

---

Theses, Dissertations, and Projects

---

2015

## Clinicians' experiences of personal wealth : impacts within clinical practice

Sarah Schwartz Sax  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

---

### Recommended Citation

Schwartz Sax, Sarah, "Clinicians' experiences of personal wealth : impacts within clinical practice" (2015).  
Masters Thesis, Smith College, Northampton, MA.  
<https://scholarworks.smith.edu/theses/658>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

## **ABSTRACT**

This exploratory/descriptive quantitative/qualitative study surveyed clinicians with wealth about their experiences working with clients who do not have wealth. While there is much research that examines the implications of race-privileged clinicians (i.e., white clinicians) when they work with clients who are race-oppressed (i.e., clients of color) there is very little research on parallel class-based dynamics when the clinician is of a more privileged socioeconomic class than the client. Thus, this research was an initial attempt to fill that gap in the literature. Fifty-four mental health clinicians with wealth voluntarily identified themselves to the researcher via a confidential online tool. Screened participants were invited to participate in an anonymous online survey about their experiences negotiating class within the clinical relationship; 33 completed the survey. Results included strategies that clinicians with wealth used with clients to address class-based tensions, strategies that clinicians with wealth used in supervision, areas of tension that clinicians with wealth regularly experience, reflections on the dominant emotive language expressed within the responses as a whole, and a call for further education about class dynamics throughout the field. These findings suggest that clinicians with wealth have complex and nuanced experiences of navigating their privileged class-status in the clinical context, but very few opportunities to reflect on or see their experiences mirrored by others. Future research on the impact of downward, upward, lateral and internalized classism could be helpful throughout the helping professions.

**CLINICIANS' EXPERIENCES OF PERSONAL WEALTH:  
IMPACTS WITHIN CLINICAL PRACTICE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

Sarah Schwartz Sax

Smith College School for Social Work

Northampton Massachusetts 01063

2015

## ACKNOWLEDGEMENTS

I happily dedicate this thesis to Sue, Al and Miles who set the stage.

And to Meg who flipped the script.

This project has been a magnificent obsession – not always comfortable, but continuously simmering behind the scenes. I am so grateful for the help and support of those of you who moved me through the process of writing this thesis. Most notably, my advisor Gael McCarthy was a stalwart supporter of this idea from the very beginning, and for that I am honored, grateful, and humbled. I submit deep appreciation for the gifts of sharing ballast and levity to Mindy Oshrain, Shannon Mackey, Rachael Gardiner, Rachel Sloane, Hannah Mason, Sarah Beller, the Resource Generation community, and Midge, Emily, Raphael, Sydney and Emil.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	iv
LIST OF FIGURES .....	v
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	5
III METHODOLOGY.....	39
IV FINDINGS .....	47
V DISCUSSION.....	84
REFERENCES .....	95
APPENDICES	
Appendix A: HUMAN SUBJECTS REVIEW APPROVAL LETTER.....	105
Appendix B: HUMAN SUBJECTS REVIEW AMENDMENT APPROVAL LETTER .....	107
Appendix C: SURVEY 1 .....	108
Appendix D: SURVEY 2 .....	111
Appendix E: RECRUITMENT MATERIALS .....	115
Appendix F: HUMAN SUBJECTS CONSENT FORM .....	117

## LIST OF TABLES

### Table

1. Age Range, Gender, and Racial/Ethnic Identity of Eligible Survey 1 Participants.....	50
2. Professional Discipline & Highest Degree Attained of Eligible Survey 1 Participants....	52
3. Political Orientation.....	53
4. Geographic Region of Practice & Manner of Wealth Acquisition.....	55
5. Number of Years in Clinical Practice.....	56
6. How Personally Affected Would you be by the Client’s Words? .....	58
7. Would you Change your Fee? .....	61
8. Frequency of Clinician Experiencing Class-Based Negativity, Neutrality, or Positivity from Clients.....	68
9. Experience of Clinician about Wealth Self-Consciousness.....	73

## LIST OF FIGURES

### Figures

1. THE SOCIAL CLASS WORLDVIEW MODEL—REVISED ..... 9

## **CHAPTER I**

### **Introduction**

Social work has long been a field with explicit intentions to help and heal those who are psychologically and sociologically wounded (NASW, 2008). As such, it has become clear that professional mental health practitioners have an obligation to remain as unbiased in their assessment of clients as possible. Established practices such as examining clinicians' social privilege and attending to countertransference gives us the tools to recognize when our own personal bias may be influencing our interpretations of our clients (Garb, 1997). Yet, unconscious clinical biases are very hard to perceive in one's practice when they are related to a dominant identity; the mechanism of privilege makes those who possess it defensively oblivious to their role in its maintenance (Israel, 2012). This research is intended for mental health professionals, as well as mental-health educators and students. The focus is based within the social work discipline, yet intends to be accessible to all clinical mental health arenas. The ultimate goal of this work is to support the field of social work to be more accountable to class biases, and thus more efficacious to our clients of all socioeconomic classes.

This research explores the role of socioeconomic class within the clinical encounter; specifically what class-based dynamics the clinician is aware of when working with a client who is from a lower socioeconomic class than the clinician. While there is much research that examines the implications of race-privileged clinicians (i.e., white clinicians) when they work with clients who are race-oppressed (i.e., clients of color) (Spanierman, Poteat, Wang, & Oh,



2008) , there is very little research on parallel class-based dynamics when the clinician is of a more privileged socioeconomic class than the client. Thus, I have identified a gap in the literature.

In order to learn about these class-based dynamics, this research focused on the experiences of clinicians with wealth. Studies of wealthy populations are generally absent from the literature. Furthermore, there is a conspicuous lack of research on the impact of social class within the helping professions, including the mental health realm (Blustein, Coutinho, Murphy, Backus, & Catraio, 2011). My interest in this particular group came from a desire to further understand the mechanisms that contribute to the internalization and reproduction of class identities. In an effort to study those who may experience class disparity between themselves and their clients, focusing my research on clinicians with wealth provided a target population who, logically, would be regularly be positioned to experience the privileged side of this class disparity. My assumption is that some of the results deriving from this study will be translatable to non-wealthy clinicians who, even though they do not have wealth, may hold socioeconomic and class-based privilege relative to their clients. This is a dynamic that is particularly salient to the field of social work, which has become a professionalized, middle-class occupation that, at its roots, is dedicated to the amelioration of poverty and supporting the well-being of all citizens, including “the least of us.” Further discussion will be dedicated to this dynamic within the Literature Review chapter.

The exploratory research questions for this study were, “How do social workers with personal wealth and owning-class privilege experience working with clients of different socioeconomic class status? Are there specific ways in which workers note discomfort or

problems in such class discrepant work? How do clinicians attempt to cope with such problems, if they experience them?”

For the purposes of this study, wealth was defined as direct possession of, or access to, material resources that release the individual from relying on earned income for daily needs, financial stability, and future economic security. Also for the purposes of this study, “wealth,” “personal wealth” and “independent wealth” were terms used interchangeably.

I surveyed mental health clinicians who self-identify as wealthy in order to learn about their subjective self-perceptions of socioeconomic differences between themselves and their clients across the clinical encounter, including but not limited to assessment, treatment, fee-setting, and use of supervision to address clinician’s responses to socioeconomic differences. Additionally, I explored what these clinicians with wealth do, if anything, to note discomfort, and how they cope with these socioeconomic differences.

While initially conceived of as a study consisting of in-depth interviews, the response to initial outreach was surprisingly abundant. Thus, during the research phase, the initially proposed methodologies were changed in order to capture responses from all eligible participants in the form of an on-line survey. Results included rich data; during the data-analysis phase, themes were coded to capture commonalties and differences in participants’ responses; the themes noted are presented with illustrative quotes from research participants in the **Findings** chapter. These results will be further elaborated on in both the **Findings** and **Discussion** chapters.

Overall, the intention of this research has been to draw more attention to the dynamics present within clinical settings as they related to socioeconomic status and social class. It is my hope that by shedding some light on the experiences of those clinicians who occupy a position of significant class-privilege, we can expand our understanding of how to understand, address, and

tend to the predominantly unspoken yet ever-present cultural conversations about class within the clinical dyad, the mental-health education system, and the field of mental health as a whole.

## **CHAPTER II**

### **Literature Review**

#### **Introduction**

There is very little direct sociological or psychological research about wealthy populations in the United States, let alone mental health clinicians with wealth. Therefore, this literature review will address previous research in the areas of social class construction, the historical and current context of social work and topics of poverty, wealth and economic inequality, and class-based dynamics within the clinical setting. It will begin with a discussion of the ways in which class, much like race or gender, is socially constructed and internalized as a working worldview. I will then discuss the historical roots of social work and the influence of economic ideology at the roots of the profession. Jumping forward, I will next discuss why an exploration of class is important within the context of current economic inequality and the racial-wealth divide. As this work intends to give insight into the experiences of social workers with wealth, the following discussion will review the slim literature about the psychology and mental health of the affluent. In the section about negotiating class within the clinical session, I will discuss implications of the clinician's class-based bias on the psychological life of the client. The impact of class-based countertransference will be discussed, as will current definitions of class-competent social work. I will also discuss the confusion regarding professional mandates within social work, and the lack of clarity around requirements for social workers and social work educators to have cultural competency around issues of class. Finally, I will outline some of the

major challenges in research on class and classism within the field of social work and the broader helping professions.

### **Theoretical Orientation**

**Theories of privilege and oppression.** To frame this research, I would like to draw upon theories of oppression and privilege that help us to understand the nature of their expression within the field of social work. Israel (2012) offers a rich theory on this dialectic. The author presents privilege as the unearned advantages that are conferred to individuals based on membership in a dominant group (Israel, 2012). Yet, these advantages are often invisible to those who hold them; instead, the American myth of meritocracy suggests that those with privilege have earned it on their own, and therefore deserve to wield power (Liu, Pickett Jr., & Ivey, 2007; Vodde, 2000). This is a powerful concept when coupled with the ideas that there are significant psychological, social, spiritual, interpersonal, moral, physical and community-based costs to those who have privilege (Goodman, 2001). For the purposes of this work, I will consider that social and economic privilege includes both the invisible unearned advantages based on powerful in-group membership, as well as interpersonal costs that are often unrecognized. Additionally, instead of using the term “social and economic privilege,” I will use the shorthand of “privilege” to refer to advantages that are social and/or economic.

The concept and function of privilege does not stand on its own, but is additionally defined by its polarity: oppression. Although there are myriad definitions, the Encyclopedia of Social Work from The National Association of Social Work, defined this concept as such:

Oppression is commonly understood as the domination of a powerful group—politically, economically, socially, culturally—over subordinate groups. Another common definition is that oppression is an institutionalized, unequal power relationship—prejudice plus power (Soest, 2013).

The experience of oppression may happen at multiple realms of social interaction: individual, familial, institutional, societal, legal, and cultural. While a deep and significant body of work is dedicated to the study of oppression and its permutations, I want to highlight the manner in which privilege contributes to the system of oppression. One of the key features of oppression is that it is institutionalized; that is, racism, classism, sexism, heterosexism, ableism, etc. are woven into the fabric of cultural norms, laws, dominant cultures, policies and unspoken societal rules. Yet such institutionalization results in invisibility of the oppressing dynamic, particularly to those who benefit from it, namely those with privilege. Thus, privilege and oppression are mutually reinforcing. For the purposes of this work, I will focus mostly on classism, which includes cognitions about social and economic class, as well as associated affects such as shame, guilt, depression and anxiety (Liu, 2002). Classism, however, can never be examined in isolation, and must be considered in conjunction with intersecting identities such as race, gender, age, ability, sexual orientation and more (Liu, Soleck, Hopps, Dunston, & Pickett, 2004).

**Classism is more complex and subjective than previously thought.** The other theory that I am using is called the Social Class Worldview Model – Revised, and comes from William M. Liu, who is prolific in the research of class and classism in psychology and other helping professions. Liu frames examinations of classism as much more complex than the classic Marxist and Weberian idea of lower versus upper class narrative. Instead, Liu suggests that social class perceptions are, like race and gender, a social construct and a deeply personal identity. By applying multicultural theory to the exploration of class, which frames individuals' intrapsychic experiences within the social and cultural condition in which they were raised and/or currently live, we can expand into the possibility that the class experience is subjective, and that all persons make their own meanings of social class and classism (Ehrenreich, 1985). In effect,

social class can have multiple meanings in people's lives, and it can be conceptualized differently depending on experience, as well as intrapsychic and contextual factors (Liu, et al., 2004). Little has been written to tie this power analysis of class to the applied field of clinical social work(Liu, 2011). The research compiled in this paper aims to begin to fill that gap.

Liu has contributed the idea of the Social Class Worldview Model-Revised, a tool to understand the intrapsychic experience of social class that can easily be applied to all forms of counseling. One's social class worldview is the schema, or lens, through which one perceives, magnifies, distorts, limits and interprets one's class-based experience. This model helps people make sense of their feelings, perceptions, economic environments and cultures. Three assumptions ground this theory: 1) the experience of class is subjective and socially constructed, 2) people's perceptions shape their realities, and 3) everyone is working in a behavioral, emotional and cognitive polarity between "homeostasis" and "internalized classism." Liu identifies homeostasis as occurring in the moments when valued social, cultural and/or economic capital is accrued that maintains one's social class worldview: in short, when people's internal sense of themselves as "classed" persons is syntonetic with their external expression of that class. In contrast, internalized classism refers to the feelings of anxiety, distress, dissonance and/or frustration that arise when people do not feel adequate within their perceived and desired social class. The discomfort associated with the triggering of internalized classism is deeply uncomfortable, and motivates people to strive harder to reach equilibrium (Liu, 2011; Liu et al. 2004; Liu, 2012). As with any polarity, individuals may be anywhere on the spectrum between homeostasis and internalized classism at any given time, and may move within that spectrum continuously. Keeping these assumptions in mind, Liu suggests that all people have an economic culture within which they are situated and attuned to, and which informs how they make

meaning of particular social, cultural and economic capital. Liu also suggests that individuals' sense of themselves within their subjective economic culture significantly defines their internal working model of their intrapsychic self. Drawing on the social work concept of understanding the "person-in-environment," a client's economic culture is important to understand as a large part of that person's environment (Gibbs & Stirling, 2013).

Economic cultures are subconsciously introjected from social messaging and exist on both conscious and unconscious levels. Liu uses a scale to identify a person's level of consciousness regarding social class. The Social Class and Classism Consciousness scale describes a ten-point spectrum of how aware individuals are of the impact of social class in the world. This scale ranges from No Social Class Consciousness, Social Class Self-Consciousness to Social Class Consciousness. Thus, the combined effect of social messaging and a person's social class-consciousness set the stage for the behavioral expressions of an individual's subjective class worldview. This worldview is behaviorally expressed on three levels: 1) Material Possessions (i.e., the material objects and relationships which perform and reify an individual's social class worldview), 2) Social Class Behaviors (i.e., observable actions that are manifestations of a person's social class worldview), and 3) Social Class Lifestyle (i.e., how people organize their time and resources in order to remain congruent with their economic culture) (Liu, 2011; Liu et al., 2004).

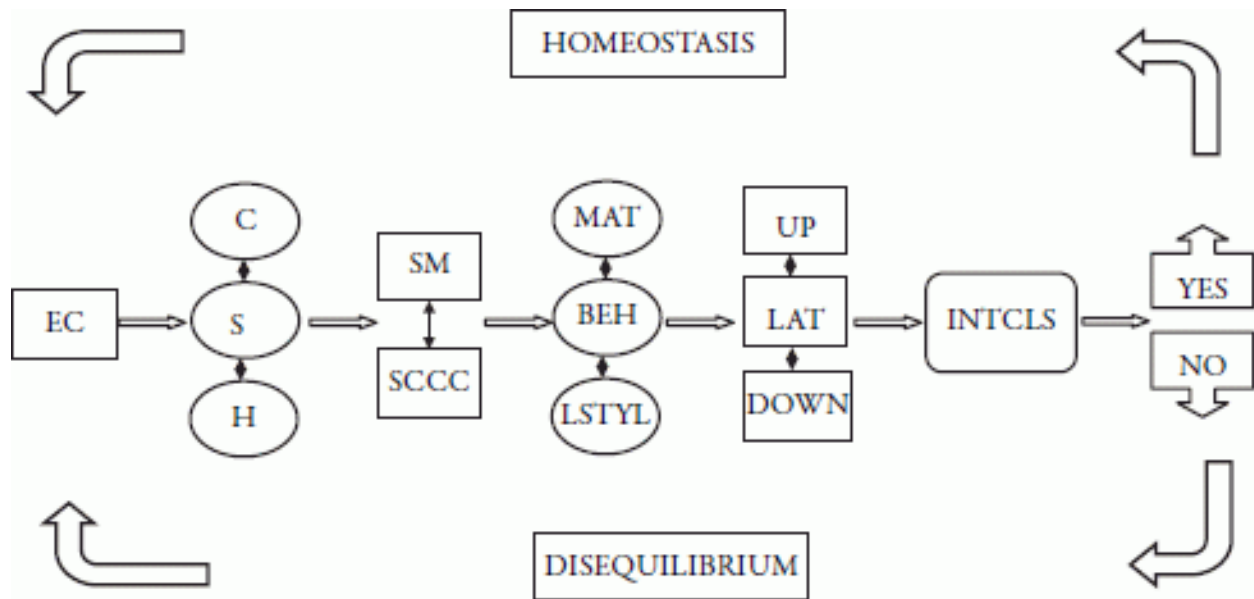
The next manifestation of intrapsychic states of social class construction is the use of classism, "conceptualized as a strategy people use to maximize and ensure their ability to accumulate the needed capital that is valued in their economic culture" (Liu, et al., 2004, p. 107). Modern Classism Theory views classism as happening in multiple dimensions as *perceived* by the subject: as downward classism (as prejudice or discrimination towards people perceived to be



of lower classes), upward classism (as prejudice or discrimination towards people perceived to be of higher classes), and lateral classism (as maintenance of one’s current social class by “keeping up” with those at the same perceived level). As previously articulated, internalized classism is the feeling of anxiety, frustration, anger and despair when a person is not able to meet the economic expectations of that individual’s social class and thus cannot find the desired intrapsychic equilibrium. Thus, reacting to the feelings of internalized classism motivates the way a person enacts classism towards others in an attempt to regain equilibrium. In short, all people use the tool of classism to measure how they compare to others, and to consciously or subconsciously meet the demands of their economic culture.

Figure 1

*Social Class Worldview Model-Revised*



*Figure 1.1* The Social Class Worldview Model—Revised. EC = Economic Culture; C = Cultural Capital; S = Social Capital; H = Human Capital; SM = Socialization Messages; SCCC = Social Class and Classism Consciousness; MAT = Material Possessions; BEH = Social Class Behaviors; LSTYL = Social Class Lifestyle; UP = Upward Classism; LAT = Lateral Classism; DOWN = Downward Classism; and INTCLS = Internalized Classism. (Liu, 2011; Liu, 2012)

Such a perspective complicates standard notions of class and classism that only consider classism as downward, and therefore invisible, elective, or absolute. The Social Class Worldview Model-Revised suggests an intrapsychic system by which social class is conceived, generated, and performed. Additionally, modern classism theory suggests that everyone is always negotiating various class-related dynamics within relationships, that classism is not unidirectional, and thus warrants an ever-present subjective class analysis.

The model helps to explain the arenas within which individuals are sensing, metabolizing, and producing their subjective experience of social class. Clinicians can better understand their clients by learning which of these lenses is the most salient for them, and then addressing conscious and latent content via that lens. Additionally, clinicians would benefit from considering social class as something that is always negotiated within micro- and macro-economic cultures and in the context of intersectionality. Class, thus, may have different meanings for the client at different times.

**Wealth: material, relational, or both?** Another important contribution to the theoretical stance that grounds this work is that of material wealth versus relational wealth. Although attempts have been made to highlight and measure the value that interpersonal relationships have on the quality of life, referred to as “relational wealth,” they have failed in a culture dominated by obsession with material wealth. Within a modern historical context, this was particularly evident in the 1970s and 1980s within societies where a strident *laissez-faire* attitude was taken to the economy. Powerful nations such as The United States under President Ronald Reagan, the United Kingdom under Prime Minister Margaret Thatcher, and Germany under Chancellor Helmut Kohl heralded the idea that “*the market is always right*,” and popularized the idea that governmental regulations in service of human needs only interfere with the natural functioning

of the market (Diwan, 2000). Thus, material wealth became the predominant sole indicator of a nation's, and resultantly a community's or an individual's, wealth and social value. Since this philosophical shift, social scientists have argued that an over-focus on material wealth is myopic. For the context of this work, I will draw on Diwan's articulation of the concept of relational wealth as a vital element of a person's, and a culture's, ultimate health.

First, human and national welfare depends on both material and relational wealth. Material wealth, made up of commodities, provides physical comfort and defines a standard of living. Relational wealth emanates from interconnections with other human beings, giving inner strength and emotional security and defining quality of life. Second, there is a tension between material and relational wealth. As material wealth increases beyond a certain level, it impinges on relational wealth. Finally, current economic practices and policies concentrate on the maximization of material wealth, with minimal concern for its negative effects. Yet the objective of a meaningful economic practice and policy is to maximize material and relational wealth jointly (Diwan, 2000).

