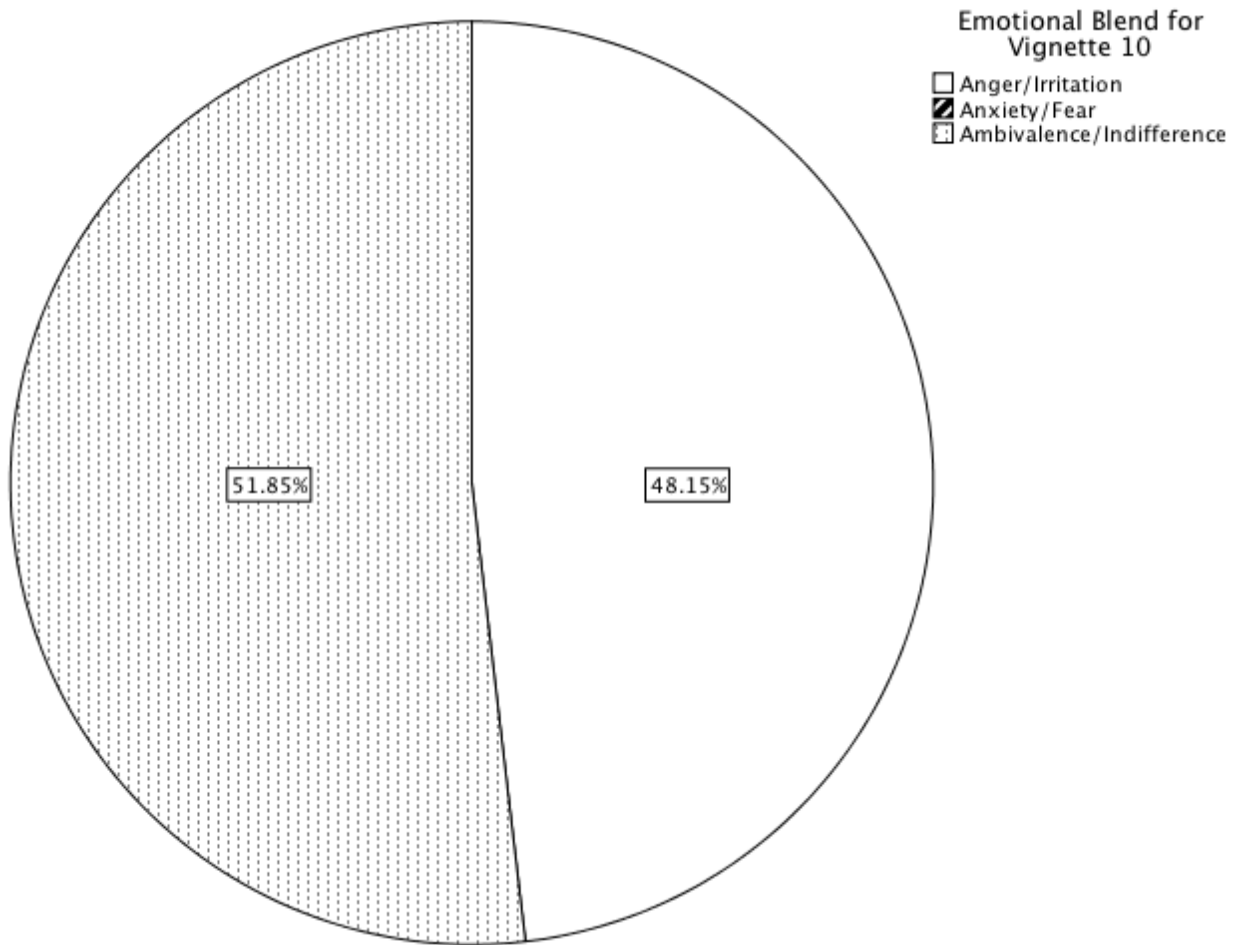
Figure 19. Emotional blend percentages for Vignette 10: You are working with your adult male client who works "under the table" for a cleaning company. Despite having minimal bills, and an income, your client would like to sign up for federal and state benefits such as welfare, health insurance, and food stamps. Your client would not be eligible for disability. Your client goes on to say, "Hey, why shouldn't I get mine?"
