
Theses, Dissertations, and Projects

2010

The Matthew effect and treatment selection for urban poor clients : social pain, countertransference or competition? : a project based upon an independent investigation

Launa Kay Bodde
Smith College

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



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

Recommended Citation

Bodde, Launa Kay, "The Matthew effect and treatment selection for urban poor clients : social pain, countertransference or competition? : a project based upon an independent investigation" (2010). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/1115>

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.

Launa Bodde
The Matthew Effect and
Treatment Selection for
Urban Poor Clients: Social
pain, countertransference or
competition?

ABSTRACT

This study is a theoretical look at the intersection of neurobiology and analytic theory as it impacts clinician's decisions about treatment selection. Historically, it has been proven that clients who are poor do not receive the same level of care, attention and service as clients from "upper classes." These poorer clients do not have the same ability to compete for resources, therefore the rich get richer while the poor get poorer. This phenomena has been coined the Matthew Effect.

This study is an attempt to find new and different ways of explaining the Matthew Effect phenomenon. What exactly are the forces behind the gap in services across social class stratifications? One possibility set forth by this writing is that neurobiology as described by Social Pain Theory and countertransference intersect and overlap leading to implicit bias and nonconscious reactions that determine a clinician's decision-making process.

THE MATTHEW EFFECT AND TREATMENT SELECTION FOR URBAN POOR
CLIENTS: SOCIAL PAIN, COUNTERTRANSFERENCE OR COMPETITION?

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

Launa Bodde

Smith College School for Social Work
Northampton Massachusetts, 01063

2010

ACKNOWLEDGEMENTS

This work is dedicated to my son, Christopher Kai. He has sacrificed more than a child should. He gave up proximity and time without complaint. He has always been a remarkable child but now become a remarkable young adult. Christopher, I could not be more proud of you nor love you more. You are a true bright light.

Next I need to thank Bala for seeing me through the year of this writing but more importantly keeping me grounded in an adventurous and passionate relationship and reminding me always of the important things in life. Yes, there is life outside of my head. You are my perfect partner.

Konstantina and Stelios, I do not need to speak the words. Of all my chosen family, you know me most intimately, who I am and desire to be. I love you both and can never thank you for being my family when no one else would have me.

I could not publish this paper without thanking the library staff at the Neilsen Library, particularly Irene Branson. No request was too big or small, and she was seemingly tireless in helping me track down some awfully obscure references.

I owe a huge thank you to Barb Lui for advising me through the writing process, as well as respecting my independence and need to experiment. Being a thesis advisor is a thankless job, so please accept this as my thank you for your work and time.

A special thank you to Joann Corbin for offering up time, wisdom and experience and sharing so openly and passionately and inspiring me to take on research as a career in and of itself.

For the sake of brevity but with no less respect, I would like to thank all the faculty at Smith I had the pleasure of learning with. I will carry each of your voices with me. You have contributed to my unique vision of freedom that this work demands.

Last and certainly not least, I think always of the clients I worked with over the past two years and the clients to be in the future. It is my deepest hope this work will be the beginning of more research and development, and that it will allow all clients the best support and compassion our profession can provide. We are not above or below but in this thing together. Our paths to freedom are inexorably intertwined. Thank you all for teaching me more about myself than I imagined possible. This profession is a gift because of the relationships it offers. May we never lose sight of that.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION	1
II METHODOLOGY	11
III THE MATTHEW EFFECT	18
IV SOCIAL PAIN THEORY	28
V COUNTERTRANSFERENCE	36
VI DISCUSSION.....	47
REFERENCES	56

CHAPTER 1

INTRODUCTION

“Only a fearless person can work towards self development and can also help in social and political development. Therefore one should fearlessly perform all his duties.” ~ Yajur Veda

Self, social, and political development -- these are large concepts for any single person to contemplate. However, as clinical social workers, we are called upon by the duties and ethics of our profession to do just that. No easy task. The concepts we wrestle with are large and unwieldy, no doubt. When it comes to integrating all three, we encounter another monster altogether. As the Veda speaks, it takes a certain amount of fearlessness to tackle this particular monster. Not that this writer feels particularly fearless, but this thesis will attempt to integrate thinking across these spheres of development but not without risk of becoming unwieldy and large itself.

For the sake of brevity and with a mission of becoming a starting point for future research, this thesis will tackle the topic of treatment selection for the urban poor based upon a theory known as the Matthew Effect, a sociological phenomena that we will utilize to help us understand how neurobiology and relationship can impact the decision-making process for clinicians. This thesis will attempt to narrow down the focus of the writing to the clinical while holding in frame the larger context of the social and political.

The Matthew Effects tells us, in simple terms, the rich get richer while the poor get poorer. This may seem like folk wisdom or maybe even common sense depending on

one's sociological and political orientation. However, it is a theory that has been studied and quantified and even applied to clinical therapeutic work. Its common wisdom extends beyond anecdote to a researched but perhaps not widely known phenomenon.

The Matthew Effect is not particularly concerned with the causes of the gap between the rich and the poor, only that they exist and continue to widen over time. It tells us those best able to compete for resources will receive them. Those that don't have the capacity, skill or access will not receive what they need. Though the Matthew Effect is not explanatory, it does provide an interesting sociological lens through which to view the treatment selection process for the urban poor.