**The clinical relationship is very significant.** Finally, this work draws on the theoretical underpinning that values the clinical relationship. It has been well documented that the most important common factor in the success of psychotherapy is not the modality used, but the clinical relationship between the therapist and the client (Elkins, 2012). Additionally, perceived sociocultural identities, such as race and class, of both therapist and client are always negotiated when building rapport. This work attempts to acknowledge the impact of privileged and oppressed identities within the therapeutic relationship. This concept will be further elaborated below, but bears note as an orientation to the working theories.

### **Historical Roots of Social Work and Persisting Economic Ideology**

**Class dynamics at the origins of American social work.** To begin the exploration of the role that social class disparities play in the clinical setting, a reflection on the origins of the social work field are in order. Modern American social workers consider the profession to have emerged during the Progressive Era at the end of the 19<sup>th</sup> century when industrial growth rapidly

developed in the eastern urban areas of the United States. One result of this rapid industrialization was that 50% of the nation's wealth was owned by 1% of the population (Ehrenreich, 1985). Along with industrial growth came a new labor force, mostly consisting of southern African Americans and European immigrants to the United States, who lived crowded together in tenements and contending with poverty and hunger. Politicians often overlooked the plight of these communities. However, some middle- and upper-class, college-educated people, most of whom were women, considered it their "moral obligation" to help those poorer than themselves (Patterson, 2013). They systematically organized themselves to intentionally support the cohesion and betterment of marginalized communities (Weil, 2012). These volunteers are considered to be the first American social workers (Jimenez, 2010). Strier states "Social work evolved as an interclass profession, with its core target populations coming mostly from the lower classes and its founders and practitioners generally based in the middle class" (2009, p. 239). Ultimately, such efforts were considered an altruistic endeavor, and some cast the coordination of better social services as a new form of "scientific philanthropy" (Marx, 2014). Huppertz notes that the trope of "caring" and "moral mentorship" as an expression of middle-class femininity resulted in both nursing and social work being dominated by women: "It has been argued that historically social work was a project of moral middle-class intervention into the morality of the working-class; social work was a 'calling' for women from the middle-classes" (2010, p. 127). Thus, even in the roots of the social work profession, a class disparity between "helper" (i.e., middle- or upper-class) and the "helped" (i.e., poor and working-class) is both evident and intersecting with gender expectations. However, the lack of research on social workers with wealth can still be observed in this case, as much of the historical narrative focuses on the role of middle-class women in the field (Blustein et al., 2011; Smith, 2005).

**Influential ideologies about the rich and poor.** As a profession that is situated between the individual and society at large, Abramovitz points to a tension that is inherent to social work: adjusting people in order to fit their circumstances, or changing the status-quo of society at large in order to better accommodate the reality of people's lives (1998). At the heart of this tension as it relates to economic inequality are various ideologies about how people become and/or remain wealthy or impoverished. The ideology of upward mobility is a quintessential American one, and is based on the idea that any who work hard enough can "pull up their bootstraps" and move up the economic ladder. This mythic narrative emerged in the 19<sup>th</sup> century as a reflection of the increased opportunity in the manufacturing industry. However, since that time the vast opportunities in the labor market have dwindled, and structural obstacles to upward mobility significantly impact and restrict marginalized groups (Jimenez, 2010). Yet the myth of America as a meritocracy has persisted and solidified into an ideology suggesting that those in poverty have not tried hard enough to make it, and those with wealth are morally superior and righteously entitled. Such thinking comingled with the development of Social Darwinism at the end of the 19<sup>th</sup> century. By applying a "survival of the fittest" philosophy to human beings, the thinking was that those who were poor were the least able to adapt to their environments, and in effect should die out. Any help to those in poverty would keep the entire human race stalled at a low level of development (Jimenez, 2010). Therefore, Social Darwinism was used as a quasi-biological justification of massive inequality, and contributed significantly to a culture among economic and political elites of racism and in favor of eugenics. Such examples of the ideological context in which social work emerged are still relevant today. Although prevailing philosophies as to why economic inequality persists have diversified and refined, the myth of

upward mobility and the use of Social Darwinism still exert an influence on public opinion about the poor and the rich.

### **Why Important Now: Current Context**

**Current reality and impact of economic disparities.** As social work in a person-in-environment model, it is important to acknowledge the role that the current economic environment may have on the experiences of clinicians with wealth. In short, the economic inequality, both income- and wealth-based, is expanding in the US economy (The Stanford Center on Poverty & Inequality, 2014). It is no secret that the rich and the poor in the United States have become increasingly polarized over the past years 30 years. Anecdotal evidence, as well as hard data, media headlines, and federal economic policy have propelled this polarization into the spotlight of national politics. Recent results from the Federal Reserves' consumer finance survey conducted between 2010 and 2013 show that the gap between the nation's middle-income families and highest-income families is the largest since the Federal Reserve began collecting data on consumer finances in 1983. The Stanford Center on Poverty & Inequality reports that The Great Recession of 2007 increased the amount of income inequality, increased consumption inequality once the Great Recession ended in mid-2009. Additionally, during the post-Recession years of 2009 to 2013, "...taxable income of the one percent grew 31 percent...while income of the rest of the distribution grew only by .04 percent." (The Stanford Center on Poverty & Inequality, 2014, p. 33) The report concludes: "The equalizing effects of tax and transfer policy had a mild compressive effect on some forms of inequality in the Great Recession, but the longer-term trend towards growing inequality has resumed as more ambitious tax and transfer policies are relaxed." (The Stanford Center on Poverty & Inequality, 2014, p. 6)

As median net worth plummeted by 47% between 2007 and 2010, wealth inequality increased for the first time since the early 1980s (Wolff, 2014). This particularly impacted the net wealth of Black and Hispanic households. Much of this drop has been attributed to the decline in housing values that are the main asset of less economically advantaged groups. Additionally, the median wealth of the country's upper-income families was reported to be seven times that of middle-income families. The nation's upper-income families possess a median net worth *seventy times* that of lower-income families (Fry & Kochhar, 2014). Additionally, following longstanding patterns, the wealth inequality continues to widen along racial and economic lines with whites owning 13 times more wealth than African Americans, and 10 times more than Latinos in 2013 (Kochhar & Fry, 2014). Sociologists refer to this phenomenon as the racial wealth divide. As a field that examines the individual within the context of their family, community, and culture, social work had an obligation to consider the impact of such dramatic economic inequality, and advocate for a more equitable system.

**Class tension in American society and identity.** Despite deep statistical evidences, and vast anecdotal experiences about unequal access to resources, class continues to be a force that is often invisibilized as a factor in measuring disparity (Isaacs & Schroeder, 2004). Some scholars suggest that this ignorance of class and the sociocultural impacts of classism are intentional. Like the use of racism as a tool to disguise and distract from the undergirding superstructure of white supremacy, institutionalized classism is used as a tool to distract from the tension between American ideals and modern corporate capitalism's ministrations (Kasser, Cohn, Kanner, & Ryan, 2007). Yet the tension between America as a free and equal society and as an economic superpower is, at times, extremely palpable; 1999 protests against the World Trade Organization in Seattle, and the recent Occupy Wall Street movement exemplify the electricity of this tension.

Kasser and Kanner note, "...the aims and practices that typify American corporate capitalism often conflict with pursuits such as caring about the broader world, having close relationships with others, and, for many people, feeling worthy and free" (2007, p. 1). Cultural memes and messaging play a key role in this tension. As "the land of milk and honey," the United States is mythologized as a place where all people have equal access to opportunity, as long as they work hard enough and "pull up their bootstraps" (Kasser et al., 2007). Another powerful cultural message is that cultural and social capital is acquired through the acquisition of objects, i.e. consumption (Diwan, 2000; Holt, 1998). Thus, for some, achieving the American dream is less about putting sweat equity into building small, independent businesses (as the bootstrap myth suggests), but instead is focused on using one's labor to enable the purchase of objects that send implicit messages about one's social position. Liu explains this phenomenon in his Social Class Worldview Model-Revised (Liu, 2011). As individuals immersed within the dialogue of this class tension, messages are internalized and personalized, and eventually intrapsychically integrated (Liu, 2011). Researchers suggest that decreased standards of living due to laissez-faire economic policy result in interpersonal anxiety and frustration, overcompensation in the form of material-goods consumption, and the loss of community cohesion due to class-based fissures (Diwan, 2000; Kasser et al., 2007).

**A vacuum of statistics about clinicians with wealth.** As previously noted, there is a conspicuous lack of research on the impact of social class within the helping professions (Blustein et al., 2011). The research on clinicians with wealth is even sparser, and this gap in literature should be rectified with further study. While the Bureau of Labor Statistics and the National Association of Social Workers keep records of labor trends within the field of social work that includes median salary, this researcher has not uncovered any comprehensive



information about more detailed socioeconomic demographics such as personal wealth. Evidence for the historic positioning of social work as a middle-class profession can be seen in salary figures (Mendes, 2005). A 2010 survey by The National Association of Social Workers and The Center for Workforce Studies reported that the majority (60%) of social workers in 2006 earned a salary between \$35,000 and \$59,999, with only 3% of social workers earning more than \$100,000 (2006). Given such salary levels, we can assume that most social workers that have wealth did not earn it from their jobs as social workers. I personally speculate that wealth may often come to social workers from inheritance, lottery winnings, investments, and via marriage. Yet, without any concrete data, drawing conclusions other than speculative assumptions would be irresponsible. Thus, this research moves forward with a blinding gap as to how large this population of study truly is.

What are the implications for clinical mental health? The invisible and complex mechanisms of class in contemporary American society function on multiple interdependent levels: institutional, policy, interpersonal, and intrapsychic. Clearly, there is a role for clinical mental health practitioners in understanding the impact of class and classism on our clients, and ourselves (Liu, 2011; Liu, Hernandez, Mahmood, & Stinson, 2006; Liu et al., 2004; Liu, 2012, 2013). As those who specialize in the “person in environment” model, it is particularly salient for the field of social work to take up the mantle. Such an objective requires the effects of classism to be examined at multiple sites related to the clinical encounter: within the psyche of the client, within the psyche of the clinician, within the third-space created by the client and practitioner’s intersubjective meeting, within the organization, setting, or institution where the encounter takes place, and within the professional field as a whole.

## **Psychology and Mental Health of the Affluent**

Within social science literature, there is significant research on the social, psychological, political and economic effect of oppression. While such scholarship has intended to contribute to an amelioration of the functional maladies that those with oppressed identities face, we are generally only seeing half of the picture. As systems that focus on the cyclical relationship between oppression and privilege, it is critical to also be curious about the systems and people who benefit from oppression. Israel articulates this concept well:

This tendency to focus on oppression rather than privilege is something I've observed in our profession, as well as in my own experience. Although oppression and privilege are interrelated, it seems much easier to look through the lens of our own oppression to see other people's privilege than it is to examine our own privilege. Of course, there is much work still to be done by focusing on oppression, and I think those conversations will be most effective if we bring exploration of privilege more centrally into our process and integrate it with an understanding of oppression so we have a more complete picture of how power operates in our society. The conversation about privilege is not unrelated to the conversation about oppression, but it takes us in a slightly different direction. And, without it, we're missing a piece we need to do the work that we are best equipped to do as counseling psychologists working with societal inequities. (Israel, 2012, p. 160)

Thus, this work turns attention to examining what light the literature can shed on the nature of privilege within the field of mental health via populations with wealth. Additionally, this exploration is intended to suggest further exploration of the intrapsychological effects that wealth may influence, such as feelings of isolation, materialism, narcissism and control-seeking behaviors. The intent is to broach a conversation on how such unconscious social class worldviews may influence the therapeutic relationship when the clinician has access to wealth (Liu, 2011; Liu, 2012).

**Subjective social status and psychological health.** As previously discussed, research has demonstrated that there is no specific formula which results in psychological health or well-being. Psychological health is, in fact, also subjective. Vast bodies of research point to a

connection between socioeconomic status and physical and psychological well-being. Yet a direct, objective relationship between robust socioeconomic status and well-being remains illusive; money does not always make us happier, and it may not always make us healthier either (Binswanger, 2006; Csikszentmihalyi, 1999). However, one's own subjective sense of socioeconomic security has been linked to more positive psychological outcomes (Adler, Epel, Castellazzo, & Ickovics, 2000).

With sensitivity to the subjective nature of both socioeconomic status and mental health, let us turn our attention to the psychological effects of material wealth and privilege. Gift, Strauss, Ritzler, Kokes, and Harder showed that psychiatric patients with higher socioeconomic standing had fewer neurotic symptoms two years after discharge than their lower socioeconomic standing counterparts (1986). However, the authors are careful to remind us that their findings do not indicate causation: low socioeconomic status is not the cause of psychiatric illness, just as psychiatric illness is not the cause of low socioeconomic status. Instead, the authors suggest that those with higher socioeconomic status are more likely to conform to society norms which are considered desirable and acceptable, leaving those with lower socioeconomic access to appear deviant (Gift et al., 1986). What then are the psychological and developmental costs of such conformity? And even more important, what unconscious patterns are clinicians with wealth harboring that influence their interpretations, countertransference, and rapport with clients?

**Does money make people happier?** One powerful assumption that is tightly woven into the myth of the American dream is that hard work will result in money, and money will in turn result in the purchase of things that people desire such as safety, security, material goods, health, and pleasurable experiences. In essence, there is an intuitive assumption that more money results in more happiness. In examining such assumptions, researchers remain conflicted. A 2010 study

suggested that emotional well-being increases with income until incomes reach \$75,000: above that figure, emotional well-being does not increase (Kahneman & Deaton, 2010). Some studies that measure well-being in developed countries suggest that people would be happier if they had more free time, yet less income (Binswanger, 2006). Yet, while a higher income can substantively contribute positively to a person or family's well being, it is not the only determining factor. The link between well-being and money may be small, but it is none-the-less substantive and results in significant quality of life differences (Lucas & Schimmack, 2009). Other research on well-being indicates that happiness can be better explained as a function of other sociological factors than money, such as relationships, interpersonal connections, and positive attitudes (Csikszentmihalyi, 1999; Diwan, 2000).

**Affluent youth: at risk and invisible.** Most of the research about the mental health of the affluent comes from the exploration of affluent youth and vulnerabilities inherent in the structure of their upbringing. Some of this research derives from a desire to better understand high-profile crimes perpetrated by affluent youth, such as the recent case of Thomas Gilbert Jr., a young man who was accused of fatally shooting his father after an argument regarding the 30-year-old's allowance (Lieber, 2015). Overall, affluent youth have been found to be at high risk of substance abuse, anxiety, and depression; specifically, older female teens tend towards depression, male teens seek peer approval via substance abuse, and all genders internalize the expectations placed on them by their economic cultures by self-monitoring with increased anxiety (Luthar & Becker, 2002). It has been theorized that these behaviors appear in affluent youth because of significant parental and cultural pressure to "succeed," as well as physical and emotional isolation from others, particularly parents who often work long hours in order to remain affluent (Luthar & Latendresse, 2005). Some have even suggested that affluent youths' attachment to material

possessions and substance abuse is a replacement for attachment to safe self-objects. Kleefeld states, “Unrealistic expectations combined with chronic parental absences lead to mirror-hungry personalities and false-self adaptations which great inherited wealth often complicates” (2000, p. 1). Additionally, because affluent youth are not considered the typical high-risk teens, their needs and struggles are often invisible to teachers, school councilors, and even their own parents (Bogard, 2005).

**Psychoanalytic interpretations of the wealthy.** Although it is beyond the scope of this paper to examine all of the psychological underpinnings that influence stereotypes of wealthy people as selfish, greedy, materialistic and uncaring, it is useful to question how such characteristics have become attributed to the wealthy. Pervious research suggests that system justification and defense of the status quo are strategies for reducing the intrapsychic anxieties of guilt, dissonance, discomfort and uncertainty (Jost & Hunyady, 2002; Kay et al., 2009). From a psychoanalytic perspective, I wonder if the characteristics of narcissism, greed, and materialism are intrapsychic defensive tools that people with wealth cultivate in order to reduce social rejection, uncertainty and isolation.

As previously discussed, Kasser et al. suggest that the structure and values of American corporate capitalism such a competitiveness and material acquisition may impede its citizens from valuing human connection and caring about the greater human condition (2007). For those who have been raised in a culture of wealth that normalized emotional isolation (Luthar & Latendresse, 2005), entering into a system which both replicates early socio-emotional patterning and validates the utility of isolation for the sake of wealth may in fact experience soothing in this system, as it replicates an early environment. Additionally, research on the link between social and emotional rejection and the spending of money has concluded that those who feel rejected

may lean on the acquisition of goods, or materialism, in order to quell the pain and appear more appealing to others (Baumeister, DeWall, Mead, & Vohs, 2008). However, materialism has been equated with lower levels of psychological well-being (Christopher, Kuo, Abraham, Noel, & Linz, 2004) and feelings of inadequacy in relationship to money (Christopher, Marek, & Carroll, 2004). Therefore, the use of materialism as a coping mechanism to defend against the socio-emotional isolation of wealth may only offer an short-term antidote which, in order to be sustained, must continuously be updated, reinforced, and justified. Although it is beyond the scope of this paper to do so, exploration about money and materialism from an object relations perspective would be further illuminating.

Another relevant interpretation comes from the work of Kaplan, which uses a psychoanalytic perspective, to consider how greed can be seen as an adaptive function. By relating the consumptive, excessive, and insatiable nature of greed to the Freudian concept of orality, greed can be seen as a strategy to stave off the anxiety of one's primary needs not being met (Kaplan, 1991). Furthermore, when seeking out social relationships in order to reduce the impact of social isolation, people tend to be drawn towards those whom they find twinship with. Individuals who follow greed tend to surround themselves with other greedy people so as to both appear "normal" and narcissistically advantaged (Kaplan, 1991). However soothing such greed, materialism and narcissism are to the individual in the short term, their long-term costs to the community and society are larger are well documented (Campbell, Bush, Brunell, & Shelton, 2005).

In short, psychoanalytic approaches may help to understand some of the nuanced intrapsychic experiences of people with wealth. Although the characteristics of materialism, greed and narcissism are by no means a determinant or result of wealth, the early socio-

emotional conditioning of those who grew up in the context of great wealth may be illuminating as to what clinicians with wealth need to be on the lookout for in terms of their own wealth-induced and adopted cultural bias.

### **Connection over Difference: Negotiation of Identities within the Session**

**Rapport is a reciprocal, ongoing process.** Research suggests that the assessment and negotiation of similar and dissimilar social identities is a reciprocal process undertaken by both the client and the therapist. Such identities may be seen, invisible or assumed, and may be overtly, subtly or unconsciously negotiated. Previous research sheds some light on how perceived social class identities are negotiated within the clinical setting. Thompson, Cole and Nitzarim used qualitative methods to explore subjective psychotherapy experiences among a diverse group of clients who identified themselves as low-income or poor, and had been attending six or more therapy sessions within the past six months (2012). Overall, respondents reported that their perceptions of their therapist's socioeconomic class was always a factor in how comfortable and known they felt in sessions (Thompson et al., 2012). One limitation of this research is that it was done with self-selecting clients who had enough strong feelings about therapy that they took an extra step to tell a researcher about it. Regardless, these data show us that perceived socioeconomic class can often be a factor for clients. Chalifoux's interviews with working-class women about their experiences in psychotherapy with non-working-class therapists revealed similar insights: clients often felt that the therapist could not attune to the client's basic life experiences and decision-making rationales (1996).

From the perspective of the therapist, the literature on clinician's attitudes to treating those of lower social classes than themselves is mixed. On one hand, it is clear that therapists' evaluation of their clients' class can have significant effect on the resultant psychosocial

assessment of the clients, their treatment plan, and the clinicians' expectations of success for the clients in treatment (Redlich, Hollingshead, & Bellis, 1955). However, the subjectivity of the therapists' own and possibly diverse experiences and biases as classed persons themselves has only recently become a recognized factor within research. The early body of counseling psychology research on working with low-income clients both erroneously assumes that clinicians will all hail from middle- or upper-class backgrounds, and that bias against working with such "challenging" populations is a given (Lorion, 1974). Although a deeper exploration of the history of social class attitudes regarding psychiatric treatment is not possible within the scope of this work, it is an important element in the literature to flag.