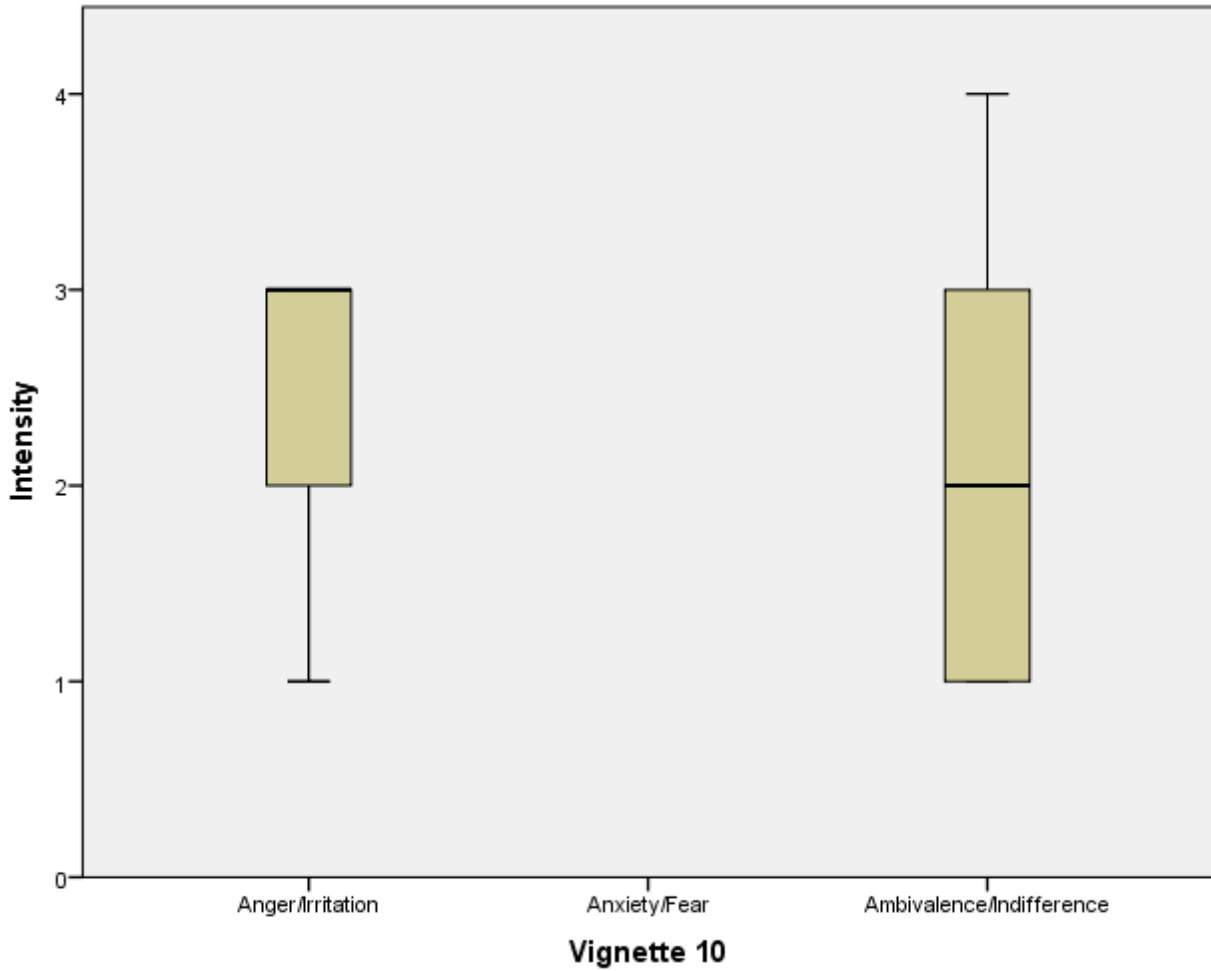
Figure 20. Intensity for each emotional blend for Vignette 10: You are working with your adult male client who works "under the table" for a cleaning company. Despite having minimal bills, and an income, your client would like to sign up for federal and state benefits such as welfare, health insurance, and food stamps. Your client would not be eligible for disability. Your client goes on to say, "Hey, why shouldn't I get mine?"