While the use of cultural competency has attempted to address such overt clinical biases, attitudes of overt and subtle classism still have some influence on clinical judgment. In a 1970 quantitative study, clinicians judged the appropriateness and success of psychotherapy for two different analog case studies, one with a person who identified as middle class, and other person who identified as working class (Vail, 1970). As with other studies that employ analogs to gauge clinician response and bias, caution must be used when generalizing results to in-vivo experiences. Therapists' responses to a case study or clinical vignette may be very different than their responses to a client in front of them (Dougall & Schwartz, 2011; Vail, 1970). Yet, the results from the Vail study show that a client's potential for treatment is not influenced by race, or the assessing social workers' level of experience, but by socioeconomic class. While some further research has corroborated these results, other research refutes it (Mitchell & Atkinson, 1983; Siassi & Messer, 1976). Mitchell and Atkinson suggest that this discrepancy in data may have to do with the fact that research previous to theirs assumed homogeneity of the therapist's social class, while theirs took into account the therapists' subjective class experience. Other



research has suggested that negative countertransference may play a part in cross-class therapeutic dyads; the higher the clinician's social class, the more irritation and anger the clinician may feel toward clients who are financially challenged (Patterson, 2013). There is speculation that this is the case because those in higher classes have fewer practical skills to alleviate economic hardship, and fewer skills in meaningfully relating to those in poverty. The author of said study suggests the use of supervision and countertransference discussion groups for clinicians to build camaraderie and a shared understanding of how class plays into such negative countertransference. Yet, evidence of clinicians' classist attitudes is not exclusive to those of lower socioeconomic status. While slim in volume, what research there is also points to negative attitudes towards those of higher socioeconomic status, particularly the affluent (Cashman, 2007; Kleefeld, 2000; Luthar & Sexton, 2004).

**Class-based clinical bias.** It could be tempting to assume that clients and therapists' assessments of each other are mutual and harmless. However, within a psychotherapeutic setting, the clinician's assessments may impact the diagnoses, treatment planning, and services provided to clients (Franklin, 1986). Lack of familiarity with a client's cultural group often causes clinicians to default back to the standards derived from the clinician's own culture (Ginsburg, 1951). Clinical biases are dangerous, particularly because they can play into dominant cultural norms and prevailing prejudice. As the focus of this work is on social class, I will define social class bias as an assumption of the value of upward mobility and the belief that people should always be striving to improve their economic positions and social classes. Upward mobility is normalized, and those who do not strive for upward mobility are considered deviant (Liu, et al., 2007; Liu, et al., 2004; Liu, et al., 2004). In a 1997 qualitative study, Garb reviewed research about clinical bias from all of the PsychLIT publications between 1974-1996. His analysis of 22

years of research revealed that clinicians tended to present specific biases with regards to race, gender, and social class. He cited a race bias in differential diagnosis of schizophrenia and psychotic affective disorders, and a gender bias in differential diagnosis of histrionic and antisocial personality disorders. A social class bias was implicated in the referral of clients to psychotherapy (Garb, 1997).

While most research only looks at bias within a clinical capacity, it is worth considering the therapists' own identity-based reactions. For example, it may not simply be the clients' socioeconomic statuses that the clinicians are responding to, but also their own situations within the hierarchy of social class. Some have suggested that all mental health clinicians are potentially classist because of their privileged status as white-collar professionals, and the theories used in their education and practice are based in models of upward mobility bias (Lott, 2002; Smith, 2005). Counselors, particularly those with class privilege, must be aware of their bias to see those who are not upwardly mobile as lazy, unmotivated, or pathological (Graff, Kenig, & Radoff, 1971). Conversely, counselors must be wary of idealizing those of different classes, or seeing the poor as noble, or as victims, and without agency (Liu et al., 2007).

It is important to consider what social factors have influenced the patterns of social class bias. In fact, all clinical bias could be a partial result of countertransference. Dougall and Schwartz (2011) examined the impact of the client's socioeconomic status on the psychotherapist's attribution bias and reactions of countertransference in a sample of 141 clinicians via a web-based analog case study and follow-up survey. In this quantitative study, each clinician received an analog vignette about a client with either a low socioeconomic identity, or a high socioeconomic identity. After reading the case and watching a four-minute video about the client, participants completed a survey that included relevant questions from the

Clinical Attribution Scale, the Impact Message Inventory-Circumflex, the Marlowe-Crowne Social Desirability Scale, and Clinical Judgment items. The results showed that there were no significant differences in attribution bias between socioeconomic classes. However, the vignette of the client from a high socioeconomic position evoked countertransference reactions of feeling dominated, via direction, control, leadership or influence, by the client. Findings also showed that clinicians more readily diagnosed those from a lower socioeconomic position as having more severe problems than the mild problems of those from a higher class (Dougall & Schwartz, 2011).

**Class-competent work and responding to countertransference.** Skillfully responding to clinical bias and countertransference with cultural competency is a skill that social workers aim to use to reduce the impact of their own unexamined reactions on their clients (NASW, 2001). It has become common practice within the helping professions to become “culturally competent” by becoming self-aware, knowledgeable, and skillful when working with “cultural others” (Sue, Arredondo, & McDavis, 1992). This idea has been critiqued as assuming that identity formation is static; intersubjectivity theory, however, suggests that we are all always re-defining our identities vis-à-vis relationships with other people. Thus, it may be unlikely that one could ever become fully competent about the culture of another. Therefore, cross-cultural competence may be an unreachable goal, but is yet worthy of striving towards within the conscious context of one’s lack of cultural knowing (Dean, 2001).

Within psychodynamic theory, the assumption is that, if well attuned, the therapists can remain neutral, or at least non-harming, in their reactions to and interpretations of the client. With clients who do not share the same demographic characteristics of the therapist, this sensitivity to countertransference can help strive towards cultural competence with regards to

their different identities. Yet this perspective alone lacks an analysis of power. Spanierman, Poteat, Wang and Oh (2008) suggest that cultural competence from a clinician with a dominant identity requires being in touch with one's feelings and experiences regarding that dominance. Due to the lack of research on class differences between clients and therapists, I will use the analog of race to frame the impact of social power within the clinical dyad. Using two interrelated investigations in their quantitative study, the authors assessed the responses of 311 white counseling trainees to see how their own reported psychological costs of racism (as measured by the Psychosocial Costs of Racism to Whites scale) related to their multicultural counseling competency. Results showed that those who were in personal touch with their affects regarding race privilege, measured by white empathy and white guilt, had higher levels of multicultural competency in their practice (Spanierman et al., 2008). Thus, it is important for social workers with dominant identities to not only learn about their biases when working with people who possess marginalized identities, but to be able to hold the inherent contradictions of their own privileged identities within the therapeutic space. While this research focused on race as a mediating factor of the therapeutic relationship is helpful, further research is needed on the impact of classism on class-privileged clinicians.

Yet, what beyond "being aware of your own feelings" does research in cultural competency lend to the practice of social workers with wealth? Strier argues that over the course of social work's development, the field has significantly shifted from one that singularly advocated for the alleviation of suffering due to an oppressive class system, to one in which "social class has lost its visibility as a major contextual component to diversity" (2009, p. 239). While it has been crucial for social work to deepen and expand its power analysis to take into account race, gender and culture within an intersubjective and deconstructivist framework, this

has resulted in a dismissal of class as a factor that warrants deeper re-interpretation (Liu, 2011).

Within psychoanalytic social work, the conversations about class have been particularly absent

(Smith, 2005). Strier suggests a 4-part comprehensive framework for class-competency:

Class-competent social work should be defined as the knowledge, skills, theoretical approach and critical awareness required to effectively help clients oppressed by class structure.

First and foremost, class-competent social work requires class knowledge. Social workers should have the capacity to understand the dynamics inherent in their client's class situation and be able to analyze the inter-connectedness of class with other diversity components such as race, culture and gender. Social workers must have the knowledge needed to identify the systematic barriers associated with class constraints. This understanding must exceed the scope of the economic sphere and should include cultural, social and symbolic aspects related to it.

Second, class-competent social work demands the acquisition of specific professional skills in order to assist clients in challenging class oppression. Skills include a wide range of practices used in social work, such as case and policy advocacy, participatory action research, group work, community practice, consciousness-raising methodologies oriented to address the personal, interpersonal, organizations and political aspects of class issues. Additionally, given the inter-class nature of many worker-client encounters, social workers should deploy skills and methodologies aimed at developing more egalitarian worker-client relationships.

Third, class-competent social work entails a certain theoretical approach that acknowledges the structural nature of social problems, recognizes the essential influence of the clients' class situation on their personal and collective lives, and is cognizant of the class-based nature of social policies.

Lastly, class-competent social work also implies a sense of critical self-awareness. Social workers should be aware of their own class biases and assumptions, and they must be open to critical debate on how these biases and assumptions may affect the cross-class nature of worker-client relationships. They must be conscious of the extent to which power and class conflicts are involved in the interactions between clients and social workers. Furthermore, social workers must be prepared to critically identify and deconstruct class-based discourses of different theoretical perspectives in social work. Most important, class-competent social workers must be able to promote their clients' class awareness and be ready to support their class interests (2009, p. 241).

There are various tools and strategies available the assist in striving towards class-based cultural competency, such as the Social Class Worldview Model-Revised, or the Social Class

and Classism Consciousness model as described previously (Liu, Corkery, & Thome, 2010; Liu, 2012). The efficacy of such tools lies in the learners -- to understand class as a personal experience and associate each client's affects and cognitions to the client's own experiences: in short, such tools teach the subjectivity of the intrapsychic class experience.

Yet social class and classism within the helping professions deserves more scholarship and attention within the academe than it currently has. As the field of multicultural counseling has rapidly expanded, the study of class and classism has not kept pace, yet the groundwork had been laid by the deep study of race and gender in the clinical setting. Scholars suggest that we need to shift from a static sociological methodology and terminology that is based on simple indices such as income, wealth, poverty levels. Instead, the helping professions would do well to shift the focus to a intersectional, intersubjective, meaning-making approach to the role of class in client's lives (Liu, Hernandez, Mahmood & Stinson, 2006; Liu, 2013).

### **Professional Mandates to Address Class and Power**

The above findings would suggest that a major educational and training component within the helping professions should be a rigorous study of our own positionality within systems of privilege, oppression and power. However, such depth of training and reflection as it relates to class is conspicuously absent from the vast majority of social work education, and thus from practice. Smith (2005) has argued that psychotherapists' lack of competency and willingness to work with those of lower socioeconomic status is a chronic negative bias, part of an accepted yet unexamined classism that is deeply imbedded in the field. Liu (2004; 2013) suggests that this negative bias is compounded by an upward mobility bias that assumes healthy people are always striving to make more money and climb the socioeconomic ladder.

One possible reason for this lack of class-related cultural competency within social work education is a lack of specificity within the NASW Code of Ethics (2008). Throughout the code, reference is made to the field's primary roots and modern day focus on poverty and unemployment alleviation. For example, within the value of social justice, the centrality of examining issues of class is clear from the focus on issues of poverty, unemployment and discrimination.

**Value:** Social Justice

**Ethical Principle:** Social workers challenge social injustice.

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. *Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity.* (Emphasis added) Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

However, the 2001 NASW Standards for Cultural Competence in Social Work Practice identifies social class as an area within which the field must gain further and deeper competence (NASW, 2001). In the most recent revision to the code in 2008, a clause was added to section one, Social Workers' Ethical Responsibility to Clients, which has a conspicuous lack of discussion about poverty or class as a dimension that requires cultural competence.

1.05 Cultural Competence and Social Diversity

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability ("NASW Code of Ethics," 2008).

In order to produce culturally competent and intersubjectively reflexive clinicians, it is essential for the field to clarify what constitutes the intersection of social justice, cultural competency and social welfare as they relate to class.

### **Challenges to Research on Class Differences within the Clinical Setting**

**There is very little research about wealthy clinicians.** Overall, clinical and sociological research about populations with wealth in the United States is scarce, particularly in comparison to research about populations experiencing poverty. This phenomenon may be indicative of the privileges that any powerful social position offers: invisibility of those in power, and the creation of a pathological position of the dialectically “deviant other.” Thus, it may not be surprising that very little direct research exists about clinicians with wealth who work with non-wealthy clients. As the reader can tell from this literature review, very few researchers take on the topic directly. William M. Liu’s work on classism within the context of clinical psychology is one exception. Throughout his significant body of work on the effects of class and classism, he considers the mental health effects of classism on those who suffer from it, as well as those who benefit from it (Liu, 2011; Liu et al., 2006, 2007; Liu et al., 2004; Liu, 2006, 2013; Liu et al., 2004). Yet, within this work, he specifically calls for more research into the latter arena. He states,

For counseling psychologists to be culturally competent scientist–practitioners, it is important that the research available to them be meaningful. In terms of social class, this review shows that the available research is inconsistent and may be confusing. Hence, it may be difficult for counseling psychologists to use the research findings in practice and scholarship ( Liu, et al., 2004).

Therefore, one of the most glaring limitations to this review of the literature is that there is very little literature to review. I have attempted to address this by reviewing current research in areas that are contiguous to the research question. While this review may read as disparate in focus, it is my attempt to cover many different aspects of classism within the clinical encounter in the absence of a linear line of previous research.



**Lack of a consistent measure for socio-economic status.** Within the research that has been available about the impact of classism and wealth in the clinical encounter, two significant challenges have emerged: the lack of a consistent measure for class or socioeconomic status, and the lack of an operationalized definition of social class and socioeconomic status. Liu et al. found that the use of social class in counseling psychology literature is inconsistently defined, assessed and analyzed. Of the 3915 articles that they reviewed in their 2004 quantitative study, only 18% (710) included social class as a variable within empirical and theoretical literature. Within these, social class was peripherally mentioned more often than deeply integrated into the analysis; 31% integrated social class into the methods section, but only 10% included social class in the discussion (2004). Yet even within these discussion sections, it was pointed to as a limitation to the study, or a parenthetical cultural construct to be flagged for future research. Liu et al. noted the inconsistent use of words to denote social class, citing 448 different key words. This points to class as a concept that has not been properly operationalized, and thus deeply hard to isolate for research. In short, psychological research on class and classism has been significantly restricted by the shortcomings of its sociological methods and terminology.

Such lack of clarity impacts the fields of sociology and psychology's understanding and framing of "the problem of poverty." Baker points out that using class indicators such as *poor*, *working-class*, *middle-class*, and *owning-class* to describe the results of classism is an echo-chamber, as such categories are integral aspects of the economic stratification that they purport (Baker, 1996). This argument heralds back to Audre Lorde's famous article, "The Master's Tools Will Never Dismantle the Master's House" (Lorde, 1984). The field of research on social class and classism in the United States is inherently restricted because the language we have to

describe the problem is, in itself, marinated in a hyper-capitalist paradigm which views economic disparity as inevitable.

Beyond paradigmatic considerations, a major challenge to the research is that there is no universally accepted, cross-discipline measure for social class that neutrally takes into account the myriad factors that constitute a person's class. Oakes and Rossi, in fact, claim that the debate about how to measure "socioeconomic status" has been alive since the term was first coined in 1883, and will end only when social scientific research ends (2003). When measurement against the Federal poverty line may once have sufficed, that standard is no longer acceptable as it is "an arbitrary classification that was first used in 1963–1964 to define the amount of money needed to buy the cheapest foodstuffs multiplied by three" (Liu, 2006, p. 337). The field of social work has long considered the person-in-environment as the context in which we can understand human interaction, development and motivation, and this perspective has spread throughout social science disciplines such as psychology, epidemiology, public health, and medicine. Yet the precise variables that each field considers relevant to the measure of class are not consistent, and researchers have failed to develop a satisfactory measure or language to dependably study and define social class and classism (Oakes & Rossi, 2003).

As previously discussed, attempts have been made to pin down a precise yet universal measure of social class, but with mixed results and disagreements between researchers. For example, in response to the American Psychological Association's 2000 *Resolution on Poverty and Socioeconomic Status*, Smith published an article outlining the various ways in which class is ignored within counseling psychology's teaching, research and practice. Most notably, the lived experiences of people in poverty are not considered valuable enough to include in most counseling psychology curriculums. In response, Liu et al. proposed that class is much more

complex than Smith's assertion when considered in a postpositivist light: not only is it constantly negotiated within social, legal, and institutional interactions, it is also a deeply subjective experience as to how individuals within each interaction experience the class-associated subtext (Liu, 2006, 2012). In effect, one major challenge is not simply that researchers haven't been able to agree on an operationalized definition for this field of study. Instead, the challenge is that the meaning, function, and response to social class and classism changes depending on the grounding philosophy that researchers use.

**Research done on WEIRD subjects.** Another important critique of the research is that much of it has been done at major American research institutions that draw heavily from the student body as subjects (Dougall & Schwartz, 2011; Garb, 1997; Liu, et al., 2004; Vail, 1970). This undoubtedly skews the data in a variety of ways. A 2010 article in *Behavioral and Brain Sciences* noted that behavioral scientists regularly publish research whose samples are entirely composed of people who come from western, educated, industrialized, rich and democratic (WEIRD) societies (Henrich, Heine, & Norenzayan, 2010). By comparing databases from across the behavioral sciences, the researchers found that such populations cannot be considered standard subjects from which to generalize about universal human nature. In fact, these "WEIRD" subjects are frequently outliers when compared to the psychology, motivation and behavior of the general population. This is an important perspective to take into account in the context of this literature review, as much of the research the author has cited about social class, clinical bias, and classism has included studies on "WEIRD" populations. Furthermore, due to the current cost of higher education in the United States, one can presume that such study populations may not be representative of diverse socioeconomic class experiences because they do not include the experiences of people who cannot afford to go to college.

**Assumption that all social workers are middle class and white.** Related to this is the assumption within literature that all clinicians, particularly social workers, are middle-class. Research is often presented from the perspective of the clinician as unbiased and neutral. Tacitly, this suggests that the clinician is a model of social neutrality: white, middle-class, and aspirational of upward mobility (Liu, 2011). Although this may often be the case, a more nuanced examination of the countertransference patterns, employed defenses, and areas of resistance from wealthy therapists when working with non-wealthy clients may give us deeper perspective into the dynamics of classism and class privilege within a therapeutic dyad.

### **Summary**

Given the lack of previous research about social workers with wealth, this literature review has attempted to construct a landscape of previous research about social class, classism, and the social work profession within which to frame the following research on clinicians with wealth. By using an intersubjectivity framework to consider the complexity of social class, I explored the question of wealth as material, relational or both. By combining this question with critical theories of power, I propose that, like race, class is constantly being re-defined and re-negotiated within social relationships. The clinical relationship is no exception, and thus deserves attention from the field as a whole. By examining the historical roots of the social work profession, it is clear that the field developed with the goal of ameliorating the effects of poverty, and was mostly driven by middle-class women. Thus, there is a long history of class-based difference between clinician and client. However, given the current state of dramatic economic inequality in the United States, how does the field of social work justify its drift away from directly addressing issues of economics in the lives of its clients? Overall, the field has communicated a dedication to responding with appropriate attunement to “the cultural other” in

order to reduce clinician bias. However, deep integration of this ethos has not yet trickled down into social work education, especially when it comes to the examination of the social worker's socioeconomic class. One predominant strategy that social workers use in striving towards such competence is knowing their own triggers, sites of oppression, and places of privilege. Ideally, this results in a dynamic flexibility about the meaning of one's own reactions and interpretations to the client, and allows the client to remain at the center of meaning making within the session. However, without a pulse of the clinician's own class-bias and class-based countertransference, clinicians are left in the dark when it comes to bringing class into the therapeutic space. For clinicians with class privilege, there are multiple macro-cultural factors that may contribute to clinicians' remaining less than cognizant about their class-bias, namely the invisibility of class privilege and the assumption on upward mobility. What research there is on the affluent shows that youth may be deeply vulnerable to substance abuse and depression, while adults may use system-justification to allay their anxiety about their positionality within the hierarchy of class. Social workers with wealth may be simultaneously asked to see their privilege for the sake of the field, yet simultaneously deny it for the sake of compliance with the invisibility of their class status. Thus, social workers with wealth may be caught in a double bind. This research attempts to fill some of the many gaps surrounding the role of social class within the clinical relationship by further exploring how clinicians with wealth experience class-based tension when working with clients who are "classed-others."

## **CHAPTER III**

### **Methodology**

#### **Formulation.**

The purpose of this study was an exploratory, descriptive effort to investigate the experiences of clinicians who self-identify as wealthy, and to understand the impacts, if any, that a clinician's access to wealth may have upon all aspects of clinical work with clients of different socioeconomic class backgrounds.

This research surveyed mental health clinicians who self-identify as wealthy. The goal was to learn about their subjective self-perceptions of socioeconomic differences between themselves and their clients across the clinical encounter, including but not limited to assessment, treatment, fee-setting, and use of supervision to address clinician's responses to socioeconomic differences. Additionally, this research explored what clinicians with wealth do, if anything, to note discomfort, and how they cope with these socioeconomic differences. The intent and benefit of this research is to support the field of social work to be more knowledgeable about class-based issues as they related to clinicians with economic privilege, and thus more sensitive to our clients of all socioeconomic classes. Implications for social work education, research, and policy are discussed in the discussion chapter.

The over-arching research questions were: 1) How do clinical mental health professionals with independent and/or personal wealth experience working with clients of different socioeconomic class status? 2) Are there specific ways in which workers note discomfort or

problems in such class-discrepant work? 3) How do clinicians attempt to cope with such problems, if they experience them? This chapter provides an overview of the process by which this research was conducted, including sampling, data collection, and analysis.