Table 2

Education levels and social class backgrounds amongst outreach clinicians.

	Social Class			
	Upper	Middle	Working	Lower
Master's	4	3	6	3
Doctoral	4	4	3	--
Total	**8**	**7**	**9**	**3**

When examining social class and how intensely participants experienced the vignettes, a number of inferences can be made. Anger/irritation as an emotional blend is particularly interesting as the average intensity increases as you move up through the social classes. Regarding anxiety, the working class experienced anxiety most intensely while the middle class experienced anxiety the least intensely. Finally, ambivalence was experienced most intensely by the lower and middle classes whereas participants in the upper class experienced ambivalence the least intensely. Within the social classes, there were also interesting differences. The lower and middle classes experienced all three emotions at different levels whereas the working class experienced the emotions similarly across categories. The upper class as mentioned previously experienced anger most intensely, but experienced anxiety and ambivalence at the exact same intensity. Table 3 presents the means and standard deviations.

Table 3

Means and standard deviations for levels of intensity amongst social classes.

	Anger/Irritation	Anxiety/Fear	Ambivalence/Indifference
SES	(*M*, SD)	(*M*, SD)	(*M*, SD)
Lower	*3.00,* 2.64	*2.67*, 1.52	*4.33*, 1.52
Working	*3.78*, 2.04	*3.11*, 2.2	*3.33*, 2.87
Middle	*3.86,* 1.86	*2.00*, 1.52	*4.14*, 1.46
Upper	*4.25*, 1.98	*2.88*, 1.64	*2.88*, 1.95

T-tests were conducted to determine if there were any significant differences between master's and doctoral level clinicians and proclivity towards emotional blend. Participants in the doctoral group ($M = 4.91$, $SD = 1.57$) experienced anger more frequently than master's level participants ($M = 3.13$, $SD = 1.89$), $t(25) = .601$, $p = .017$. Participants in the master's level group ($M = 4.25$, $SD = 2.11$) experienced ambivalence more frequently than those in the doctoral level group ($M = 2.45$, $SD = 1.75$), $t(25) = .109$, $p = .029$. There was no significant difference between the groups master's, ($M = 2.75$, $SD = 1.94$) and doctoral ($M = 2.64$, $SD = 1.56$) when experiencing fear/anxiety, $t(25) = .453$, $p = .874$.

While a number of participants provided responses that were well distributed across emotional blends, specific participants provided interesting individual data. For example, participants six and ten responded to the vignettes with anger 70% of the time. Whereas participant 15 responded with ambivalence 90% of the time. When considering all of the emotional blends across vignettes, only one participant did not feel anger/irritation, four participants did not feel fear/anxiety, and three participants did not feel

ambivalence/indifference. The level of intensity that participants felt ranged from 1.7 to 3.9 on a

likert scale of one to five with one being least intense and five extremely intense, ($M = 2.71$, SD

$= .647$). Possible explanations and future research implications will be discussed in the following

chapter.

Chapter 5

Discussion

Research Implications

Countertransference and its impact on therapeutic work have been of interest to many clinicians for a century. How education levels and social class influence our therapeutic work may have sparked some conversations, but the field remains under researched. This study has shown us that education level and social class influence negative countertransference.

The results show us that the average outreach clinician ranges in age and ethnicity. No relationship could be determined between education level and social class; however, this is likely due to the small sample size and likely would have shown significant results with a larger sample. To elaborate, in this study the highest frequency of master's level clinicians was from the working class group, with the rest of the sample being evenly distributed amongst the remaining social classes. The doctoral clinicians were evenly distributed amongst the upper, middle, and working classes, but had no representation in the lower class. A larger sample would likely have teased out any disparities or uneven distributions. The frequencies of this data however, support previous research (Huppatz, 2009; Ochoa, 2004) that social workers are typically women from working or middle class backgrounds. Further, that psychologists often come from middle or upper class backgrounds (Karon & Vandenbos; 1977; Liu, Pickett, & Ivey; 2007).

Understanding the emotional blends. The data produced numerous interesting findings regarding the emotional blends and the vignettes. The following section will discuss each vignette and potential research implications. In vignette one, "It is your fourth session with a new client in their home. You arrive at the front door and ring the door bell. While you can't see your

client, you can hear them moving around inside. You wait patiently, and even call the client on

your personal cell phone. While you can hear the phone ring, no one answers. You get back in

your car and leave." The predominant emotional blend was anger (67%). (See Figure 1). It is

likely that ambivalence was not chosen more frequently because in this vignette the clinician is

more apt to personalize the rejection rather than associating the client's behaviors with part of

the job. Green (2006) describes therapists as feeling frustration, rage, and despair when a client

rejects the therapist's efforts to do their job.

In vignette two, "You are at your client's home and in the middle of the session, her

teenage daughter joins your session at the kitchen table. The seventeen year old begins talking

about her problems and is dominating the session. Despite your best efforts to refer the client's

daughter to her own therapist (who she decided she no longer wanted to see), the teenager insists

on sitting at the table. The parent joins in on the conversation. This has become a recurring

issue." This vignette elicited a fairly even distribution between anger/irritation and

ambivalence/indifference. (See Figure 3). Further, intensity was evenly distributed with a median

intensity of two.

Potential explanations are that this vignette did not elicit any significant emotional

reactions. Participants may have viewed this vignette as mildly irritating or mildly indifferent to

the interaction, rather than feeling strongly in any one direction. The teenager in the vignette also

exhibits symptoms of an emerging personality disorder. In an empirical study by Rossberg et al.,

(2008) they found that clients with clusters A or B personality disorders were more likely to

incite negative countertransference. This could account for the participants who selected

anger/irritation.

Vignette three depicts the following scenario, "As you arrive for your first session and knock on the door, you hear a large dog barking and trying to get towards the door. Your client puts the dog in the crate and tells you not to worry about it. Months later, the dog is in the basement, barking loudly at your arrival. Your client says, "He's going to come and get you, ha-ha." Not surprisingly, anxiety/fear was the predominant emotional blend (41%). (See Figure 5). Levels of intensity varied from low to severe. (See Figure 6). As noted by Lion and Pasternak (1974), fear in the countertransference is a normal response and should be paid attention to especially when there is real danger. In this vignette, the client was able to test boundaries and "act out," a situation that would not have occurred in an office (Knapp & Slattery, 2004). It becomes easy to relate to the clinician's sense of being taunted, and why all three emotional blends were commonly selected.

In vignette four, "You are working with your adult client when their small child interrupts the session. Initially, the parent asks the child to leave, sternly but calmly. However, when the child interrupts the session again, your client begins swearing at the child and yelling. The child becomes visibly upset." The results showed that there was high anxiety/fear and anger/irritation amongst participants. (See Figure 7). The median intensity was three, or moderately intense for both emotional blends. (See Figure 8).

Participants likely felt strongly about this scenario as the clinician is put in a precarious position, to intervene (in vivo), to address the issue later on, or to dismiss the incident. Making that decision could be anxiety provoking to some clinicians. An article by Hora (1951) supports this view, "Countertransference can create in the therapist an unconscious need to reject, dominate or over-protect the patient, or to be punitive, demanding, prohibitive, moralistic, restrictive or impatient towards him" (p. 560).

In vignette five, "You are working with your client, an eight year old girl. Your co-worker, Kelly, sees her 11-year-old sister, Tina. One session, your client says to you, "When are we going to do cool stuff like Tina does with Kelly?" the majority of participants (63%) responded with ambivalence. (See Figure 9). Burnout can have the potential for clinicians to begin to show a less involved attitude since they are not always appreciated (Gibbons et al., 2011). Additionally, clinicians may likely recognize that children often want what their sibling has and not consider the exchange as threatening to their ego.

In vignette six, "You've been *working* with a client for three months. However, every two weeks the client calls and says there is an emergency, or someone is sick, or that they missed the bus. You genuinely like this client. Despite this sentiment, you have decided to issue an attendance contract. Your client starts attending regularly for three weeks, but then on the fourth week does not show. When you call to address this issue, they report that they did not have any money for the bus and they no longer have any minutes on their phone." The majority of participants responded with anger (63%) versus ambivalence (33%). (See Figure 11). Clark et al. (1982) note that the clinician needs to have significant ego strength in order to be an outreach therapist. Most clinicians can rationalize one or two missed appointments, however, a fourth missed appointment can make the clinician begin to question the perceived mutual respect. Lack of transportation and resources is one of the key barriers in many lower class groups from being able to participate in therapy (Maxfield & Segal, 2008). Thus, some clinicians will accept this scenario as a component of working with lower class individuals and respond with ambivalence or indifference.

In vignette seven, "Your long standing client calls you in crisis. They tell you that their home has been broken into and that their boyfriend has been involved in some neighborhood

criminal activity or violence. They report that they are worried and don't know how much longer they can take living in their home. You ask the client if they believe it is safe for you to continue seeing them in the home and they say yes." Anxiety/fear dominated the majority of responses (67%). (See Figure 13). Interestingly, only 4% of participants responded with anger/irritation. It is evident that the participants were anxious/fearful for likely themselves and their client, but also that they were not angry with the client for indicating that the home is safe. Participants experienced this vignette with moderate intensity, with some participants indicating severe intensity. (See Figure 14). Unfortunately, a common aspect when working in outreach therapy is being exposed to potentially dangerous situations. This vignette likely incited memories of being anxious or fearful in many of the participants.

Vignette eight depicts the following scenario, "You and a few other co-workers are treating four different members of a family. You learn that one of the clinician's has been attacked by the family cat, Twix. The clinician has been taken to the hospital to receive a round of rabies shots. Meanwhile, the family members are saying that the cat has been kicked out of the home, and is wandering the streets. However, they cannot provide proof. They do not believe that any of the clinicians are at risk, and would like the clinician's to return to the home." There was an even distribution between the emotional blends, but the intensity differed for each blend. (See Figures 15). Participants responded with severe anger, moderate anxiety, and less intense ambivalence. (See Figure 16). Knapp & Slattery (2004) state, "Psychologists should never put themselves or their supervisees in a situation where their safety, dignity, or clinical effectiveness is limited" (p. 556). This vignette depicts all three of these "boundary crossings" and showcases how all three emotional blends are likely to be experienced by participants.