### **Definition of Terms**

For the purposes of this study, “clinicians” was defined as master’s- or doctoral-level mental health clinicians in the fields of social work, psychology, psychiatry and counseling. Those currently in a master’s- or doctoral-level graduate program were also included in the sample.

“Wealth” was defined as: direct possession of, or access to, material resources that release the individual from relying on earned income for daily needs, financial stability, and future earnings. Personal wealth may come in the form of money, land, stock, or other material assets. Personal wealth may have been inherited, earned, gifted or won. In this study, this study, “wealth,” “personal wealth” and “independent wealth” are terms that will be used interchangeably.

### **Study Design and Sampling**

This exploratory, descriptive study involved participants who self-identify as “clinicians with wealth.” Participants completed two online surveys; the first was a confidential survey of participant demographics, and the second was a confidential, anonymous quantitative and qualitative survey in responses to specific questions. Both surveys began with a required informed consent acknowledgement. Both surveys were administered via SurveyMonkey,

**Survey 1.** Survey 1 collected demographic information, and requested that interested participants self-identify with the target population as defined by the researcher (See Appendix C). This screening survey included 16 questions relating to the following fields: name, race, ethnicity, age-range, number of years in the field of clinical work, clinical discipline, political ideology (ex. progressive, liberal, moderate, conservative), geographic region of work, and manner of wealth acquisition (ex. inheritance, lottery, earnings, etc). The demographic information gathered by this screening tool from all respondents is included in the findings section of this report, excluding identifying information. This demographic information has been used in the report to acknowledge the demographic diversity, including limitations and insights, that the eligible respondents offered this study; this will be discussed further in the findings section. Finally, Survey 1 offered the interested participants an opportunity to ask the researcher questions about the study. I offered my email address to participants at the conclusion of Survey 1, and welcomed comments and questions within the recruitment emails.

**Screening.** Screening of Survey 1 participants was achieved in two steps. First, interested participants filled out Survey 1, which provided the opportunity to self-screen via a confirmation of membership in the target population; those who did not identify as having “wealth” as defined by this study, and those who did not hold the professional qualifications of a mental health clinician. Four interested participants screened themselves out in this manner, and did not complete Survey 1. I completed the second screening from the data collected by Survey 1. Fourteen interested participants indicated that they did not identify as the target population yet completed the survey. I screened out this group by not inviting them to complete Survey 2. Of the 54 interested participants who completed Survey 1, 41 were not screened out and invited to complete Survey 2. Of these people, 33 completed Survey 2.



*Survey 2.* Once eligible participants were screened for membership in the target population, I sent them a link to Survey 2, an anonymous survey soliciting quantitative and qualitative reflections on their experiences as clinicians with wealth (See Appendix D). Survey 2 was comprised of 23 questions. Survey questions were a mixture of Yes/No and Likert-scale (quantitative) and short-answer text boxes (qualitative). Research participants were given the option to decline answering any questions of the questions (excluding questions assuring informed consent), and could exit the survey at anytime. Survey 2 was designed be anonymous because the researcher believed such a design would give eligible participants the opportunity to be more candid about their experiences than in an interview. However, an interview option was offered to eligible participants in order to include those who preferred to share their experiences verbally. While these interviews were not anonymous, they have been kept confidential. One participant elected to be interviewed by the researcher instead of participating in Survey 2. Her interview was transcribed and included in the final Survey 2 results. Out of the qualitative and quantitative data gathered, the researcher used a mixed-methods approach to arrive at survey results.

Preliminary feedback from piloting Survey 2 research questions indicated that it would be beneficial to supply participants with the case vignette and questions so that they could think and reflect on their answers before completing the survey. This was particularly salient, as the topic of the clinician's class is often a cultural taboo, as identified in the literature review. All eligible participants for Survey 2 were provided with a PDF copy of Survey 2 when they were solicited by email to complete the survey.

***Informed Consent.*** Informed consent of participants was gathered in two ways. For those who participated in one or both of the online surveys, acknowledgement of informed consent was an initial, required survey question (See Appendix C and Appendix D). For those who requested an interview instead of participating in Survey 2, I used the US Postal Service to send each confirmed and screened participant two copies of the informed consent paperwork and a self-addressed and stamped return envelope. One of these copies was for their personal records, and one of these copies was returned to the researcher in the mail with the participant's wet signature. I required that these informed consent documents be returned before any interviews took place. When interviews did take place, I verbally reviewed the informed consent information and received a verbal confirmation that participants understood and agreed to give consent to participate in the study.

***Confidentiality & Anonymity.*** Confidentiality was addressed throughout the process of gathering data. In the case of Survey 1, data included the identifying information of name and email address so that the researcher could communicate with the research respondents. In the analysis of Survey 1 demographic data by the Smith College School for Social Work research analyst, identifying information was excluded, and thus confidentiality was retained. Names and identifying information were protected by storing them separately from other data.

In the case of Survey 2, both confidentiality and anonymity were assured. Due to the fact that Survey 2 was sent to Survey 1 respondents who were screened for eligibility, but no identifying information was gathered in Survey 2, the researcher had no way of connecting quantitative or qualitative from Survey 2 to the identities disclosed in Survey 1. In other words, data from Survey 1 could not be linked to participant identities.

**Population.** The populations that I studied were master's- or doctoral-level licensed mental health clinicians in the fields of social work, psychology, psychiatry and counseling, who self-identified as having access to wealth, and whose caseload included at least some clients who come from different class backgrounds. I excluded clinicians for whom any of the following was true: a bachelor's level of clinical training or below, those whose did not self-identify as wealthy due to reliance on earned income for financial stability, and clinicians who exclusively worked with wealthy clients. My sampling frame was that of members of the population that I wished to study. No federally defined vulnerable populations were targeted. There were no known risks involved with this study, and participants did not receive gifts or incentives for participating.

**Recruitment.** To recruit participants to my study, I sent an appeal to a variety of constituent-based online listservs, to which I already had access or contacts. This appeal (Appendix E) included a link to Survey 1; eligible participants were screened-in, and sent Survey 2. These listservs fell into two different categories: clinical associations and responsive philanthropies. For the category of clinical associations, I sent recruitment emails to the American Association of Psychoanalysis in Clinical Social Work listserv, and the North Carolina Society for Clinical Social Work listserv. For the responsive philanthropy category, I sent recruitment emails to the Threshold Foundation listserv, and the Resource Generation listserv and membership Facebook page.

**Data Collection.** I recruited research participants by appealing to online listservs and networks that I believed would include members of my target population. To these listservs and networks I sent an email that included a link to Survey 1. Survey respondents were screened for eligibility using the following three criteria: respondents self-identify as persons with wealth as defined by the researcher; respondents have or are currently in the course of masters- or doctoral-

level of training; and respondents work with at least some people who do not identify as having wealth. Survey 1 was open for 139 days, and returned 54 respondents. Of these, 41 survey respondents were eligible by virtue of meeting eligibility requirements. Of these 41 eligible participants, all were emailed Survey 2 and asked to respond by March 31, 2015. Survey 2 was open for 67 days, and 33 eligible participants responded. As an alternative to filling out Survey 2, eligible respondents from Survey 1 were also offered the option of completing Survey 2 in an interview format via Skype or telephone with the interviewer. One eligible participant accepted the offer to be interviewed.

***Retention of Data.*** All quantitative and qualitative data collected by Survey 1 and Survey 2 were periodically exported from Survey Monkey into Excel files. These were stored in a secure, password protected external hard drive. Identifying information was stored separately from other data to ensure confidentiality, and when possible, anonymity.

In the case of the one interview the researcher conducted in lieu of Survey 2, that interview was recorded using a LiveScribe pen and iPad, which enabled the researcher to save the audio-recordings and written notes electronically. I transcribed the interview directly into Survey 2. All gathered audio, written, transcribed and analyzed data was securely stored in an external hard drive that was password protected in order to ensure confidentiality of participant responses.

All research materials including recordings, transcriptions, analyses and consent/assent documents were and will continue to be stored in a secure location for three years according to federal regulations for research involving human subjects. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then appropriately

destroyed. All electronically stored data was password protected, and will continue to be so during the storage period.

**Data Analysis.** For the quantitative data, I sent the spreadsheet of all the data collected to the analyst at Smith College School for Social Work to run frequencies/descriptive statistics for all variables. Correlations were run using non-parametric statistics due to the size of the sample, which did not permit use of parametrics. The aim was to derive any patterns of relationship, particularly between demographics or years in practice and discipline or theoretical model participants identified and the patterns of response evident in their survey responses. For the qualitative data, I used open coding to derive recurrent and divergent themes; all analyses are discussed in the **Findings** chapter following.

## **CHAPTER IV**

### **Findings**

The purpose of this study was an exploratory, descriptive effort to investigate the experiences of clinicians who self-identify as wealthy, and to understand the impacts, if any, that a clinician's access to wealth may have upon all aspects of clinical work with clients of different socioeconomic class backgrounds. The research questions were: "How do clinical mental health professionals with independent, personal wealth experience working with clients of different socioeconomic class status? What are the specific ways in which clinicians note discomfort or problems in such class-discrepant work? How do clinicians attempt to cope with such problems, if they experience them?" The major findings of this exploratory study yielded descriptive, deep, qualitative data about how clinicians with wealth experience working with clients who do not have wealth, how they experience themselves within the clinical sphere, and how they negotiate class-based expressions, transference, countertransference, enactments, and content.

Using an exploratory/descriptive research design through a mixed-methods study, I conducted two online surveys to collect information about clinicians with wealth and their experiences working with clients who did not have wealth. Survey 1 was used as a demographic and screening tool to assess if respondents qualified as "a clinician with wealth" as defined in this study. Survey 1 consisted of 16 items: 10 items concerning demographic data of the participants, and three regarding informed consent. Survey 2 consisted of 23 items: 6 multiple-choice items, thirteen subjective items, and two items concerning demographic data of the

participants, and two regarding informed consent. The **Discussion** chapter will offer implications from these findings.

### **Survey 1 Findings**

Survey 1 was used as a screening tool, and collected demographic information of those who were interested in participating in the research. Recruitment took place via online appeals to communities that I thought would have members of the target population. In particular, I approached communities of responsive donor organizations, including the Threshold Foundation and Resource Generation, and communities of mental health professionals, including the North Carolina Society of Clinical Social Workers and the American Association of Psychodynamic Clinical Social Workers. These organizations received two email-based appeals, and when available, posts to the organization's Facebook page. Recruitment for Survey 1 resulted in many more people identifying themselves as interested in participating in the study than my adviser and I had expected. While we may have guessed that 12-15 people would report interest, we received over 30 initial responses of interest from participants. This quantity of responses was rather surprising, as we had not expected to receive so much interest from participants. Thus, instead of conducting interviews with all of the interested participants which was beyond my capacity for the given research time-period, we changed our methodology so that all eligible respondents could share their experiences via a second online survey. This initial large group of interested respondents gave us confidence that we would be able to further recruit candidates at the American Association of Psychodynamic Clinical Social Worker's 2015 conference in Durham, NC during the spring, and that this further recruitment would result in enough respondents to make our results statistically significant.

Of the 54 people who ultimately identified themselves as potential survey participants, 40 were invited to complete Survey 2 because they fit the criteria for participation as defined by this study. The 14 people who were not invited to participate in Survey 2 were excluded on the ground of 1) respondents did not fit into definition of a “person with wealth” as defined by this study (5 people), 2) respondents’ clinical experience did not relate to the field of mental health (4 people), 3) respondents did not provide contact information as required in Survey 1 and thus exited Survey 1 without completing it (5 people). We include this information within the findings chapter to illustrate how seductive our initial response numbers were, and why they lead to a change in methodology mid-way through the research process. These initial numbers, however, were not as promising as hoped, and we were unable to recruit enough participants for Survey 2 to make the results statistically significant.

### **Respondent demographics**

Of the 40 people who were invited to participate in Survey 2, 33 completed that survey. Two participants opened the survey, but did not fill in any information. Five invited participants did not participate in Survey 2. Due to the anonymous nature of Survey 2, it was not possible to link Survey 2 responses to Survey 1 demographics, and thus no correlations between demographics and survey responses are possible. However, demographic information from Survey 1 respondents who were invited to complete Survey 2 can provide a generalized demographic snap-shot of that group. This group will be referred to as “eligible Survey 1 respondents,” meaning that they responded to Survey 1 and were eligible to complete Survey 2 because they fit the participant qualifications as outlined above.

In general, females represented the majority of Survey 1 respondents, with 35 self-reporting as either “female” or “woman.” The remaining 5 participants all self-reported as



“male.” This finding is consistent with an over-representation of females within the field of social work, however it is inconsistent with the over-representation of males within populations with wealth. It may be possible that this majority of female respondents volunteering has to do with the fact that research has shown that women are more willing to complete online surveys than men. Over one quarter of eligible Survey 1 respondents were between the ages of 30-39 years old, with 18-29 year-olds representing the second-most represented group. The fact that, as a group, those between the ages of 50-79 years of age represented 46.2 percent of respondents shows that this study appealed to older clinicians. This large spread of ages represented within the eligible Survey 1 group shows that there was much age diversity within the group. In terms of race, the vast majority of participants self-identified as white and/or Caucasian, with one person identifying as mixed-race. Diversity of ethnic identities included French, Turkish, Italian, American White of German Dutch Danish extraction, and Jewish, with Jewish self-identification representing 20% of the sample. These results are displayed in Table 1 (*Age Range, Gender, and Racial/Ethnic Identity of Eligible Survey 1 Participants.*). The abundance of white-identified people within this sample is consistent with literature about the racial-wealth divide -- namely that white people own and control the vast majority of the wealth in the United States. That Jewish self-identified ethnicities represented 20% of eligible Survey 1 respondents is consistent with the higher representation of self-identifying Jews across the mental health professions.

Table 1

*Age Range, Gender, and Racial/Ethnic Identity of Eligible Survey 1 Participants*

Age Range	Frequency	Valid %
18-29	5	12.8
30-39	10	25.6
40-49	4	10.3
50-59	6	15.4
60-69	6	15.4
70-79	6	15.4
80+	2	5.1

Gender	Frequency	Valid %
Female	33	82.5
Male	5	12.5
Woman	2	5.0

Race and/or Ethnicity	Frequency	Valid %
American White of English German Dutch Danish extraction	1	2.5
Caucasian/White	29	72.5
Jewish	1	2.5
Jewish, French and Turkish	1	2.5
Mixed-race	1	2.5
White (Italian)	1	2.5
White, Jewish	6	15.0

Table 2 (*Professional Discipline & Highest Degree Attained of Eligible Survey 1 Participants*) shows that the majority of eligible Survey 1 respondents were clinical social workers, with clinical psychologists representing coming next, followed by clinical psychologists. No psychiatrists completed this survey. Thus, eligible Survey 1 respondents were, as a group, not representative of the mental health disciplines.

When considering the highest degree acquired, just over half of respondents had attained a master's degree, with one respondent still in graduate school. One quarter of respondents had completed a doctorate degree, with a further 10.4% with a doctorate degree in progress, and 5.1% identifying as having completed advanced psychoanalytic training. Thus, 41% of the sample were in the process of, or completed, training beyond a master's degree. This finding is unrepresentative of the field, where the majority of the population has at the most a master's degree, and only a slim population has advanced training. We can speculate about the role that access to wealth plays in the acquisition of a post-masters degree education, and would suggest further research in this area.

Information about the number of years in practice of survey participants will be discussed within the context of Survey 2.

Table 2

*Professional Discipline and Highest Degree Attained of Eligible Survey 1 Participants*

Professional Discipline	Frequency	Valid %
Clinical Social Work	27	69.2
Clinical Counseling	4	10.3
Clinical Psychology	8	20.5

Highest Degree Attained	Frequency	Valid %
Master's Degree	22	56.4
Doctoral Degree	10	25.6
Master's Degree in Progress	1	2.6
Doctoral Degree in Progress	4	10.3
Advanced Psychoanalytic Training	2	5.1

Table 3 (*Political Orientation*) displays the political orientation that invited participants most closely relate to. Three stock answers were available (Conservative, Moderate or Liberal), and one option of “Other” which included a write-in box to further self-identify. Of the 41 total participants, 40 responded and 1 declined. The vast majority of respondents self-identified as liberal at 79.5%. Only 10.3% of respondents identified as moderate, and none of the respondents self-identifying as conservative. Of those who claimed the “Other” designation, the following responses were submitted: Left, Progressive, Radical/Progressive, and “ I don’t identify myself politically this way.” Due to the fact that three of the four write-in responses indicated political orientations farther to the left than the “Liberal” label which I offered, the actual percentage of respondents who self-identify as “to the left” is would be higher than the reported 79.5%. Although social work is generally a politically liberal/left field, these findings are not

representative of the field as a whole. The respondents that I invited to participate are overall more left-leaning than the field of social work. These findings are also not representative of the overall population of those with wealth. Historically in the United States, wealth has been associated with more conservative political values. While this trend may be shifting towards a more moderate or liberal wealthy population, there is still a significant representation from conservative mental health clinicians absent from my responses.

Table 3

*Political Orientation*

Political Orientation	Frequency	Valid %
Conservative	0	0.0
Moderate	4	10.3
Liberal	31	79.5
Other	4	10.3

Table 4 (*Geographic Region of Practice & Manner of Wealth Acquisition*) shows the various responses to the stock-answer questions about where respondents live, and how they acquired their wealth. Both of these questions were presented as stock-answers, and participants were invited to select all answers that apply to them. Developing valid percentages for responses to these questions was not possible because some participants selected more than one answer. The frequency of responses was presented here in order to get a generalized understanding of participant demographics.

The geographic region represented with the most frequency was the Northeast (17), followed by the West Coast (10) The Southeast, Southwest, and Midwest were all tied with 5 responses, and the Mid-Atlantic and Rocky Mountain region each had one response. No one who practices in Alaska, Hawaii, Puerto Rico, Guam, US military bases or stations, or outside of the

United States responded to the survey. These frequencies are not representative of the geographic spread of clinical mental health clinicians, or people with wealth, in the United States: overall, there is much more geographic diversity within both categories than my survey respondents present.

The vast majority of eligible survey respondents acquired some if not all of their wealth through inheritance of money from a family member (31). The next most frequent type of wealth acquisition came from earnings (17), followed by wealth acquisition via marriage (13). None of the respondents received their wealth from lottery winnings or legal settlements. These frequencies are consistent with overall wealth acquisition trends, as inheritance, earnings and marriage are much more common than wealth resulting from lottery winnings or legal settlements.

Due to the small sample size of this group, no generalizations can be made about the demographics of clinicians with wealth from this data. Instead, it is offered as a contextual characterization of the group invited to Survey 2.

Table 4

*Geographic Region of Practice & Manner of Wealth Acquisition*

Geographic Region of Practice	Frequency
Northeast	17
Mid-Atlantic	1
Southeast	5
Southwest	5
Midwest	5
Rocky Mountains	1
West Coast	10
Alaska	0
Hawaii	0
Puerto Rico	0
Guam	0
US Military Bases or Stations	0
Outside of the United States	0

Manner of Wealth Acquisition	Frequency
Earnings	17
Inheritance	31
Lottery Winnings	0
Via Marriage	14
Legal Settlements	0

**Survey 2**

The following findings are from Survey 2, and include a combination of qualitative and quantitative responses. Data has been synopsised in order to glean insights into the experiences of clinicians with wealth.

**Years in practice demographics**

Within Survey 2, the only solicited demographic information was question 10: Number of years in practice. Survey 2 respondents' years in practice ranged from 1 year to 50 years, with a median of 10 years of practice and a mean of 16.56 years of practice. Those who identified themselves as still being in graduate school were considered to have 1 year of practice.

Table 5

*Number of Years in Clinical Practice*

Years in Practice	Frequency	Valid %
1 year or less	6	22.2
2-4 years	4	14.8
5-9 years	2	7.4
10-14 years	3	11.1
15-19 years	1	3.7
20-30 years	5	18.5
> 30 years	6	22.2

For qualitative responses to Survey 2, years of practice have been assessed for correlations and findings are discussed.

**Clinical vignette**

In order to offer all participants the same clinical material to respond to, Survey 2 begins with the following clinical vignette:

Chris is a clinical social worker who has been operating a private psychotherapy practice in a small American city for ten years. Chris bills both private insurance and Medicaid, and sees out-of-pocket paying clients on a sliding scale from \$30 to \$120/hour. It has been important to Chris to keep the low end of the scale at \$30 so that clients are valuing the services that Chris offers. Additionally, Chris has felt taken advantage of when previously seeing clients for less than \$30, which seemed to negatively impact the therapeutic dyad.

Chris was raised in an affluent community, and received an inheritance of \$5 million dollars upon becoming a legal adult. That money has been invested and managed by a financial planner, and as a result Chris does not need to rely on income from clinical practice for daily expenses or future planning. Chris’s family lives comfortably, and without financial worry. The family annually donates to local community organizations and institutions.