Vignette nine describes a potential countertransference scenario, "You are working in a home where you see both of the children and are doing a joint session with them. While you are playing, you hear the mother's boyfriend come home, intoxicated. He and the mother begin to engage in a fight, and suddenly, you hear a large thud to the ground. You know from previous talks that this happens often, and that the kids are never harmed." Participants responded primarily with moderate to intense anxiety (60%). (See Figure 17). Participants who responded with anger and ambivalence also had more intense reactions to the vignette. (See Figure 18). Safety and risk of violence to oneself and others are likely the key factors in this vignette that raised people's countertransference, particularly anxiety. In a study on therapists' perspectives of home based therapy by Christenson (1995), she found that a majority of therapists regarded safety as a major concern. Further, therapists were eager to learn how to feel safer and how to deal with threatening situations. Similarly to vignette seven, the validity and probability of this scenario occurring in a "real" situation likely incited high anxiety regarding safety.

Finally, in vignette ten, "You are working with your adult male client who works "under the table" for a cleaning company. Despite having minimal bills, and an income, your client would like to sign up for federal and state benefits such as welfare, health insurance, and food stamps. Your client would not be eligible for disability. Your client goes on to say, "Hey, why shouldn't I get mine?" This vignette produced interesting results as there was an even distribution between moderate anger (48%) and less intense ambivalence (52%). (See Figures 19 and 20). It is likely that clinician's view this vignette as they do to many of their daily interactions with clients, either with conviction or acceptance. It is the author's belief that this vignette speaks to clinician longevity within the agency. As interns or new employees begin working in an impoverished area, clinicians can become highly frustrated with a client's

nonchalant and lackadaisical attitudes. However, if you have been working in that environment

for a longer period of time, it is easy to become accustomed to these attitudes.

All clinicians strive to be non-judgmental, and to understand their clients; to separate

themselves from the job. As noted by in the literature (Clark et al.,1982) clinicians in outreach

therapy have little room for growth, and the pay is often fee-for-service and at a lower rate than

other employment opportunities in the field. It may become difficult to not develop an angry or

indifferent countertransference to someone who feels entitled to benefits that they do not "need."

Education level and social class. Significant differences were found between master's

and doctoral level clinicians regarding their proclivities towards feeling anger and ambivalence.

One possible explanation is that some doctoral training programs encourage and spend more

academic hours discussing clinician's individual personalities and exploring their emotional

reactions to their clients. Winnicott (1994) discusses hate in the countertransference as an often

necessary emotion. To move forward one has to embrace their feelings towards their clients,

even if that feeling is hate, or in this case, anger or irritation. Master's level programs,

particularly in social work, may not have the time allocated (two year vs. four year programs), or

the intrapersonal focus to discuss these concepts. In turn, ambivalence or indifference may be a

more likely reaction for those practicing at the master's level.

As discussed in the literature review, social work and psychology have a history of being

founded in different class backgrounds (Hodge, 2004; Smith, 2005; Strier, 2009). Doctoral level

psychologists may feel that outreach therapy has a case management component that they are not

trained in, or have a proclivity to do. It is the experience of this author that many of the doctoral

level clinicians found themselves saying, "This is not my job. This is not what I was trained to

do." Anger and irritation was a recurrent emotion in discussions regarding the topic of job responsibilities.

In terms of social class, there were interesting differences between the intensity felt in the emotional blends. As reported in the results, anger/irritation intensity increased through the social classes. This is likely a result of clinician's own social class background in relation to working with a lower class population. Clinicians who come from lower or working class backgrounds are able to work with clients within that population more readily and comfortably than those from middle or upper class backgrounds (Liu et al., 2007; Lorion, 1974).

Other explanations for the results could be related to work environment and associated issues. Outreach clinicians work long hours, utilize their own vehicles and cell phones, and are often not compensated financially for their hard work (Clark et al., 1982). Predoctoral interns are compensated on a minimal level and are submerged into an environment where most of the participants have never had experience in outreach settings. It is possible that if the work environment were different, than the longevity of outreach clinicians would increase, and that levels of burnout would be reduced.

Limitations of Research

Sample size. The major limitation of this research is the sample size. In the beginning of the research study there was a large number of responses in comparison to the second half of data collection. Had the sample size been larger, the effects would likely have been clearer. Despite the small sample size however, the data was able to explicate some interesting findings.

Measures and recruitment. As this was the pilot study for these measures, there were some potential errors in design. Two participants had to be excluded from the study as they only circled intensity, leaving out emotional blend, on their response sheet. Online, some participants

stopped after the demographic portion perhaps indicating irritation with the number of demographic questions.

The number of participants may have been increased if more time was spent face to face recruiting participants. While we live in an online society, outreach clinicians like most professionals, are exceptionally busy. Participation seemed more likely in person when the measures were in front of the clinicians. That is, the majority of people that were asked to participate in person did, whereas the online response could have garnered higher numbers.

Recommendations for Future Research

Future research could allow this study to go in numerous directions. First, the research could seek to include positive countertransference scenarios. This inclusion would provide participants with a wider range of potential emotions. Further, an empathy/pity emotional blend might also add richness to the study.