Chris sees clients of various socioeconomic backgrounds, including some who have been “hit hard” by the recent financial crisis. One of Chris’s clients, Charlene, has been particularly struggling financially, and spends much of her time in sessions worrying about how she will pay for all of her expenses. In previous sessions with Charlene, Chris has worked hard to pay attention to countertransferential feelings of guilt and a desire to help financially. In



supervision, Chris identifies that other feelings associated with Charlene's financial position include shame, helplessness, frustration, pity, remorse, blaming, writing-off, and discrediting.

In today's session, Charlene enters the office upset. She has experienced another financial setback, and is asking Chris if she can continue therapy at a lower payment level of \$15/hour. When Chris explains that this is not possible, Charlene reacts by yelling, "Why is everyone taking advantage of me?! Why can I never get a break?! It seems like you just don't understand how hard this is for me and my family! But then again, I guess you wouldn't be able to understand. After all, I've seen that car you drive, and I know what it cost you! You must have money since I know a social worker can't buy a car like that without daddy's help. Plus, those stickers on the car for your kid's private school also give you away. And I've seen your name on major donor lists for lots of organizations in our community. You must really be loaded to be able to just give money away! But then again, this is just like the rich to be selfish and to take, take, take from poor people like me who are just trying to get along. I ask for a little understanding, a little help as my family and I are struggling, but all you can think about is your bottom-line!" After the session, Chris feels very dysregulated, and notices feelings of anger, frustration, guilt, isolation, exhaustion, and a desire to write-off Charlene's powerful words.

### **Effect of client's words on clinician, and clinical response**

A series of questions followed this clinical vignette, all of which were intended to illuminate the impact of the client's words from the vignette on the clinician with wealth.

Question 3 asked, "If you were in Chris's place, how personally affected would you be by your client's words?" and presented a Likert scale for responses: Not at all, Slightly, Moderately, Significantly, Extremely. Thirty people responded to this question, and three declined to respond. Overall, the majority of respondents reported that they would be moderately, significantly, or extremely affected by the client's harsh words.

Table 6

*How Personally Affected Would You Be by the Client's Words?*

	Frequency	Valid %
Not at all	1	3.3
Slightly	4	13.3
Moderately	8	26.7
Significantly	13	43.3
Extremely	4	13.3

In order to determine if there was a relationship between years of practice and how affected they were likely to be by a client's words (5-point Likert scale) a Spearman rho correlation was run. No significant correlation was found.

Question 4 followed-up with more qualitative information: "If you were in Chris's place, how would you respond to the client? What words would you use?" Five people skipped this question, and 28 participants responded. Responses were coded and grouped to include a series of interventions and responses that clinicians with wealth may have to a situation such as the clinical vignette. Direct quotes from participants further articulate these themes.

***Acknowledge Client's Pain***

I would reflect on Charlene's feelings and match her energy level. "You're really angry that I'm charging you \$30 a session when it is clear to you that I am in a financial position to charge less. You feel that I am taking advantage of families that are struggling. This is affecting the therapeutic relationship that you and I have together. You feel that you tried to bring this up respectfully and I didn't fully consider your request before saying no. I bet that felt invalidating and like I didn't have a full understanding of your needs or my privilege.

I understand you are struggling and are feeling taken advantaged of. I also hear how angry you are about feeling misunderstood. I am interested in figuring out how to best support you given the hardships you have shared, and my fees structures. I am sorry it feels unfair.

### ***Acknowledge Clinician's Sociocultural Positionality***

I understand how you feel about my having more than you do. The world isn't fair, and I was luckier than you. But I also work hard to help you and others, so I can pay a little back to society. Now, why are you so much more angry now than before?

I would thank her for her honesty use it as an opportunity for some self-disclosure, and to carefully acknowledge that I have been blessed with family wealth that allows me to see clients for a reduced rate (she is smart enough to see it, and that disparity should be spoken to) then to move on to explain why it is important to charge \$30, because it affirms a sense of valuation of the work, and that you have clients that you charge \$120. Also to validate her feelings of separation and alienation and being unseen.

### ***Empathize***

I hear you feel very frustrated and like everyone is taking advantage of you and that your family is facing financial challenges that are very scary for you all. I also hear that you're angry with me because you have seen the car I drive and you've seen my name on lists of donors for organizations. Would it be helpful to talk about these issues directly? I imagine from what you see, and the struggles with your financial crisis that it brings up feelings of mistrust or injustice....

### ***Name the injustice of economic inequality***

I would acknowledge her experience and work toward talking about her experience in her community and in this country and how the systems are unfairly balanced.

### ***Explain fee structure***

I might describe the history of my practice and the decision I had come to set my base fee at \$30.

### ***Discuss change in therapist and/or frequency***

I can see that you are upset right now, and that this is no longer becoming a safe space for you, so I would like to end the session early for today. Unfortunately my lowest rate is \$30/hr, and in order for this to be fair for all of my clients at this time I am unable to lower the rate. I would like to continue meeting with you and hopefully give you some space to process some of the very intense emotions and feelings you have brought up this session, but if you feel that paying the \$30/hr fee is too much I would be happy to help you find another therapist nearby who would better be able to work within your budget. Again, I would like to meet with

you next week and work through some of the difficult emotions and feelings you have brought up this session, but completely understand if at this point you would like to meet with someone else. Do you have any questions about any of that?

This is my line of work. I can work only so many hours. I would recommend that we meet less often and use our time together highly productively.

***Explore client's feelings of not being understood***

While it is crucial to acknowledge the "real" situation, the therapeutic traction is in the transference. What is her experience of being taken advantage of? Of not being understood? I imagine this could open up much important material that would have the potential to be extremely helpful. If both patient and therapist are able to slog their way through it together.

You are feeling very frustrated and angry with me right now. You wonder if I'll be able to help you.

Question five asked "If you were in Chris' place, would you adjust your fee for the client?" Twenty-nine people answered the question by indicating "Yes," "No" or "Not Sure," and four people skipped the question. Twenty-nine people responded to this question, and four skipped it. Many respondents (16) indicated that they would not adjust their fees, while nine indicated that they were not sure. Four people reported that they would change their fees, representing some ambiguity about the "appropriate" response. While reflections on these responses were captured in the following question, the researcher considers that the large number of "Not Sure" answers could be based on wording within the clinical vignette, which indicates that Chris had personal reasons for not negotiating the fee with the client. This question was intentionally designed to be vague in order to give the participants an opportunity to interpret the question themselves.

Table 7

*Would you Adjust Your Fees?*

	Frequency	Valid %
Yes	4	13.8
No	16	55.2
Not Sure	9	31.0

In order to determine if there was a difference in years of practice by whether respondents would adjust their fees a one way anova was run. No significant difference was found, indicating that years of practice had no bearing on the clinician’s decision to adjust fees

Question six asked participants to further elaborate on their answer to questions 5: “Please share your thoughts about why you would, or would not, adjust your fees.” Twenty-nine participants responded to this question, and four skipped it. As before, responses were coded for common themes.

***Citation of professional standards***

I think that if we lowered our costs every time a client with a significant financial struggle came along, we would end up doing almost exclusive pro bono work. I think that there can be some value in that occasionally, but we are people too and our training, time, and labor should be valued just like any other working individual, and as such we need to maintain a consistent barometer for our lowest sliding scale level and stick to it, regardless of our many clients' varying circumstances.

Regardless of having wealth, it is important as a profession to uphold standards for the profession. Services provided hold a certain value and it is important to the client to prioritize the sessions as valuable as well. If the amount continues to be discounted this will continue to discount the work that is done.

Ultimately, I think the reason that you keep the fees the same is that it's important to be thoughtful about how you set your fees ahead of time, be open and honest about those fees, then establish the boundary of sticking to what you have disclosed.

### ***Negotiating the clinician's personal and professional integrity***

I tend to undervalue my work because of my financial privilege, and feel that I should just volunteer or work for less because I can rely on the "cushion" I have from my inheritance. This leads, however, to making me feel bad about myself.

I would maintain my fee because I need my practice to be self-sustaining, and because my work as a therapist is a job, not a hobby.

### ***Avoidance of clinician's resentment towards client***

Being treated by a resentful therapist is not helpful. In this case it might even be unethical if the therapist makes a change in the fee knowing in advance that she would be resentful.

In my experience I have found myself resenting this request when I hear that the client may have spent money on sports tickets, the lottery etc.

I'm torn on this. I feel like at the end of the day I would not lower my fees for a client, as I wouldn't want to resent the client for seeing them at lower fees.

### ***Explore a reduction in fees with client***

However, I'd want to explore if \$15 would make a difference. I could imagine it really making a big difference, in which case I would want to adjust it, and maybe compensate by taking on another high-paying client?

A significant part of my countertransference here is that I grew up relatively poor lower working class and my access to financial security did not come till my late 40's. I've always been committed to sliding fees partly because people did that for me. Even though \$15 is ridiculously low I might try to work out a temporary reduction. I have been known in the past to (way past) to charge a pack of cigarettes and apples and bananas.

### ***Change treatment plan***

It would be preferable to pause therapy or refer client to a clinic that they could be followed.

### ***Attending to class background in sessions and in supervision***

Questions seven and eight were intended to offer an opportunity for survey respondents to articulate how they negotiate consciousness of their class background in the clinical context, including both during sessions with clients and during supervision.

Question seven was “How can clinicians with wealth acknowledge and recognize thoughts and feelings associated with their class background while in session with a client of a different socioeconomic class experience?” Twenty-nine participants responded to this question, and four skipped it. Responses were coded and include direct quotes from survey participants. Results include a high reliance on clinical skills such as attendance to countertransference, and considering acknowledging the intersubjectivity inherent within the clinical dyad.

***Pay attention to clinician’s countertransference***

I'm always trying to pay attention and look at my countertransference. This results in a range of responses. I especially pay attention to envy. Sometimes I noticed that I have envy towards my client, and sometimes I can feel my client having envy towards me.

Be attuned to feelings of guilt, pity, and rage and anger at systems.

We feel triggered, activated. We should note this and identify if it is my issues or if I'm feeling what the client is experiencing and not able to express. If it is mine I should do my work to process my unresolved issues being triggered by the client.

By bearing witness and giving the clients space to speak whatever is on their mind, we can listen and learn from their experiences and give their voice power, but we need to constantly check ourselves, and our privilege, to make sure that we are never empathizing to the point of minimizing their experiences.

***Assume a stance towards the client of curiosity***

I also acknowledge differences, and different experiences and make it clear where I don't share the same experiences and perspectives and lead with respectful curiosity.

***Assume that full understanding by the clinician is impossible***

I think it is important to never assume that you know what a client is going through or that you make it known that you can fully understand what it is like to live their life. As a person with wealth I will never know the experience of not being able to feed my family or not being able to pay rent and worrying about being evicted, and it would be wrong to try to pretend that I would know what these experiences are like.

Be honest and open about personal limitations in lived understanding of clients' SES.

***Address the theme of client's feeling separate, unseen, or that needs cannot be met***

I will normalize that sometimes clients have apprehension that a white, male, (perhaps) younger, [fill-in-the-blank] clinician will be able to understand their situation... Sometimes I think a simple "There must be things that you think I'll never be able to understand about who you are and how you grew up."

***Use supervision, consultation, or reflection techniques***

I don't think it's appropriate to bring attention to this unless the client initiates the conversation. As clinicians we are expected to be able to recognize our thoughts, feelings and triggers and not let them interfere. Processing by journaling or discussing one's thoughts and feelings with a neutral third party in a way that doesn't compromise confidentiality.

There is always someone better off than you are. Know your own feelings about wealth & jealousy. It's human.

For one respondent, this question was very triggering: "That's like asking how can a clinician recognize thoughts and feelings of a patient with a disease. This is an unfortunate question! In fact a troubling question." I imagine that that for this respondent there may have been some misinterpretation of the question, given that all other respondents gave meaningful answers.

Question eight focused on the supervision experience: "How can clinicians with wealth acknowledge and recognize thoughts and feelings associated with their class background while in supervision or consultation about a client of a different socioeconomic class experience?" Five people skipped this question, and 28 responded. As before, questions were coded and grouped by theme. Quotes are included to further illuminate the responses.

***Discuss challenges with a trusted supervisor***

Honestly, I hope that the clinician can speak freely in supervision. It helps if the clinician is 'out' about their finances, at least with their supervisor or colleague that is providing consultation.

I think I've always talked in supervision about these issues. And I've looked for supervisors who I believe can work with me on this. I'm particularly vulnerable to



feelings of envy from a client, so have certainly chosen supervision where I trust I can get help with this.

I do try to keep what I know about my class experience and blind spots in the forefront so that it's always a question I bring up.

### ***Strategies for not disclosing too much to unsympathetic supervisor***

If the therapist is unable to discuss an area of countertransference with his/her supervisor (assuming the issue is well analyzed in the therapist), it might be time for a different supervisor

I think that this can be done without outing yourself (if you aren't ready) for specific numbers, but that acknowledging that your social capital and class privilege are factors that could have very strong impacts on the therapeutic relationship.

Again, there was a unique answer from the same respondent who was challenged by question seven: "As above- why r u setting wealthy clinicians apart and assuming they are any different from other therapists and can't handle their own feelings, their patients feelings, and any counter transference! Again, very troubling. What is your bias?" As before, I question whether the wording of the question was problematic, but did not find evidence of this from other respondents.

### **Respondents' experiences as clinicians with wealth**

For question nine, I wanted to offer an open-ended, general question for respondents about being clinicians with wealth. The placement of this question at this point in the survey was intentional, as respondents had already been primed to consider the clinical material (such as countertransference, fee-setting, supervision, etc) within the context of their class-based identities. Thus, this question was somewhat vague by design in order for the respondents to be able to interpret its meaning for themselves: "I want to learn about how clinicians with wealth experience working with their clients of different socioeconomic backgrounds. What has your experience been as a clinician with wealth?" Four participants did not respond to this question,

and 28 did. In addition to the following themes, clinicians identified the feelings associated with the intersection of their wealth and their clinical identity: guilt, gratitude, confusion, shame, “white savior complex.” As before, coded responses and quotes are included below.

***Role as clinician is an opportunity to serve society and “give back”***

I appreciate the opportunity to serve my clients and help them in ways that involve meaningful human connection and care.

My experiences have been fulfilling, rewarding, and concrete in effecting interdisciplinary change for clients.

***Consciousness of clinician’s sociocultural positionality***

I must keep myself educated, curious, and sensitive as to how my identity interacts with that of the client. I must also remain open minded, and willing to learn from my mistakes.

***Differentiated reactions of clinician towards clients’ socioeconomic status***

I sometimes have a more difficult time working with clients from affluent backgrounds. My countertransference can be much stronger and I can find myself more judgmental of wealthy clients that present as "entitled." I think that I am more internally forgiving of and compassionate towards clients from lower socioeconomic backgrounds.

***Informing clinician’s macro worldview and personal life***

Any of my experience of how things aren't fair, certain inequalities / injustices in the system, get translated more into other efforts in my personal life. Not into my one-on-one work with clients.

It is truly heartbreaking what people in poverty experience and the injustice of the system. At the same time, the macro issues are something I address in other parts of my life and I have to remember what is most going to serve my client in the here and now. I do feel as though I'm gathering information that informs my philanthropy and ways I might work on a more macro scale in the future.

***Conscious attempts to not “showcase” wealth signifiers***

I never wear clothes with labels or intentionally flaunt my status via my wardrobe. I try to limit or avoid talking about college experiences or other experiences of childhood that signal access to wealth (extravagant family vacations, summer camps, technology, even going out to the movies or to dinner). While I am minimizing parts of myself in this regard, I feel that I can still be authentic and

real with my clients without giving away excessive information that showcases my SES.

### ***Separation from colleagues who do not have wealth***

Because I have wealth I can afford to slide my fee further than I otherwise might have been able to do, which I like. It was very helpful to have financial means while I was building my practice and while I was getting my degrees. However, I do notice that I do not feel driven to work as many hours or to have as many patients as some of my colleagues do, and I have wondered sometimes what impact that has had on my professional development.

I could tell that the other clinicians could tell I had money (because I drove a mini cooper), and I had to hold that sense of shame and separation. They were in the trenches, stressed, and smoked regularly on breaks...they were there because of both passion and necessity. They didn't realize I was too (the necessity of needing to have purpose and a way to connect with the world).

### **Frequency and type of client response to clinician's perceived socioeconomic class**

The following six questions were intended to understand the frequency of and type of responses to the client's perception of the clinician as a person with wealth. Type of responses were characterized as Negative, Neutral, and Positive. These questions are rather subjective as they explore the clinician's consciousness of a client's experience and expression. Given that this is a new area of study with no previous research, I thought it prudent to explore how often and in what ways clinicians with wealth are dealing with reactions to their class background.

Question 11 asked "How often have you been in a situation with clients where they expressed negativity, frustration or anger in response to their perception of your class background?" A 5-point Likert scale was provided: Never, 1 or 2 times, 3-5 times, 6-10 times, More than 10 times. Six people did not answer this question, and 27 did.

Table 8

*Frequency of Clinician Experiencing Class-Based Negativity, Neutrality, or Positivity from Clients*

Negativity	Frequencies	Valid %
Never	8	29.6
1 or 2 time	9	33.3
3-5 times	6	22.2
6-10 times	2	7.4
> 10 times	2	7.4

Neutrality	Frequencies	Valid %
Never	7	28.0
1 or 2 time	2	8.0
3-5 times	6	24.0
6-10 times	1	4.0
> 10 times	9	36.0

Positivity	Frequencies	Valid %
Never	11	44.0
1 or 2 time	3	12.0
3-5 times	7	28.0
6-10 times	2	8.0
> 10 times	2	8.0

These data suggest that while most clinicians experience negativity, frustration or anger from their clients in response to their perceived socioeconomic status, it is not a very common occurrence. However, when correlated to years of experience, the data show that more time in the field means more reports of experiencing negative expression from clients. In order to

determine if there was a relationship between years of practice and how often clients have expressed negativity (etc) (5-point Likert scale) a Spearman rho correlation was run. A significant moderate positive correlation was found ( $\rho=.567$ ,  $p=.003$ , two-tailed). A positive correlation means that as one scale goes up so does the other (i.e., they move in the same direction), so this finding suggests that as years of practice increases they report having experienced more clients expressing negativity (and vice versa).

In response to client's negative expression, question 12 requested further elaboration: "What was your response (if any)? What words did you use?" Coded responses and quotes indicate clinicians' responses. Twenty responses were given, and 13 people skipped this question.

### ***Acknowledgement and joining client in emotions***

As I said before I would acknowledge the anger saying something like "It's not much fun not having enough money to live on, especially if you think that your therapist who is suppose to help you seems to be more comfortable financially than you are."

### ***Ignore***

In those instances I was a much younger social worker and hadn't done as much personal work to think about my wealth and class privilege, so I ended up ignoring the comments; this resulted in some strong countertransference that I couldn't name and I ended up having more negative experiences with these clients.

### ***Emphasize seeking understanding***

I don't agree with the system and don't think its right, however I am here to support you and work through \_(whatever the issues are)\_\_\_\_\_

### ***Explore not feeling understood***

I hear your frustration and upset about your perceptions of my economic situation. can you tell me more about it. What are your fantasies about how I live? What

does it mean to you? How does it affect how we talk to each other? Do you feel that I can't possibly understand your situation? Tell me more about that?

The following was an example of combining acknowledgement, joining, empathizing, and exploring not feeling understood:

I tend to validate anger and feeling not-understood. I might say something like, "You've experienced a lot that you think I can't understand; some of it, you know I've never experienced." I then work to show that I am honestly interested/ concerned and want to learn their story/ experience. Sometimes, if the focus is on how I couldn't possibly understand, I might have said something like "You must experience that a lot-- needing to work with people who have no idea what it's like to be you." And I will ask specific questions about whether they think it's possible to work with me, are there specific things they want me to know or want me to say/ not-say: "Do you think about that a lot while working with me? That there's no way he can understand what you go through day-to-day? I do want you to know that even since we've worked together I can see \_\_\_\_ and how hard it must be on you that \_\_\_\_\_"

Question 13 was "How often have you been in a situation with clients where they expressed neutrality in response to their perception of your class background?" This question generated 25-responses, and 8 skips. Responses were highest for Never, 3-5 times, and More than 10 times, indicating that survey participants had various conscious experiences of their client's neutral attitudes about their wealth.

In order to determine if there was a relationship between years of practice and how often clients have expressed neutrality (5-point Likert scale) a Spearman rho correlation was run. No significant correlation was found.

The follow-up questions number 14, "What was your response (if any)? What words did you use?" illuminated confusion about this question for many respondents. Sixteen people did not respond, and of the 17 that did, there was much agreement that this question was too vague and thus difficult to answer. The qualitative responses that emerged included the following themes.

### ***Clinician does not bring up clinician's wealth if the client does not***

If someone wasn't expressing anything about class issues I wouldn't bring them up. If it doesn't appear in the room, I'm not going to force it to come in.

### ***When topic is broached, explore it with the client***

If a patient brings up the topic, my working assumption is that it has meaning.

I generally ask whether they would feel comfortable talking about it if they do experience other feelings.