As mentioned in the results, some participants gravitated towards anger or ambivalence a majority of the time. Future research could examine potential personality differences by enlisting a variety of measures including the Minnesota Multiphasic Personality Inventory (MMPI) as an example. It is likely that clinicians' personalities influence their proclivity to anger, anxiety, and ambivalence.

Future research may also want to increase data collection to other agencies that provide outreach therapy. This would offer a broader range of participants and reduce any possible effects that are agency specific. Finally, future studies should implement reliability and validity measures. The utilization of such measures would add integrity to the study and generate more replications of the study.

Personal Reflections

Throughout the internship year, myself and a majority of my colleagues felt intense negative countertransference reactions. Through personal conversations and group discussions it became apparent that there was a separation between many of the predoctoral interns and the clinical staff. When reflecting on this dynamic, it seemed plausible that education level and consequently, social class could be determining factors. The literature supported this notion (del Gaudio et al., 1975; Mitchell & Atkinson, 1983) citing that those who come from lower class backgrounds are better able to help those from lower class backgrounds.

The aim of this dissertation was to delineate any differences between social class groups in an effort to improve our understanding of how individual factors influence our countertransference towards working with the poor. With an understanding that individual factors, specifically, education level and social class have an influence on negative countertransference, the author offers suggestions in an effort to reduce the negative countertransference. First, the implementation of countertransference discussion groups will be of significant help. While many clinicians feel comfortable speaking to their supervisor privately regarding countertransference, a group setting offers a sense of camaraderie and shared experience.

Supervision of both master's level clinicians and predoctoral interns should incorporate countertransference. The literature shows that supervision of outreach clinicians needs to be intensive and specific to the modality as most training programs do not offer guidance on the topic (Cortes, 2004). Trainings on outreach therapy, what to expect, and the reality of being in the home and what that looks like therapeutically needs to be discussed ad nauseaum. This notion is particularly important for predoctoral interns who have not been prepared for outreach

therapy in conjunction with other demands of internship (i.e., didactics training, psychological testing, potential relocation, productivity, and other professional development areas).

Managed care has placed its demands on the mental health field. The insurance companies want to see efficacious and effective results. An increase in compensation for providing outreach therapy may provide such results. As fee-for-service clinicians, many therapists are driven to carry large case loads, some with as many as 38 clients a week. Further, if clients do not show up, the clinician is not compensated and often is scrambling to change schedules to accommodate their clients. A salaried position, or increase in hourly rates would allow clinicians to see fewer clients, reduce burnout, and most importantly increase positive results in their clients. Other benefits such as guaranteed health insurance would also increase employee satisfaction and overall work performance.

While the data has provided interesting results, there is still much research that needs to be done in order to understand this issue more fully. As the mental health field moves forward and the number of people employed as social workers, psychologists, counselors, therapists, advocates, and substance abuse counselors grows, we need as a community, to take time to reflect and understand our individual differences. The field recognizes that countertransference is an integral component of any therapeutic relationship. Understanding this countertransference will not only improve the way we practice and our ability to treat a broader population, but also who we are as individuals both personally and professionally. Perhaps most importantly however, will be an increased ability to treat our clients in the best practice.

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Appendix A

Informed Consent Form
Antioch University New England
Department of Clinical Psychology
40 Avon Street
Keene, NH 03431

How class background influences negative countertransference in outreach therapy

Kathryn A. Patterson, M.S., Principal Investigator

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<u>INFORMED CONSENT STATEMENT</u>

1. **Invitation to Participate and Description of the Project.** As a student at Antioch
    University New England, I am conducting a study on class background and
    countertransference in order to further our understanding of this topic. **I am asking you to
    participate in the study.** You are being asked to participate in this study due to your
    experience in working in outreach therapy. Your participation in the research study is
    voluntary. Before agreeing to be part of this study, please read and/or listen to the following
    information carefully. Feel free to ask questions if you do not understand something.
2. **Description of Procedure.** If you participate in this study, you will be asked to fill out a
    demographic questionnaire regarding you and your parent's class background. Additionally,
    you will read a series of four descriptions and you will then select a description that best fits
    or describes you and your family. You will then be given a questionnaire asking you to
    respond to a series of vignettes regarding potential countertransference reactions while
    practicing outreach therapy. The entire process should take no more than ten minutes.
3. **Risks and Inconveniences**. There is a possibility that some of the questions or vignettes may
    make you feel uncomfortable. You will be asked about personal things and you may feel
    uncomfortable at times when answering questions regarding your background or responding
    to the vignettes. This rarely happens, but if you do feel uncomfortable, you can do any of the
    following: you can choose not to answer certain questions, you can take a break and continue
    later, or you can choose to stop your participation in the study.
4. **Benefits.** This study was not designed to benefit you directly, however, there is some
    possibility that you may learn about some of your own countertransference through your
    participation. In addition, what we learn from the study may help us to better understand
    how class background and development influence clinicians' countertransference in outreach
    therapy and can potentially influence other fields of study.