### ***Strategies for addressing clinical fees***

I am classifying the times when clients have said "How much do you get paid? I bet you get paid a lot," without really much affect or reaction as "neutral." I may say nothing or I might ask something like "Have you worked with doctors, clinicians, lawyers, administrators or anyone in the past that made a lot of money? Did working with them ever make you feel one way or another?" just to probe to see if it's an important issue.

Question 15 was "How often have you been in a situation with clients where they expressed acceptance, or positivity in response to their perception of your class background?" Eight people skipped this question, and 25 answered.

In order to determine if there was a relationship between years of practice and how often clients have expressed acceptance or positivity on a 5-point Likert scale, a Spearman rho correlation was run. A significant moderate positive correlation was found ( $\rho=.666$ ,  $p=.000$ , two-tailed). This finding suggests as years of practice increases they report having experienced more clients expressing acceptance (and vice versa).

For the qualitative follow-up question "What was your response (if any)? What words did you use?" Seventeen people skipped it and 16 people responded. The following themes were identified.

### ***Explore meaning to client***

I think my wealthier clients feel some type of 'kinship' with me; even though they do not know my financial situation, they speak as if I am 'one of them' and that

their issues/feelings/upset are ok, even if trivial compared to someone without a home or food. I think there is some embarrassment on the part of some wealthier clients that they are worried about their children or marriage or feeling depressed. I normalize these feelings because these are issues that are classless. Most people are concerned about their children, relationships and depression is not based on socioeconomic status.

In general I'm just not feeling vulnerable to needing/wanting anything from what they say one way or another, so I entertain their thought and feeling about it and wait for the next layer/part. I may ask something about what they are noticing my circumstances evokes, what does it make them think of in their life.

### ***Look for disguised class-related hostility***

It really depends on whether they are doing so with disguised hostility. So all the time I am looking for clues to that.

Again, try to understand the meaning for each patient at that particular point in the therapy. Is it an idealization? Disguised envy? Or any number of other things. I'd keep listening and ultimately help patient to understand the meaning -- especially if it seems there is masked hostility.

### ***Sharing strategies to negotiate systems***

My clients wanted to learn about my college experiences and were thinking about going back to community college themselves, and I felt that sharing some aspects of what I was learning and of the benefits of education was an important thing to disclose in that moment.

### **Self-consciousness of clinicians with wealth**

The next two questions explored if and how clinicians with wealth may feel self-conscious about their socioeconomic status when with clients. Questions 17 asked “Have you ever felt self-conscious about your access to wealth during an interaction or session with a client?” Five people declined to answer, and 28 responded. The data shows that the vast majority of clinicians with wealth have felt self-conscious about their wealth when interacting with a client.



Table 9

*Experience of Clinician about Wealth Self-Consciousness.*

	Frequencies	Valid %
YES	23	82.1
NO	5	17.9

A t-test was run to determine if there was a difference in years of practice by whether clinicians ever felt self-conscious about wealth. No significant difference was found. However, Only 5 said “No,” so the two groups being compared were not similar in size.

The next question asked participants illustrate their experiences of self-consciousness: “Please describe one or more of the experiences in which you felt self-conscious about your wealth during an interaction or session with a client.” Twenty-one people responded, and 12 did not. The following themes were coded from the qualitative answers, supported by quotes.

***Clinician’s external expressions of wealth***

I was in a major psych hospital in an inner-city. And I had a diamond engagement ring, and I was so anxious about it and what my clients would think of me. I had a wonderful supervisor who laughed at me and told me "You just have to be who you are."

When I got a new, (non-breaking-down) car, and was driving to in-home sessions, I often parked my PT cruiser as far away from the home as possible so that client's wouldn't see it.

***Different opportunities for clinician than client***

Most recently there have been several experiences with clients about my traveling schedule. This has included their sense of my wealth but also issues about my availability. I do have to contain feelings of guilt about lucky I am to have access to a life I never imagined.

Basically always I went to elite schools and have always had access to more than I need. It can be VERY difficult to remember that isn't true for everyone.

During the holiday season or around kiddos' birthdays, I always feel a bit self-conscious of the privileged childhood that I had, and the ways in which my child clients have not been provided with extra purely fun (and sometimes educational) resources on these important gift-giving days.

### ***Discomfort with personal questions***

When clients ask if I have another job outside of my three day per week fieldwork.

Clients on a few occasions have commented on seeing public information (death, gift giving signs in private school) about a family member and their prominence.

### ***Desire to fix client problems***

Literally every session I've ever had. The worst one is a client of mine who I felt extremely close to. She was facing jail time over a fine of \$500. We brainstormed all kinds of ways for her to avoid it, I advocated for her with different systems, but ultimately she stopped coming and I heard "through the grapevine" that she did go to jail. I ran into her two young daughters, who I also felt close to, and they said how much they missed their mom. I talked with my supervisor about how much I wanted to pay the \$500 for her. But I did not disclose my wealth, and how relatively inconsequential it would have been for me to actually give it. I think my supervisor thought it was more hypothetical. I wanted to send the check anonymously, I didn't know what to do. I didn't do anything, but I still feel very guilty about it. But I also don't know if it would have been the "right" thing.

### ***When personal and professional worlds collide***

My father hired a client for a service and they put it together. It was an attorney but I still felt uncomfortable

### ***When negotiating fees***

We had to negotiate a fee. I knew it was not easy for her. She was paid low and her boyfriend worked hard to support her & her kids. I didn't need the money but I needed to charge her to keep the therapeutic relationship, frame, container, agreement. I agreed to a very reasonable rate but I still felt uncomfortable about taking her money. We maintained the work for months that way. We did good work but I was self-conscious about the money.

Question 19 explored “When do you experience your class background most significantly when working with a client from a different socioeconomic background?” This question was intended to gather data on the types of interactions clinicians with wealth are conscious of, but

may not specifically feel “self-conscious” about. Ten people declined to answer, and 22 responded with the following themes.

### ***Setting fees***

When I know the reality of their income and how hard it is to pay my fee  
When discussing fees.

### ***When the client is faced with hard financial choices***

When the client has needed to prioritize their children eating rather than themselves.

When clients discuss working to pay for school, when clients experience housing instability, when a client discusses how she is unable to save any money working at her full time grocery store job. When clients ask for diapers for their children.

### ***Interactions with institutions that the wealthy can avoid***

When working with students and discussing their worries with student loans. I am frequently reminded that this was not something I have ever had to worry about.

Filling out paperwork/applications on behalf of client, and/or interacting with law enforcement/other formal institutions on behalf/in advocacy of client needs.

When clients talk about the ways in which systems impact them and feeling shut down by trying to access systems that are not responsive to their needs (MA, DV court proceedings, public assistance benefits, being undocumented, etc.) I feel that if I were to be interacting with the same systems, even if I were a recipient, I would be treated differently because of race and class.

### ***When taking time off***

When I tell them I will be out of the office again, such as when I only work two days in the summer to be at my summer house five days from mid-June to mid-September.

During the holiday season or whenever I am able to go on a vacation and take time off from work.

### **Stories related to class within the clinical setting**

The next three questions were open-ended and intended to solicit more anecdotal accounts of what various clinical experiences presented for clinicians with wealth. These

questions focused on countertransference, and the clinician's perception of the impact of their own class identity on their clients. As before, themes were coded from the responses, and quotes are offered to support the findings.

Question 20 generated 20 responses, and 12 skips: "Please tell me about a time, if you are aware of one, when class-based countertransference played a role in a session with a client."

### ***Fantasies of fixing client's financial problems***

A lot of struggles the child faced were based in the family's poverty and where they lived. I remember that as I worked with the kid I wanted the sessions to run long. I harbored unrealistic fantasies about fostering the kid (even though his situation at home was stable). I talked about these feelings in supervision but it did not otherwise change the outcome of the sessions (they ended after just three meetings).

I worked with an extremely poor family when I worked in community mental health. At Christmas I delivered a gift to their little girl. While that was well-meaning on my part (for which they were appreciative), it was also done partly to assuage my guilt. The gift was a baby doll and looking back on it, I think I was partially expressing the wish that I could mother this little girl. The gesture was not harmful to the therapy -- although it definitely had an impact -- and I probably would do it again, but it was not purely good-hearted. It also contained countertransference meaning.

### ***Client's transference is soothing to clinician***

There have been times when I wanted to continue to see a patient whose insurance ran out, especially a female who was transferring "good father" to me. I personally have only sons and wish I had a daughter of my own

### ***Client expression of upward classism***

A working-class father consistently would bring up that he "didn't have a college degree or anything like that," when he met with me. I started to feel defensive.

### ***Over-sympathy for client financial struggles***

I think I feel a lot of sympathy for clients who struggle financially and this is sometimes helpful but not always.

In a first session I had with an older client in a wheelchair I made the assumption he was a veteran and had been injured in a war- as I learned more about him, I

realized that he actually was injured from driving a truck and his back got messed up from it.

### ***Anger towards clients with wealth***

I had a client who was very wealthy and status-conscious. She treated me like I wasn't quite good enough, and - even though I knew that her issue - I discovered I had a lot of feelings about it! I found myself feeling upset and like she was disappointed that she had such an average therapist.

I have become angry at a client from a wealthy background who flaunts his wealth in a way that I perceive to be insensitive in group therapy, in front of others from different backgrounds.

### ***Ambiguity regarding fees and/or insurance***

When a client was billed a huge amount of money because she and I were not informed of missing paperwork for her case. I felt embarrassed and ashamed as well as guilty I had not thought about following up on the paperwork.

Fee-setting, first few years of my practice, was rife with ambiguity. I tended to take clients' reports and requests at face value, to their detriment.

Questions 21 was "Tell me about a time when you found your class identity to be helpful to your client(s)." Twenty-two responses have been coded below, and eleven people declined to answer this question.

### ***Working with client who also have wealth or experienced an upward class transition***

I have a client now who is from a wealthy area with which I am very familiar. It is a place with a very, very strong culture, and she has difficulty putting some of her issues with it into words. I feel like it helps both of us right now that I know something about where she came from.

I guess it's helpful with some types of patients who have wealth themselves, but haven't done a lot of psychotherapy and who still have a lot of shame. There is a sameness there, and I find that I can join with them easily.

I have a client now who is from a wealthy area with which I am very familiar. It is a place with a very, very strong culture, and she has difficulty putting some of her issues with it into words. I feel like it helps both of us right now that I know something about where she came from.

### ***When negotiating systems that I have privilege within or experience with***

At my former job I was able to leverage my class privilege to get free summer camp scholarships for child clients I work with, relying on connections I had made at a previous job and using my knowledge of the scholarship system to advocate for my client and get them access to something they would have otherwise been unable to attend.

My class identity has often been most helpful when communicating and advocating for services, and with other professionals in networks of care for client (doctors, law enforcement, social services, employment etc).

I have been able to advocate for clients' needs successfully within systems when doing more case management types of roles (as a social worker). I felt that in part, I was using my class background, whiteness, and knowledge of how to interact in "upper middle class" ways in order to push for MA to get reinstated, food stamps to get reinstated, or schools to take another look at IEP needs.

### ***The privilege of developed skills to help others***

I think my class background has allowed me to develop ways to articulate myself verbally, and I bring this knowledge and access to my clients.

### ***Donor activism and macro-scale change***

My class identity involves my being a donor activist, so I feel grounded and pretty OK with how I conduct myself. I think that stance and identity translates in many ways in my therapeutic stance and responses.

### ***Ability to chose the work one loves***

I've been able to focus on the work I choose and the clients I've chosen, in part thanks to SES privilege.

Question 22 inquired about the inverse of the previous question: "Tell me about a time when you found your class identity a hindrance to your client(s)." This question generated 20 responses and 13 skips.

### ***When class cultures between clinician and client feel insurmountable***

There have been times where I've said things especially as a very new clinician which come out sounding trite because I can't connect with true empathy in the moment-- and their situation is far from what I've experienced.

I consider my education to be wrapped up in my class identity, and in the past I have sometimes felt awkward about how even though I don't have children, I know more about baby safety, feeding, and educational enrichment than some of the parents that I work with. It can be challenging to try to act as an advocate and offer neutral education on parenting matters, when I don't have any lived experience as a parent.

I've had a long term client who for years talked about how I could never understand her, both because she knew I was married and perceived I was wealthy because I married into wealth. This has given us an incredible opportunity to work on her issues. So while she always used to verbalize the hindrance, that hasn't stopped her from staying in therapy with me.

### ***When clinicians do not know how to negotiate systems, or miss structural barriers***

I think that there have been times that I have missed the structural barriers (need to work many hours, exhaustion, stress over finances, etc) that clients' parents have had when working with them on their children's needs. (I work in children's mental health).

I don't know as much about how to navigate insurance and benefits systems.

I'm sure my own anxiety and ignorance about financial matters comes through in subconscious ways

### ***Negotiating client judgments about perceived wealth***

I am guessing, but there are probably times when somebody made a judgment right away about me and never came back.

Early in my private practice I had a young woman leave treatment because I wouldn't adjust her low fee even further - like the dyad in your vignette. She left owing quite a lot of money. However, she returned a few years later, paid her bill, and resumed treatment. When she came back she was able to talk about her envy and disappointment toward me, so this story has a happy ending.

It has seemed that the times it got in the way have been with clients' pre-judgments or at times there has been envy at vacations or time away from "work."

### **What else should we know about clinicians with wealth?**

The final question of the survey was open-ended, and intended to give voice to experiences of being a clinician with wealth that my limited survey was unable to capture: "What question(s) have I failed to ask that would help me to understand better your experience as a clinician with wealth? Is there anything else that you would like to tell me about your experience

as a clinician with wealth?" While the issues that I am exploring are of interest and value to this research, they may not reflect the lived experiences that clinicians with wealth find most significant. Thus, this open-ended question points towards areas of focus for future research.

This question generated 19 responses, and 14 skips.

### ***The importance of supportive relationships and dialogues***

Things that have helped me with my acceptance of my wealth in my work have been other relationships, my own psychotherapy has really helped in my own process of acceptance. I really value some deep friendships that I have. I also really rely on my sibling bonds. There are times in my friendships when I am aware of our class difference and/or access to money. I try to make it not taboo to talk about. In the 60s and 70s we really didn't talk that much about money. But now I feel like there are many more safe spaces, and for that I have gratitude.

I do write this from an expensive ski vacation that my clients must deal with as I am out of the office ( "OUT WEST" rather than at my condo in Aspen). I have talked about expecting vacations like this as I have always had them. Having friends that know and are comfortable with and also share these circumstances in many cases creates balance in my life. It keeps me on my toes as to being in the moment with whomever I am with and what the context is.

### ***Desire to include exploration of class and privilege in graduate work***

We are asked to do a lot of personal work in social work school around our own internal biases and backgrounds, but class really isn't touched upon. I believe that spending more time discussing class issues in school would have been helpful. I am someone who is relatively comfortable being "out" about my class background, and have discussed it with others in my life before, but many students have not. I feel like I would like to be able to process class feelings in the classroom, but at the same time would not want to make peers from poor and working class backgrounds uncomfortable by discussing my own issues.

Not addressing this aspect in graduate school was very unhelpful. There seems to be some aspect of shame associated with being a social worker and having wealth, like the stereotype is social workers do not have a lot of money.... It is a shame as it could help to diminish the stereotype that people with trust funds are bad, spoiled, or do not have to work.

### ***Gratitude for being able to offer services that society cannot***

I feel so fortunate that I can help when society does not provide enough services for those who would benefit from ongoing therapy.



I do offer some pro bono hours through organizations that work with vulnerable populations, and I support mental health agencies through donations and consultations. I also support institutions that train clinicians, and I provide low-fee supervision for recent graduates, so that good, new people can come into the field. I believe it's very important to support psychotherapists, patients and psychotherapy from a lot of different directions, and I'm very grateful and proud that I have the ability to do that.

### ***The loneliness of exceptionalism***

I think that the issue that has not been captured is the loneliness of being exceptional in any way that awards privilege: extraordinarily rich, beautiful, educated, or athletic, etc.... The loneliness is in the exceptional quality of my circumstance that many, including me, believe is unfair. But I also believe that each of us must come to terms with their unique circumstance. Wealth has a political component that intelligence, athleticism, or beauty may have less of even as they do indeed provide similar privilege. I think this is why I love my job and intend to continue far past traditional ages of retirement particularly when one does not need the money.

### ***We don't know what we don't know***

The questions you ask are good and help me to reflect. The whole situation of the wealth gap is really heartbreaking in so many ways. There are a lot of times I just feel at a loss and do what I can when I can. I don't know how much I'm blind to what I'm experiencing from my clients in relation to my class background...

### ***Class has been less of a clinical issue***

In my experiences I have encountered more, exploration, questions, conflicts, confrontations and dynamics related to clients' perceptions of my racial, ethnic and gender identities.

### ***Internal conflict***

I think that I feel very conflicted about the role of clinicians focusing on mental health when inequity in our economic systems and oppression create a lot of the mental health problems in the first place. I sometimes feel that I am directing my energy in healing symptoms of our system's functioning and maybe that's not the best direction to take. However, I also feel that this is where my skills and abilities lie. Sometimes I feel very conflicted about all of that.

I feel very strongly that what I do is a vocation, and I do offer my services at fees that many people can afford. However, I'm very aware that what I provide is still an expensive service, and not everyone can access it directly through me.

I like getting paid for my work but I've come to realize that I've been playing a game, trying to impress myself. I hope to have more integrity by being honest with myself about why I work, what I want to create, what I need.

From the initial findings of this exploratory, descriptive study, it is clear that clinicians with wealth are a members of a population that is often negotiating various aspects of class within its clinical practices. The themes presented here are simply an initial foray with this population, yet the findings create a sketch of complex and layered experiences. The **Discussion** chapter will offer further exploration of presented themes and significant findings.

## **CHAPTER V**

### **Discussion**

The purpose of this study was to explore the manner in which clinicians with wealth attend to, address, and negotiate their position of socioeconomic privilege within clinical encounters with clients of lesser means. The research questions were: “How do clinical mental health professionals with independent, personal wealth experience working with clients of different socioeconomic class status? What are the specific ways in which clinicians note discomfort or problems in such class discrepant work? How do clinicians attempt to cope with such problems, if they experience them?” This chapter will discuss implications of the key findings from the study, show the connection or lack thereof between the current research’s findings and the existing literature, highlight limitations of this study, and state its implications for clinical social work practice. Lastly, I will provide suggestions for future research done in this area.

Through an exploratory/descriptive research design, I captured some initial experiences of clinicians with wealth as they relate to assessment, treatment, fee-setting, and use of supervision to address clinicians’ responses to socioeconomic differences. Additionally, I explored what these clinicians with wealth do, if anything, to note discomfort, and how they cope with these socioeconomic differences.

The research participants who were invited to participate in the study were, in general, female-identified, white, older, and a significant number of them had completed advanced

education beyond a master's degree. The vast majority of respondents self-identified as liberal, with some identifying as progressive or radical. Additionally, they practiced mainly in the Northeast or West Coast of the United States. These regions of the United States tend to be more politically liberal in general, although a direct correlation could not be drawn from this data. Wealth was acquired via inheritance, earnings and marriage. For further study, it would be very illuminating to learn about the different attitudes that clinicians take to their clinical work depending on their manner of wealth acquisition. I contend that we could learn a lot about the class-identity-formation of those whose class identity has shifted within their lifetimes, such as those people who acquired wealth through marriage. The majority of the respondents were social workers, which may account for the higher percentage of female-identified respondents: unlike other mental health disciplines (psychology, psychiatry, counseling), social work tends to be a female-dominated profession. That the majority of respondents were white points to the reality of the racial-wealth divide in the United States; people of color become increasingly under-represented as wealth increases, and are conversely over-represented within poor and socioeconomically disadvantaged communities. The under-representation of people of color in my sample may additionally be related to the fact that the vast majority of participants identified that at least some of their wealth came from inheritance. As previously discussed in the literature review, the American tax policy system has constructed inheritance laws so that wealth may be strategically passed from one generation to another. The effect of such policy is that families with historical wealth can maintain, cultivate, and exponentially grow their wealth and political influence over generations. Those people without the advantage of historical wealth are often people of color who have been strategically excluded from wealth-building social programs via such systems as redlining, the exclusion of minimum-wage protections for agricultural and

domestic workers, and regressive taxation. The fact that my sample is primarily white may, in part, reflect such various racist policies, both historical and current. Finally, I speculate that the large percentage of survey respondents with advanced training could be related to their ability to pay for and pursue such programs. I suggest further research to examine if there is a correlation between high socioeconomic status and advanced mental health training. Another speculation is that the high response of those with advanced degrees may be related to the fact that my sample population was, in general, older than the overall population; respondents may have simply had more time to pursue further study. Overall, the demographics of my invited research sample may also be a result of the recruitment organizations and networks that I solicited during my outreach phase.

### **Research Implications**

Various aspects of the clinical dynamic were revealed in the survey results. Of particular note were the strategies that clinicians with wealth used with clients to address class-based tensions, strategies that clinicians used in supervision, areas of tension that clinicians regularly experienced, and the dominant emotive language expressed within the responses as a whole.

While some people reported that they were constantly aware of class with their clients, others did not identify it as a primary preoccupation. However, the vast majority of respondents reported that there were times during their clinical practice when they felt self-conscious about their wealth. Data showed that as number of years in clinical practice grows, so does the frequency with which participants experience both positive and negative feedback from clients about the way the clinician's own wealth is perceived. This may be, in part, related to that fact that more time in the field will result in more face-to-face experiences. However, some clinicians notes that as they have gotten older and deeper into their professional careers, they have become

more comfortable with their wealth identity, and thus may display it more to clients. One limitation to this research is that I did not inquire what types of practice clinicians have. I would speculate that those in private practice who do not accept insurance are working with wealthier client populations, and may thus feel more comfortable displaying tropes of higher class status.

Overall, clinicians with wealth tend to rely on some of the tried-and-true tools of the mental health professions in order to negotiate class-based tensions in their work. Many reported that if faced with a direct challenge from a client about the clinician's personal access to wealth, they would aim to use the challenge as clinical content, instead of interpreting it as a personal attack. Clinicians reported that they would be thinking about the role of transference and countertransference, and how the client's fantasies and speculations about the clinician's wealth may offer a new direction into the client's experiences of their own relational class, or early attachment. Clinicians identified that making meaning with the client about the role of money, and the client's relationship to money, would be an important tool as well. Another clinical strategy that was regularly cited was that of seeking understanding with the client, even when it may not be possible for the clinician to understand. Many continued this train of thought by further acknowledging that the client and clinician have different lived experiences as a means of joining with the client, and empathetically discussing with the client the pain of not being understood. These findings reflect previous research on culturally-competent clinical work which suggests pure cultural competency may be impossible to achieve, yet still worthy of aspiring to (Dean, 2001). Some clinicians even identified that their socioeconomic status could help them empathize with the pain of not being understood as it relates to class. This identification connects it Liu's conceptualization that no one is immune to the alienating effects of classism, as it can be experienced downwardly, upwardly, laterally, and internally (Liu, 2011).

Clinicians reported that, in general, they would not significantly adjust their fees with a client as presented in the vignette. Many cited that while they do not technically need the client's co-pay to run their business, the metaphor of payment for services is significant: it represents a co-commitment to the therapeutic process that both client and clinician are agreeing to. Some reported that requiring fees was a matter of professional integrity for the clinician, and that maintaining them was a form of boundary-setting that enabled the clinicians to avoid feeling taken advantage of when offering services at a reduced rate. Additionally, many respondents included caveats that they would want more information about the client and the therapeutic work (e.g. if the client is working hard in sessions) in order to make a firm decision about changing their fees. This finding echoed Elkins' suggestion that the most influential and important factor across therapeutic modalities is the therapeutic relationship, rapport and mutual sense of progress and safety (2012).

There was consensus amongst respondents that ideally clinical supervision or peer supervision is the appropriate place to process one's own responses to challenging client content. Having a supportive supervisor who knows about and can be supportive of one's "muddling-through" of class dynamics is key. However, some respondents acknowledged that within their agency-based settings, it may not be appropriate or safe for the clinician to disclose to the supervisor that they have access to wealth. Respondents cited fear of upward classism, or the disruption of relationships with supervisors or colleagues. Strategies to negotiate this included speaking with one's supervisor about class disparities with clients but not specifically identifying that the clinician has wealth, seeking outside supervision, or seeking non-clinical support from friends or family who can offer a safe holding environment to discharge about wealth.

Respondents identified core themes with regards to tensions or conflicts they commonly experienced in their work. Anxiety about the outward presentation of wealth was paramount, and many shared anecdotes about feeling self-conscious with how they dressed. Some responded by intentionally wearing clothes what did not signal access to wealth, and others described attempts to hide their new cars from colleagues, their engagement rings from clients, or to down-play their office accessories. Tension was also identified with other professionals, particularly when the participant self-identified that s/he worked in a community mental health setting. The effect of class tension on the working relationships between mental health colleagues could be another area for future study. Tension was additionally identified by clinicians when negotiating and setting fees, reporting to clients how long they were taking vacation time, or hiding experiences such as visits to Europe or involvement in philanthropic activities. Respondents also identified that there are many blind spots that they have when it comes to negotiating public assistance, legal and educational systems that their wealth has shielded them from. Some reported that this made them less efficacious in their work, while others reported that they readily used their class-privilege and self-advocacy skills to secure services on their clients' behalf. Finally, many respondents reported that it is very upsetting to see their clients struggle with money-related problems, particularly when their problems resulted in challenging compromises. My interpretation is that such responses are related to a low-frustration tolerance for money-related life compromises, which results in the clinicians' feeling guilty that they may not have to make such challenging choices.

The content of emotive language expressed throughout the responses was additionally of note. While becoming familiar with the content, I noticed that there were recurring emotionally charged words that respondents used as it related to their own wealth. This type of language



appeared to fall within two categories: conflicted and appreciative. Phrases that expressed conflict related to one's owning class status include guilt, shame, frustration, impotence, envy, and resentment. This finding reflects literature indicating that wealthy people may experience often unrecognized intrapsychic costs as a result of that privilege (Goodman, 2001; Kleefeld, 2000; Luthar & Becker, 2002; Luthar & Sexton, 2004; Luthar, 2003). Phrases that expressed appreciation included gratefulness, luck, empathy, an opportunity to serve others and peace. Although these groupings are somewhat subjective, I believe they represent an unintended finding: clinicians with wealth have complex emotions related to their wealth and their role as mental health providers. This finding contributes to Liu's suggestion that classism is much more complex than generally acknowledged (2006). I encourage further study to better understand these emotive expressions, and the way that the clinicians' feelings impact their work.

Finally, I would note that many respondents expressed an appreciation for the opportunity to reflect on their experiences as people with wealth, and to explicitly link that to their professional lives. Beyond simply expressing thanks to the researcher, comments suggested that opportunities were few and far between to see themselves reflected in research. This feedback is very much in accordance with previous research suggesting the class is under-studied within the helping professions, and lacks a consistent and reliable measure (Blustein, et al., 2011; Oakes & Rossi, 2003). Some respondents urged graduate-level educational systems to include material about class and classism within the curriculum. Others reported that having a space to reflect on their experiences as a clinician with wealth helped them to think about their work with clients differently, and speak with trusted loved-ones about their experiences.

## **Research Strengths and Limitations**

As with any research, the evaluation of the project's strengths and limitations both suggest implications for further research and refined research tool design. One of the most significant strengths of this research was that it filled an identified gap re: mental health clinicians with wealth in existing published literature. Additionally, it contributed to the very small body of literature about the mental health of affluent populations, and intrapsychic dynamics of class privilege. The findings were innovative and new, contributing more depth to the field and suggesting further areas for research. This research has proven that studying the experiences of clinicians with wealth is both worthwhile to the profession as it expands the available narratives about cross-class clinical work, and targets the oft-denied cultural undercurrent of classism.

Limitations to this study include the change in methodology part-way through the process, as well as challenges with recruitment. When this project was initially conceived, I did not expect to receive such strong initial response from interested participants. My initial hope was that I would get 12-15 people who would be willing to do interviews; however, over 50 people identified themselves to me as interested participants. Given this large number of interested participants, I realized that time and capacity did not permit me to interview all of them. Additionally, I realized that some respondents might be hesitant to share their experiences without the condition of anonymity. Therefore, I changed my methodology to include an anonymous second survey to which eligible participants were invited to respond to online. The final data that resulted from this methodological change was deep and relevant, and in the end I do not question the decision to make the change. However, it did mean that relevant demographic data from Survey 1 could not be directly applied to participant responses to Survey

2. Instead, the demographic findings from Survey 1 give generalized information about the gestalt of the invited participant pool, but not specifics. This de-coupling of the two surveys meant that further correlations between demographic and thematic responses were not possible. Now that I know there is a population of clinicians with wealth willing to be studied, I would design future research so that demographic and thematic data could be anonymously collected together.

Another challenge to the research came from recruitment. While initial recruitment via online communities of mental health practitioners and responsive philanthropists was promising and resulted in a change to methodology in order to accommodate the interest in research, further recruitment efforts did not result in significantly increased response rates. I attempted to recruit more research candidates during the national conference of the American Association of Psychodynamic Clinical Social Workers by setting flyers about the conference space, and asking to speak with attendees. My hope was that this group would have many members of my target population in attendance. I asked to make an announcement during a paper presentation in a session with the topic of class-dynamics within the clinical space. However the presenter invited me to make the announcement while I was out of the room, and her characterization of the research did not compel attendees to support my outreach efforts as I had hoped. Unfortunately, these efforts produced only a few additional responses; instead of the dozens that my research advisor and I had been expecting. Additionally, participant attrition was a challenge. Of the total number of eligible respondents identifying themselves for Survey 1 (n=40), only 33 responded to Survey 2. While the initial flare of interest suggested that I could easily get enough participants for results to be statistically significant and appropriate for deriving correlations, recruitment significantly slowed. Even though the resultant data offer significant results, results are not

numerous enough to allow for generalizations to be made about clinicians with wealth as a population.

### **Suggestions for Future Research**

As previously noted, there is virtually no previous research on the experiences of clinicians with wealth as studied in the current project, and comparatively little research about the impact of class within the clinical relationship. Therefore, areas for future research are abundant. As Israel adeptly noted, research on privileged populations expands our understandings of the mechanisms of power, oppression and privilege, and makes visible the mechanisms of privilege that are otherwise invisible (2012). Deep research and theory on social class in the United States is challenged by both a lack of consistent measure of socioeconomic status, and a general evasion of topic as it applies to the helping professions (Liu, et al. 2004; Oakes & Rossi, 2003). Therefore, any further research that contributes to understanding the intersections of privileged identities, social class, and the mental health profession will be a boon to the field.

Many of the respondents in to my survey called for the development of graduate-level curriculum and/or continuing education programming that builds consciousness and skills around negotiating class within the clinical setting. Similar to Suchet's suggestion that field's avoidance of addressing racism within clinical work is an enactment of a widespread, dissociated split to shield from the pain of racism, I propose that so too is the avoidance of classism (2004). More than just an intellectual curiosity, we have an ethical and moral obligation to produce mental health practitioners who are capable of effectively dealing with class and classism. In addition, further research and training should be developed for supervisors to effectively support their supervisees when addressing issues of class. While little research has been uncovered that

explores the tools that supervisors use when supporting their clients in the exploration of class within their clinical work, it would be a valuable and rich area for future work.

### **Personal Reflections**

If nothing else, this project has clarified for me how some clinicians with wealth think about and respond to the class-based position of privilege that they occupy in relation to their non-wealthy clients. I appreciate the candor and, at times, confusion that the research respondents shared, because I believe they have offered a nuanced and complex perspective on the ways in which class interactions may happen within the clinical sphere. I have found that some of my own experiences as a social worker in training are also reflected within the gathered responses. As someone who can afford to pursue a social work master's degree, I often work with individuals and families who living within a lower socioeconomic class than I do. Furthermore, social workers are increasingly being turned to for the provision of community mental health: the profession itself is mandated to foster the development of poverty abatement strategies ("NASW Code of Ethics," 2008). As a member of this increasingly professionalized workforce with roots in American middle-class, there is often an assumed class-discrepancy between myself and my clients (Strier, 2009). Learning more about the strategies used by other clinicians with class privilege relative to their clients, regardless of whether those clinicians have wealth or not, has given me more insights into how I may be able to negotiate that same intersubjective space with my clients in the future.

## References

- Abramovitz, M. (1998). Social work and social reform: an arena of struggle. *Social Work, 43*(6), 512–526.
- Adler, N. E., Epel, E. S., Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy, White women. *Health Psychology, 19*(6), 586–592.
- Baker, N. L. (1996). Class as a construct in a “classless” society. *Women & Therapy, 18*(3-4), 13–23.
- Baumeister, R. F., DeWall, C. N., Mead, N. L., & Vohs, K. D. (2008). Social rejection can reduce pain and increase spending: Further evidence that money, pain, and belongingness are interrelated. *Psychological Inquiry, 19*(3-4), 145–147.
- Binswanger, M. (2006). Why does income growth fail to make us happier? Searching for the treadmills behind the paradox of happiness. *The Journal of Socio-Economics, 35*(2), 366–381.
- Blustein, D. L., Coutinho, M. T. N., Murphy, K. A., Backus, F., & Catraio, C. (2011). Self and social class in career theory and practice. In P. J. Hartung, L. M. Subich, P. J. (Ed) Hartung, & L. M. (Ed) Subich (Eds.), *Developing self in work and career: Concepts, cases, and contexts*. (pp. 213–229). Washington, DC, US: American Psychological Association. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-09295-013&site=ehost-live>
- Bogard, K. L. (2005). Affluent adolescents, depression, and drug use: The role of adults in their lives. *Adolescence, 40*(158), 281–306.

- Campbell, W. K., Bush, C. P., Brunell, A. B., & Shelton, J. (2005). Understanding the social costs of narcissism: The case of the tragedy of the commons. *Personality and Social Psychology Bulletin*, *31*(10), 1358–1368.
- Cashman, O. (2007). *Social workers' attitudes toward adolescent clients from affluent, middle class, and poor families*. ProQuest Information & Learning, US. Retrieved from psych. (2007-99017-149)
- Chalifoux, B. (1996). Speaking up: White, working class women in therapy. *Women & Therapy*, *18*(3-4), 25–34.
- Christopher, A. N., Kuo, S. V., Abraham, K. M., Noel, L. W., & Linz, H. E. (2004). Materialism and affective well-being: the role of social support. *Personality and Individual Differences*, *37*(3), 463–470.
- Christopher, A. N., Marek, P., & Carroll, S. M. (2004). Materialism and attitudes toward money: An exploratory investigation. *Individual Differences Research*, *2*(2), 109–117.
- Csikszentmihalyi, M. (1999). If we are so rich, why aren't we happy? *American Psychologist*, *54*(10), 821–827.
- Dean, R. G. (2001). The myth of cross-cultural competence. *Families in Society*, *82*(6), 623–630.
- Diwan, R. (2000). Relational wealth and the quality of life. *The Journal of Socio-Economics*, *29*(4), 305–340.
- Dougall, J. L., & Schwartz, R. C. (2011). The influence of client socioeconomic status on psychotherapists' attributional biases and countertransference reactions. *American Journal Of Psychotherapy*, *65*(3), 249–265.
- Ehrenreich, J. (1985). *The altruistic imagination : a history of social work and social policy in the United States / John H. Ehrenreich*. Ithaca : Cornell University Press, 1985. Retrieved

from

<http://libproxy.smith.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat00321a&AN=fivecol.000384580&site=eds-live>

- Elkins, D. N. (2012). Toward a common focus in psychotherapy research. *Psychotherapy, 49*(4), 450–454.
- Franklin, D. L. (1986). Does client social class affect clinical judgment. *Social Casework, 67*, 424–432.
- Fry, R., & Kochhar, R. (2014). America's wealth gap between middle-income and upper-income families is widest on record. *The Pew Research Center*. Retrieved from <http://www.pewresearch.org/fact-tank/2014/12/17/wealth-gap-upper-middle-income/>
- Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4*(2), 99–120.
- Gibbs, A., & Stirling, B. (2013). “It’s about people and their environment’: Student social workers’ definitions of social work research. *Social Work Education, 32*(3), 317–330. <http://doi.org/10.1080/02615479.2012.658365>
- Gift, T. E., Strauss, J. S., Ritzler, B. A., Kokes, R. F., & Harder, D. W. (1986). Social class and psychiatric outcome. *The American Journal of Psychiatry, 143*(2), 222–225.
- Ginsburg, S. W. (1951). The impact of the social worker’s cultural structure on social therapy. *Social Casework, 8*, 319–325.
- Goodman, D. J. (2001). *Promoting diversity and social justice: Educating people from privileged groups*. Thousand Oaks, CA, US: Sage Publications, Inc.
- Graff, H., Kenig, L., & Radoff, G. (1971). Prejudice of upper class therapists against lower class patients. *Psychiatric Quarterly, 45*(4), 475–489. <http://doi.org/10.1007/BF01563209>



- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world?  
*Behavioral and Brain Sciences*, 33(2-3), 61–83.  
<http://doi.org/10.1017/S0140525X0999152X>
- Holt, D. B. (1998). Does cultural capital structure American consumption? *Journal of Consumer Research*, 25(1), 1–25.
- Huppertz, K. E. (2010). Class and career choice: Motivations, aspirations, identity and mobility for women in paid caring work. *Journal of Sociology*, 46(2), 115–132.  
<http://doi.org/10.1177/1440783309351770>
- Isaacs, S. L., & Schroeder, S. A. (2004). Class -- The ignored determinant of the nation's health. *The New England Journal of Medicine*, 351(11), 1137–1142.
- Israel, T. (2012). 2011 Society of counseling psychology presidential address: exploring privilege in counseling psychology: Shifting the lens. *The Counseling Psychologist*, 40(1), 158–180. <http://doi.org/10.1177/0011000011426297>
- Jimenez, J. (2010). *Social policy and social change : Toward the creation of social and economic justice / Jillian Jimenez*. Los Angeles : Sage, c2010. Retrieved from  
<http://libproxy.smith.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cab00321a&AN=fivecol.011272368&site=eds-live>
- Jost, J. T., & Hunyady, O. (2002). The psychology of system justification and the palliative function of ideology. In W. Stroebe & M. Hewstone (Eds.), *European review of social psychology, Vol 13*. (pp. 111–153). Hove, England: Psychology Press/Taylor & Francis (UK). Retrieved from  
<http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2005-02102-004&site=ehost-live>

- Kahneman, D., & Deaton, A. (2010). High income improves evaluation of life but not emotional well-being. *Proceedings of the National Academy of Sciences*, *107*(38), 16489–16493.  
<http://doi.org/10.1073/pnas.1011492107>
- Kaplan, H. A. (1991). Greed: A psychoanalytic perspective. *Psychoanalytic Review*, *78*(4), 505–523.
- Kasser, T., Cohn, S., Kanner, A. D., & Ryan, R. M. (2007). Some costs of American corporate capitalism: A psychological exploration of value and goal conflicts. *Psychological Inquiry*, *18*(1), 1–22.
- Kay, A. C., Gaucher, D., Peach, J. M., Laurin, K., Friesen, J., Zanna, M. P., & Spencer, S. J. (2009). Inequality, discrimination, and the power of the status quo: Direct evidence for a motivation to see the way things are as the way they should be. *Journal of Personality and Social Psychology*, *97*(3), 421–434.
- Kleefeld, C. A. (2000). *The psychopathology of affluence* (Ph.D.). Pacifica Graduate Institute, Ann Arbor. Retrieved from ProQuest Dissertations & Theses Full Text. (304677010)
- Kochhar, R., & Fry, R. (2014). Wealth inequality has widened along racial, ethnic lines since end of Great Recession. *The Pew Research Center*. Retrieved from <http://www.pewresearch.org/fact-tank/2014/12/12/racial-wealth-gaps-great-recession/>
- Lieber, R. (2015). Growing up on easy street has its own dangers. *New York Times*, *164*(56742), B1–B6.
- Liu, W. M. (2002). The social class-related experiences of men: Integrating theory and practice. *Professional Psychology: Research and Practice*, *33*(4), 355–360.
- Liu, W. M. (2006). Classism is much more complex: Comment. *American Psychologist*, *61*(4), 337–338.

- Liu, W. M. (2011). *Social class and classism in the helping professions: Research, theory and practice*. Thousand Oaks, CA, US: Sage Publications, Inc.
- Liu, W. M. (2012). Developing a social class and classism consciousness. In E. M. Altmaier & J.-I. C. Hansen (Eds.), *The Oxford handbook of counseling psychology*. (pp. 326–345). New York, NY, US: Oxford University Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2012-04472-012&site=ehost-live>
- Liu, W. M. (2013). Future directions for scholarship in social class and classism in psychology. In W. Ming Liu (Ed.), *The Oxford handbook of social class in counseling*. (pp. 544–555). New York, NY, US: Oxford University Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2013-01009-033&site=ehost-live>
- Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., Dunston, K., & Pickett, T., Jr. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology*, *51*(1), 3–18. <http://doi.org/10.1037/0022-0167.51.1.3>
- Liu, W. M., Corkery, J., & Thome, J. (2010). Developing competency in social class and classism in counseling and psychotherapy. In J. A. E. Cornish, B. A. Schreier, L. I. Nadkarni, L. H. Metzger, E. R. Rodolfa, J. A. E. (Ed) Cornish, ... E. R. (Ed) Rodolfa (Eds.), *Handbook of multicultural counseling competencies*. (pp. 351–378). Hoboken, NJ, US: John Wiley & Sons Inc. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-12790-012&site=ehost-live>

- Liu, W. M., Hernandez, J., Mahmood, A., & Stinson, R. (2006). Linking poverty, classism, and racism in mental health: Overcoming barriers to multicultural competency. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings*. (pp. 65–86). Hoboken, NJ, US: John Wiley & Sons Inc. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-10123-005&site=ehost-live>
- Liu, W. M., Pickett Jr., T., & Ivey, A. E. (2007). White middle-class privilege: Social class bias and implications for training and practice. *Journal of Multicultural Counseling & Development, 35*(4), 194–206.
- Liu, W. M., Soleck, G., Hopps, J., Dunston, K., & Pickett, T. J. (2004). A new framework to understand social class in counseling: The social class worldview model and modern classism theory. *Journal of Multicultural Counseling and Development, 32*(2), 95–122.
- Lorde, A. (1984). *Sister outsider : Essays and speeches / by Audre Lorde*. Trumansburg, N.Y. : Crossing Press, [1984]. Retrieved from <http://libproxy.smith.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat00321a&AN=fivecol.001148580&site=eds-live>
- Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. *Psychological Bulletin, 81*(6), 344–354. <http://doi.org/10.1037/h0036484>
- Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist, 57*(2), 100–110.
- Lucas, R. E., & Schimmack, U. (2009). Income and well-being: How big is the gap between the rich and the poor? *Journal of Research in Personality, 43*(1), 75–78.