5. **Confidentiality. Any and all information obtained from you during the study will be confidential. Your privacy will be protected at all times. You will not be identified individually in any way as a result of your participation in this research. The data collected however, may be used as part of publications and papers related to class background and countertransference. Your participation in this study will remain anonymous.**

6. **Voluntary Participation. Your participation in this study is entirely voluntary.** You may refuse to participate in this research. Such refusal will not have any negative consequences for you. If you begin to participate in the research, you may at any time, for any reason, discontinue your participation without any negative consequences.

7. **Other considerations and questions.** Please feel free to ask any questions about anything that seems unclear to you and to consider this research and consent form carefully before you sign.

Authorization: I have read or listened to the above information and I have decided that I will participate in the project described above. The researcher has explained the study to me and answered my questions. I know what will be asked of me. I understand that the purpose of the study is to explore the relationship between class background and countertransference. If I don't participate, there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.

I agree to participate in the study. My signature below also indicates that I have received a copy of this consent form.

Participant signature:

_____

Participant name (Print):

_____

Date:

_____

The participant will be given one copy of this consent form. One copy of this form will be kept by the investigator for at least five years.

If you have further questions about this research project, please contact the principal investigator, (Kate Patterson, at (860) 608-2335, e-mail: kpatterson@antioch.edu) or faculty supervisor (Roger Peterson, Ph.D., at (603) -283-2178, e-mail: rpeterson@antioch.edu). If you have questions about your rights as a research participant or if you have a research- related complaint please contact: Dr. Katherine Clarke, Chair of Institutional Review Board at kclarke@antioch.edu.

Appendix B
Demographic Questionnaire

Please provide the following information. If you are a predoctoral intern, or have completed a predoctoral internship, please indicate so on the highest reached level of education.

Background Information

Age: 20-25   26-30   31-35   36-40   41-45   45-50   50+

Gender: Male   Female   Transgendered

Relationship status: Single   Long Term   Married   Divorced   Widowed

Highest level of education: MSW   MS   Predoctoral Intern   Postdoc Psy.D. Ph.D.

Mother's highest level of education: No Degree H.S. Diploma Associate Bachelor   Master

Doctoral/Professional

Father's highest level of education: No degree   H.S. Diploma Associate Bachelor   Master

Doctoral/Professional

Ethnicity: Caucasian   African American   Hispanic   Asian   Multiethnic   Pacific Islander

Appendix C
Social Class Measure

The following is a series of four different descriptions related to social class. Please choose which description *best* fits you. Indicate this by circling the number paired with the description.

1. One of your parents attended college, they may have graduated. You often read newspapers, or watch a national news show. You have concerns regarding the welfare of others across the world. You and your family go out to eat frequently, at nice restaurants. You did not have to work while you were receiving your education. If you did work, it was part-time or perhaps doing skill related jobs such as teaching tennis or being a lifeguard. Your parents believed that you should graduate from college and were thrilled that you pursued a graduate degree. You spend your time with friends, reading, and engaging in physical activities, such as working out.

2. Your parents may or may not have graduated high school. Your parents' jobs may have included waitressing, retail, or other jobs that require less training or specific skill sets. There may have been times when your parents were unemployed. You began working at a young age in order to buy things you needed, or to help the family out. This may include working in a family business. Your parents are proud you went to college, but would have been just as happy if you had a steady job with decent income. You spend your time watching reality shows, at home with the family, and frequently eat fast food.

3. Your parents are both college educated, one or both of them may have graduate degrees. When growing up, you went on family vacations annually. You and/or your parents drive a luxury vehicle. You did not need to take out student loans for your degree. Your parents are able to help you out financially. Your parents believed that you should pursue a graduate degree in whatever field made you happy. You spend your spare time attending events, reading, and furthering your knowledge base.

4. Your parents did not attend college, but they did graduate high school. They may have specific trade professions, such as a plumber or electrician. The neighborhood you grew up could be categorized as decent, not great, but not horrible either. You started working at a young age in order to buy things that you may have wanted. You went out to eat on special occasions, but primarily your parents cooked at home. You went on a few vacations with your family. Your parents believed that you would have a better life than them if you went to college, however, they did not save money for you to attend. You spend your time watching television, going to the movies, or going out to eat at American restaurants such as Chili's.

Appendix D
Countertransference Measure

The following is a series of vignettes that would be possible in outreach therapy. Please rate your most prevalent (choose one) blend and intensity of countertransference (feelings towards the client) on the scales provided beneath the vignette. On the intensity scale, one is minimally intense, three is moderately intense, and five is extremely intense.

1. It is your fourth session with a new client in their home. You arrive at the front door and ring the door bell. While you can't see your client, you can hear them moving around inside. You wait patiently, and even call the client on your personal cell phone. While you can hear the phone ring, no one answers. You get back in your car and leave.

   Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
   Intensity: 1   2   3   4   5

2. You are at your client's home and in the middle of the session, her teenage daughter joins your session at the kitchen table. The seventeen year old begins talking about her problems and is dominating the session. Despite your best efforts to refer the client's daughter to her own therapist (who she decided she no longer wanted to see), the teenager insists on sitting at the table. The parent joins in on the conversation. This has become a recurring issue.

   Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
   Intensity: 1   2   3   4   5

3. As you arrive for your first session and knock on the door, you hear a large dog barking and trying to get towards the door. Your client puts the dog in the crate and tells you not to worry about it. Months later, the dog is in the basement, barking loudly at your arrival. Your client says, "He's going to come and get you, ha-ha."

    Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
   Intensity: 1   2   3   4   5

4. You are working with your adult client when their small child interrupts the session. Initially, the parent asks the child to leave, sternly but calmly. However, when the child interrupts the session again, your client begins swearing at the child and yelling. The child becomes visibly upset.

   Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
   Intensity: 1   2   3   4   5

5. You are working with your client, an eight year old girl. Your co-worker, Kelly, sees her 11 year old sister, Tina. One session, your client says to you, "When are we going to do cool stuff like Tina does with Kelly?"

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

6. You've been *working* with a client for three months. However, every two weeks the client calls and says there is an emergency, or someone is sick, or that they missed the bus. You genuinely like this client. Despite this sentiment, you have decided to issue an attendance contract. Your client starts attending regularly for three weeks, but then on the fourth week does not show. When you call to address this issue, they report that they did not have any money for the bus and they no longer have any minutes on their phone.

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

7. Your long standing client calls you in crisis. They tell you that their home has been broken into and that her boyfriend has been involved in some criminal neighborhood activity or violence. She reports that they are worried and don't know how much longer she can take living in their home. You ask the client if she believes it is safe for you to continue seeing her in the home and she says yes.

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

8. You and a few other co-workers are treating four different members of a family. You learn that one of the clinician's has been attacked by the family cat, Twix. The clinician has been taken to the hospital to receive a round of rabies shots. Meanwhile, the family members are saying that the cat has been kicked out of the home, and is wandering the streets. However, they cannot provide proof. They do not believe that any of the clinicians are at risk, and would like the clinician's to return to the home.

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

9. You are working in a home where you see both of the children and are doing a joint session with them. While you are playing, you hear the mother's boyfriend come home, intoxicated. He and the mother begin to engage in a fight, and suddenly, you hear a large thud to the ground. You know from previous talks that this happens often, and that the kids are never harmed.

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

10. You are working with your adult male client who works "under the table" for a cleaning company. Despite having minimal bills, and an income, your client would like to sign up for federal and state benefits such as welfare, health insurance, and food stamps. Your client would not be eligible for disability. Your client goes on to say, "Hey, why shouldn't I get mine?"

Type: Anger/Irritation   Anxiety/Fear   Ambivalence/Indifference
Intensity: 1   2   3   4   5

Appendix E
Letter to Gatekeeper

January 11, 2013

Elaine Campbell
Director of Internship, Clinic Director
Community Services Institute
1695 Main Street, Ste. 4
Springfield, MA

Dear Dr. Campbell,

I am writing to you to formally request that I, Kathryn Patterson, be granted permission to carry out a research study for my doctoral dissertation. The research is focusing on the class backgrounds of clinicians who have worked in outreach therapy, and how class background may influence types and intensity of countertransference. I plan on collecting date in two ways; one, by attending one of the staff meeting at Community Services Institute (CSI), and requesting that clinicians participate by filling out the three separate forms or questionnaires. The first form is an informed consent, the second is an indicator of social class, and the third is a series of countertransference vignettes.

The entire participation process should take no more than ten minutes. For people who are not available, including former CSI interns, and participants who work in West Roxbury, an internet site with the measures will be utilized. Participation in the study will remain anonymous.

If you have any questions, comments, or concerns, please contact me at your earliest convenience. I look forward to continuing my academic relationship with CSI.

Sincerely,

Kathryn Patterson, M.S.

Appendix F
Gatekeeper Letter

**Community
Services
Institute**

Licensed Mental Health Clinic

Elaine Campbell, Psy.D.
Clinic Director
Community Services Institute
Springfield, MA
Elaine.campbell@communityserv.com
413 739 5572

To Whom it May Concern,

I am writing this letter to show my support of Kathryn Patterson in carrying out her doctoral dissertation research at Community Services Institute. She will be allowed to meet with our staff both in person, and to reach out to staff online. Further, she is allowed to reach out to former predoctoral interns via email so they may participate in her study.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Elaine Campbell, Psy.D.