- Luthar, S. S. (2003). The culture of affluence: Psychological costs of material wealth. *Child Development, 74*(6), 1581–1593.
- Luthar, S. S., & Becker, B. E. (2002). Privileged but pressured?: A study of affluent youth. *Child Development, 73*(5), 1593–1610.
- Luthar, S. S., & Latendresse, S. J. (2005). Children of the affluent: Challenges to well-being. *Current Directions in Psychological Science, 14*(1), 49–53.
- Luthar, S. S., & Sexton, C. C. (2004). The High Price of Affluence. In R. V. Kail (Ed.), *Advances in child development and behavior, Vol. 32*. (pp. 125–162). San Diego, CA, US: Elsevier Academic Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2005-01912-004&site=ehost-live>
- Marx. (2014). *Philanthropy*. NASW Press and Oxford University Press. Retrieved from <http://socialwork.oxfordre.com/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-288>
- Mendes, P. (2005). The history of social work in Australia: A critical literature review. *Australian Social Work, 58*(2), 121–131.
- Mitchell, K. M., & Atkinson, M. B. (1983). The relationship between therapist and client social class and participation in psychotherapy. *Professional Psychology: Research and Practice, 14*(3), 310–316. <http://doi.org/10.1037/0735-7028.14.3.310>
- NASW. (2001). NASW Standards for cultural competence in social work practice. National Association of Social Workers.
- NASW Code of Ethics. (2008). Retrieved November 24, 2014, from <http://www.socialworkers.org/pubs/code/code.asp>

- National Association of Social Workers, & The Center for Workforce Studies. (2006, March).  
Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. The Center for Workforce Studies.
- Oakes, J. M., & Rossi, P. H. (2003). The measurement of SES in health research: current practice and steps toward a new approach. *Social Science & Medicine*, 56(4), 769–784.
- Patterson, K. A. (2013). *How class background influences negative countertransference in outreach therapy*. Antioch University. Retrieved from  
[http://rave.ohiolink.edu/etdc/view?acc\\_num=antioch1377775355](http://rave.ohiolink.edu/etdc/view?acc_num=antioch1377775355)
- Redlich, F. C., Hollingshead, A. B., & Bellis, E. (1955). Social class differences in attitudes toward psychiatry. *American Journal of Orthopsychiatry*, 25(1), 60–70.  
<http://doi.org/10.1111/j.1939-0025.1955.tb00118.x>
- Siassi, I., & Messer, S. B. (1976). Psychotherapy with patients from lower socioeconomic groups. *American Journal of Psychotherapy*, 30(1), 29–40.
- Smith, L. (2005). Psychotherapy, classism, and the poor: conspicuous by their absence. *American Psychologist*, 60(7), 687–696.
- Soest, V. (2013). *Oppression*. NASW Press and Oxford University Press. Retrieved from  
<http://socialwork.oxfordre.com/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-271>
- Spanierman, L. B., Poteat, V. P., Wang, Y.-F., & Oh, E. (2008). Psychosocial costs of racism to white counselors: Predicting various dimensions of multicultural counseling competence. *Journal of Counseling Psychology*, 55(1), 75–88.
- The Stanford Center on Poverty & Inequality. (2014). State of the union: The poverty and inequality report 2014. The Stanford Center on Poverty & Inequality.

- Strier, R. (2009). Class-competent social work: A preliminary definition. *International Journal of Social Welfare*, 18(3), 237–242. <http://doi.org/10.1111/j.1468-2397.2008.00588.x>
- Suchet, M. (2004). A relational encounter with race. *Psychoanalytic Dialogues*, 14(4), 423–438. <http://doi.org/10.1080/10481881409348796>
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20(2), 64–88. <http://doi.org/10.1002/j.2161-1912.1992.tb00563.x>
- Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: A grounded theory exploration of low-income clients. *Journal of Counseling Psychology*, 59(2), 208–221.
- Vail, S. (1970). The effects of socio-economic class, race, and level of experience on social workers' judgments of clients. *Smith College Studies in Social Work*, 40(3), 236–246.
- Vodde, R. (2000). De-centering privilege in social work education: whose job is it anyway? *Race, Gender & Class*, 7(4), 139–160. <http://doi.org/10.2307/41955731>
- Weil, M. (2012). *The handbook of community practice [electronic resource] / edited by Marie Weil*. Thousand Oaks, Calif. ; London : SAGE, 2012. Retrieved from <http://libproxy.smith.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat00321a&AN=fivecol.013960421&site=eds-live>
- Wolff, E. N. (2014). Household wealth trends in the United States, 1983 - 2010. *Oxford Review of Economic Policy*, 30(1), 21–43.

## Appendix A

### Human Subjects Review Approval Letter



---

**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-  
7994

November 2, 2014

Sarah Schwartz Sax

Dear Sarah,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,





Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

## Appendix B

### Human Subjects Review Amendment Approval Letter



---

**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-  
7994

January 23, 2015

Sarah Schwartz Sax

Dear Sarah,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

## Appendix C

### Survey 1

#### Clinicians' Experiences of Personal Wealth: Impacts

1. (Required) Thank you for your interest in my research thesis, "Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice." Please fill out the following screening survey which is intended to help the researcher select a diverse sample of research participants. The more information that you offer, the more diverse the research sample can be. The researcher estimates that this survey will take no more than 10 (ten) minutes of your time.

I attest to voluntarily offering myself as a research participant, and understand that filling out this form does not guarantee that I will be selected for an interview.

Yes

No

2. (Required) I understand that any personal information I share within this screening tool will be seen by no one other than the researcher, and will be kept confidential and secure.

Welcome

Yes

No

#### Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice

3. (Required) This research is about the experiences of clinical mental health professionals with wealth. I voluntarily identify myself as a "clinician with wealth" as defined by this researcher.

For the purposes of this study, wealth is being defined as direct possession of, or access to, material resources that release the individual from relying on earned income for daily needs, financial stability, and future earnings. Personal wealth may come in the form of money, land, stock, or other material assets. Personal wealth may have been inherited, earned, gifted or won.

Definition of Clinician With Wealth

Yes, I identify myself as someone with wealth as defined above

No, I do not identify myself as a someone with wealth as defined above

#### Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice

4. First Name (Short Answer)

5. Last Name (Short Answer)

6. (Required) Preferred Email Address (Short Answer)

This email address will only be used to contact you to communicate about this study. It will not be shared and distributed. It will be kept confidential in a secure location, and destroyed

when the research is complete.

7. Age Range (Radio Button)

- 18-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70-79
- 80+

8. Gender (Short Answer)

9. Race and/or Ethnicity (Short Answer)

Demographic

10. (Required) Professional Discipline (Radio Button)

- Clinical Social Work
- Clinical Counseling
- Clinical Psychology
- Clinical Psychiatry
- Other (please specify)

11. Highest Degree Level (Radio Button)

- Master's Degree
- Doctoral Degree
- Other (please specify)

12. Number of years in clinical practice (Short Answer)

Professional of Personal Wealth: Impacts Within Clinical Practice

13. Geographic US Region within which you primarily work [Select all that apply] (Radio Button)

- Northeast
- Mid-Atlantic
- Southeast
- Southwest
- Midwest
- Rocky Mountains
- West Coast
- Alaska
- Hawaii
- Puerto Rico
- Guam
- US Military Bases or Stations
- Outside of the United States
- Other (please specify)

Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice

14. Political Ideology (Radio Button)

Conservative

Moderate

Liberal

Other (please specify)

Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice

15. Manner of Wealth Acquisition [Select all that apply] (Radio Button)

Earnings

Inheritance(s)

Lottery Winnings

Via Marriage

Legal Settlement(s)

Other (please specify)

Clinicians' Experiences of Personal Wealth: Impacts Within Clinical Practice

16. Thank you for completing this survey. If you have any questions about this study, please include them here. (Short Answer)

Thank you and Question

## Appendix D

### Survey 2

1. (Required) Thank you for taking the time to participate in this research about the experiences of clinical mental health professionals with wealth. I have some personal relationships with social workers who have wealth and class privilege; I have wondered what professional dilemmas this brings up in a field that is dedicated to equality and social justice. Thank you for helping me to understand this issue more fully.

ALL RESPONSES WILL BE ANONYMOUS AND CONFIDENTIAL. Only de-identified information will be used for research purposes. Further, data presented in any reports and presentations will only be in the aggregated form that cannot be used to discern the identity of any survey participant. In the case of questions with open-ended responses, comments will be reported only in a form that does not disclose the identity of the respondent.

Participation in the survey is voluntary. You may choose not to answer some questions and you may decide to withdraw from the study at any time. There are no known risks to participation and no direct benefit.

The survey will take approximately 30-45 minutes to complete.

If you would prefer to be interviewed via Skype or by phone instead of completing this survey online, please exit this survey and contact the researcher, Sarah Schwartz Sax at [sschwartzsax@smith.edu](mailto:sschwartzsax@smith.edu). I will then mail an Informed Consent for you to return to me prior to scheduling a convenient time for our Skype or phone interview.

If you have any questions, please contact the researcher:  
Sarah Schwartz Sax, MSW '15  
Smith College School for Social Work  
[sschwartzsax@smith.edu](mailto:sschwartzsax@smith.edu)

Thank you for being willing to participate in this important survey!

- I understand and would like to continue this survey
- I do not agree, and would like to exit the survey

2. (Required) This research is about the experiences of clinical mental health professionals with wealth. I voluntarily identify myself as a “clinician with wealth” as defined by this researcher.

For the purposes of this study, wealth is being defined as direct possession of, or access to, material resources that release the individual from relying on earned income for daily needs, financial stability, and future earnings. Personal wealth may come in the form of money, land, stock, or other material assets. Personal wealth may have been inherited, earned, gifted or won.

- Yes, I identify myself as someone with wealth as defined above  
 No, I do not identify myself as a someone with wealth as defined above

Clinical Vignette: Please read the following vignette, and answer the questions below

Chris is a clinical social worker who has been operating a private psychotherapy practice in a small American city for ten years. Chris bills both private insurance and Medicaid, and sees out-of-pocket paying clients on a sliding scale from \$30 - 120/hour. It has been important to Chris to keep the low end of the scale at \$30 so that clients are valuing the services that Chris offers. Additionally, Chris has felt taken advantage of when previously seeing clients for less than \$30, which seemed to negatively impact the therapeutic dyad.

Chris was raised in an affluent community, and received an inheritance of \$5 million dollars upon becoming a legal adult. That money has been invested and managed by a financial planner, and as a result Chris does not need to rely on income from clinical practice for daily expenses or future planning. Chris's family lives comfortably, and without financial worry. The family annually donates to local community organizations and institutions. Chris sees clients of various socioeconomic backgrounds, including some who have been "hit hard" by the recent financial crisis. One of Chris's clients, Charlene, has been particularly struggling financially, and spends much of her time in sessions worrying about how she will pay for all of her expenses. In previous sessions with Charlene, Chris has worked hard to pay attention to countertransferential feelings of guilt and a desire to help financially. In supervision, Chris identifies that other feelings associated with Charlene's financial position include shame, helplessness, frustration, pity, remorse, blaming, writing-off, and discrediting.

In today's session, Charlene enters the office upset. She has experienced another financial setback, and is asking Chris if she can continue therapy at a lower payment level of \$15/hour. When Chris explains that this is not possible, Charlene reacts by yelling, "Why is everyone taking advantage of me?! Why can I never get a break?! It seems like you just don't understand how hard this is for me and my family! But then again, I guess you wouldn't be able to understand. After all, I've seen that car you drive, and I know what it cost you! You must have money since I know a social worker can't buy a car like that without daddy's help. Plus, those stickers on the car for your kid's private school also give you away. And I've seen your name on major donor lists for lots of organizations in our community. You must really be loaded to be able to just give money away! But then again, this is just like the rich to be selfish and to take, take, take from poor people like me who are just trying to get along. I ask for a little understanding, a little help as my family and I are struggling, but all you can think about is your bottom line!" After the session, Chris feels very dysregulated, and notices feelings of anger, frustration, guilt, isolation, exhaustion, and a desire to write-off Charlene's powerful words.

3. If you were in Chris's place, how personally affected would you be by your clients words? (Radio Button)

- Not at all  
 Slightly  
 Moderately

- Significantly
- Extremely

4. If you were in Chris's place, how would you respond to the client? What words would you use? (Short Answer)

5. If you were in the Chris' place, would you adjust your fees for the client? (Radio Button)

- Yes
- No
- I don't know

6. Please share your thoughts about why you would, or would not, adjust your fees (Short Answer)

7. How can clinicians with wealth acknowledge and recognize thoughts and feelings associated with their class background while in session with a client of a different socioeconomic class experience? (Short Answer)

8. How can clinicians with wealth acknowledge and recognize thoughts and feelings associated with their class background while in supervision or consultation about a client of a different socioeconomic class experience? (Short Answer)

9. I want to learn about how clinicians with wealth experience working with their clients of different socioeconomic backgrounds. What has your experience been as a clinician with wealth? (Short Answer)

10. How many years have you been a practicing clinician? (Short Answer)

11. How often have you been in a situation with clients where they expressed negativity, frustration or anger in response to their perception of your class background? (Radio Button)

- Never
- 1 or 2 times
- 3 to 5 times
- 6 to 10 times
- More than 10 times

12. What was your response (if any)? What words did you use? (Short Answer)

13. How often have you been in a situation with clients where they expressed neutrality in response to their perception of your class background? (Radio Button)

- Never
- 1 or 2 times
- 3 to 5 times



- 6 to 10 times
- More than 10 times

14. What was your response (if any)? What words did you use? (Short Answer)

15. How often have you been in a situation with clients where they expressed acceptance, or positivity in response to their perception of your class background? (Radio Button)

- Never
- 1 or 2 times
- 3 to 5 times
- 6 to 10 times
- More than 10 times

16. What was your response (if any)? What words did you use? (Short Answer)

17. Have you ever felt self-conscious about your access to wealth during an interaction or session with a client.

- Yes
- No
- I don't know

18. Please describe one or more of the experiences in which you felt self-conscious about your wealth during an interaction or session with a client. (Short Answer)

19. When do you experience your class background most significantly when working with a client from a different socioeconomic background? (Short Answer)

20. Please tell me about a time, if you are aware of one, when class-based countertransference played a role in a session with a client. (Short Answer)

21. Tell me about a time when you found your class identity to be helpful to your client(s). (Short Answer)

22. Tell me about a time when you found your class identity a hindrance to your client(s). (Short Answer)

23. What question(s) have I failed to ask that would help me to understand better your experience as a clinician with wealth? Is there anything else that you would like to tell me about your experience as a clinician with wealth? (Short Answer)

## Appendix E

### Recruitment Materials

Subject: Requesting Research Participants – Clinicians with Wealth

Dear [Organization Name] Listserv Members,

My name is Sarah Schwartz Sax, and I am pursuing my master's degree in social work from the Smith College School for Social Work. I am conducting an exploratory study, and am interested in the interviewing clinicians who self-identify as wealthy. My aim is to learn about their subjective self-perceptions of socioeconomic differences between themselves and their clients across the clinical encounter, including but not limited to assessment, treatment, fee-setting, and use of supervision to address clinician's responses to socioeconomic differences. Additionally, I want to explore what these clinicians with wealth do to note discomfort, and how they cope with these socioeconomic differences.

If you **self-identify** as a mental health clinician with wealth, or as a clinician who has access to more material resources than you require to the extent that you do not need to depend on earned income for daily needs, living expenses and future planning, please consider participating. If you know people within your community who might also consider themselves suitable for this study, please forward this recruitment email to them.

The aim of this research is to support the field of social work, and other mental health professions, to be more knowledgeable to social-class-based issues, and thus more sensitive to our clients of all socioeconomic classes.

I am looking for master's-level or doctoral-level clinical mental health professionals who self-identify as having access to wealth and class privilege, and who work with at least some clients who do not identify their social class as wealthy or owning-class.

In total, those selected to participate in research will be asked to: a) fill out a screening tool, b) participating in a 45 minute interview by Skype, and c) reviewing the researcher's findings for accuracy. All gathered data will be kept confidential and secure, as per federal regulations. To identify yourself to the researcher, please fill out this initial screening form: [SurveyMonkey Link]

This research is partial fulfillment of graduation requirements for a master's degree in clinical social work from the Smith College School for Social Work. Per federal regulations regarding ethical treatment of research participants, this research will require oversight by the Smith College Human Subjects Review Committee.

Please feel free to respond to me with any questions at this email address.  
Thank you. I look forward to hearing from you.

Sarah Schwartz Sax  
Master's in Clinical Social Work (MSW) Student  
Smith College School for Social Work

**Appendix F**

**Human Subject Consent Form**

**Consent to Participate in a Research Study**



**Smith College School for Social Work • Northampton, MA**

.....  
**Title of Study:** Clinicians’ Experiences of Personal Wealth: Impacts Within Clinical Practice

**Investigator(s):** Sarah Schwartz Sax, Smith College School for Social Work  
.....

**Introduction**

- You are being asked to be in a research study about the experiences of clinical mental health professionals with wealth and their experiences in clinical practice with clients of non-wealthy socioeconomic backgrounds. Specifically, I am interested in the interviewing clinicians who self-identify as wealthy in order to learn about their subjective self-perceptions of socioeconomic differences between themselves and their clients across the clinical encounter, including but not limited to assessment, treatment, fee-setting, and use of supervision to address clinician’s responses to socioeconomic differences. Additionally, I want to explore what these clinicians with wealth do to note discomfort, and how they cope with these socioeconomic differences.
- For the purposes of this study, “wealth” is being defined as direct possession of, or access to, material resources that release the individual from relying on earned income for daily needs, financial stability, and future economic security. If you identify as “wealthy” under this definition, please continue.
- You were selected as a possible participant because you responded to an online survey expressing interest in participating. You were selected as a research participant because you self-identified as a clinical mental health professional with at least a master’s degree who identifies as wealthy, and has worked with at least some client who have identified themselves to you as not wealthy.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

- The purpose of the study is learn about how mental health professionals with wealth experience working with clients who do not have access to personal wealth, and how those experiences impact clinical practice.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things:
  1. Return this Informed Consent paperwork to the researcher with your hand-written signature – 5 mins
  2. Participate in an interview by the researcher over Skype – 30-45 mins
  3. Review researcher’s findings as a means of verifying their accuracy – 20 mins

### **Risks/Discomforts of Being in this Study**

- There are no reasonable foreseeable (or expected) risks.

### **Benefits of Being in the Study**

- Participants will benefit from this research from the satisfaction of helping a nascent Master’s-level social worker complete her course of study. Participants will also benefit by contributing extensive, in-depth information and alternative narratives to the professional field.
- The intent and benefit of this work is to support the field of social work to be more knowledgeable about class-based issues, at least within this small sample interviewed, and thus more sensitive to our clients of all socioeconomic classes.

### **Confidentiality**

- Your participation will be kept confidential. Interviews will be conducted over Skype, an instrument that has been approved by the Smith School for Social Work for interviewing. Participants will be contacted by the researcher from the researcher’s private home office, and participants will be encouraged to conduct the interview in a private location. In addition, the records of this study will be kept strictly confidential. Interviews will be recorded with a digital device, and downloaded to a password protected and encrypted external hard drive. The researcher will use pseudonyms in place of respondents’ names, and mask any identifying information. A crib sheet that matches participants’ pseudonyms and real names, or any other identifying information, will be kept separately from transcriptions and data. This crib sheet will only be accessible by the researcher.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you. Information may be used in the future for research, secondary or expanded research, publications or presentations without using identifying information.

### **Payments/gift**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the

right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by *[Date determined two weeks after interview has occurred.]* After that date, your information will be part of the thesis report.

**Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sarah Schwartz Sax at [sschwartzsax@smith.edu](mailto:sschwartzsax@smith.edu) or by telephone at *[telephone number provided]*. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....  
Name of Participant (print): \_\_\_\_\_  
Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....  
**[if using audio or video recording, use next section for signatures:]**

**1. I agree to be audio taped for this interview:**

Name of Participant (print): \_\_\_\_\_  
Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

**2. I agree to be interviewed, but I do not want the interview to be audio taped:**

Name of Participant (print): \_\_\_\_\_  
Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

**Form updated 9/25/13**