The Matthew Effect, however interesting, does little for us with respect to understanding the root causes of the gap between those who have and those who don't. It also does little to help us find paths to interventions, as we are called to do in the social work profession. It is the intent of this thesis to link two disparate theories, social pain theory and countertransference, to the Matthew Effect in a way that allows us to better understand the treatment selection process for urban poor clients from a useful clinical perspective. It is this writer's hope the result will be new thinking about treatment selection and assist social work clinicians in developing new interventions with this population -- interventions that provide the best level of care possible.

Mental Health Care and Clients Who are Poor

History of the poor in psychotherapy

Analytically-informed psychotherapy has a long history of serving and "not serving" the poor. To trace the history as far back as Freud and the free clinics, one can begin to see early forces at work in defining class issues within the confines of the

therapeutic relationship. Freud himself, in the volumes of published cases, did not record working with a single, lower-class patient (Brody, 1976). Freud was, however, a powerful force in creating free clinics and advocating for free mental health care for everyone, regardless of race, class or status. The founder of psychodynamic thinking was his own paradox.

The 1950s and 1960s saw a surge of interest in class positioning as a determinant of treatment modality. The oft-cited study, *Social Class and Mental Illness* by Hollingshead and Redlich, 1958, was instrumental in instigating interest in the subject. However, after ten years or so of investigation, the subject fell off the map. Many reasons have been proposed for this lack of research, and this will be further explicated in the discussion chapter of this paper.

In the ensuing years, insight-oriented therapy and analysis have become a normative force and have not focused on serving the poor either in theoretical advancements or availability of treatment (Wachtel, 2002).

What is meant by psychotherapy?

There are many definitions of psychotherapy. Turn any given corner and one may bump into a psychotherapist of a different theoretical orientation. Originally this writer intended to narrow the focus of this writing to "insight-oriented" therapies. However, this designation excluded narrative therapies, existential therapies, cognitive therapies, etc. It is not the intention of this paper to debate the merits of any given theoretical orientation or mode of psychotherapy. Also, in the earlier research, such as Hollingshead and Redlich, the modality and orientation of therapy was not considered. They examined only

the fact that the client did or did not receive some form of psychotherapy (social therapy) versus medication or electroshock therapy.

In Link and Milcarek's work, they looked at clients receiving psychotherapy (individual, group or family) versus clients receiving rehabilitation versus clients receiving no therapeutic services at all. Other research focused on psychodynamic psychotherapy as the gold standard modality. For the purposes of this paper, we will look at treatment selection on a continuum ranging from no services to case management to rehabilitation to psychotherapy, with long-term, open-ended psychotherapy being the most desired form of treatment. This is not to say that it is always the best or the most desired form of treatment, but it is the chosen framework for this analysis.

Are the poor underrepresented in psychotherapy?

In the chapter on the Matthew Effect, this paper will review many studies that demonstrate statistically significant difference with respect to the numbers of people who are poor versus middle to upper class served by psychotherapy. The original research by Hollingshead and Redlich (1958), the follow-up study by Meyers and Bean (1968), Stern (1977), Jones (1974), and Beckham (1992) all examined this issue. The general consensus of this body of research is that the poor are, in fact, underrepresented, underserved and selected out of long-term psychotherapy. One common explanation for the lack of poor clients in long-term therapy is that this modality is not appropriate for the poor for a wide variety of reasons.

Is psychotherapy even appropriate for people who are poor?

Terestman, Miller and Weber (1974) give us three oft-cited reasons for the absence of poor clients in long-term therapy:

1. ... the typical low-income patient is said to define his problems and look for solutions in ways (deriving from his non-middle-class life-style and value system) that are not compatible with psychoanalytic practice. ... These generalizations have been described and explained frequently enough to assume the authority of axioms.
2. The typical middle-class therapist has been called unfit to treat the low-income patient and unable even to grasp the meaning of the communications. Differences in use of language, areas of sensitivity, and goals and expectations are all believed to act as barriers. ...
3. The third major justification for excluding non-middle-class patients from psychoanalytic therapy is that they seem to have benefited little from it when it has been made available.

This 1974 study refutes these three claims with the basic conclusion that “stereotypes associated with major demographic groups are highly unreliable predictors of patient characteristics and of therapeutic outcome. ” They utilize quantitative statistics but also qualitative case discussions to reinforce these conclusions.

Are therapists at fault?

There have been studies attempting to explain why therapists do not select lower-class patients for long-term therapy. Some feel depth work is not appropriate for lower-class populations, Salvador Minuchin among them (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). There is some folk wisdom around the belief that psychoanalysis does not serve the poor (Wachtel, 2002; Garb, 1997) but as previously mentioned, very little recent, quantitative research on the subject exists.

Social selection theory tells us that therapists select young, articulate, verbal, intelligent, and successful (YAVIS) clients that most closely mirror their own mores (Schofield, 1964) and provide the possibility of extrinsic reward. Link (1983) studied attitudes of practitioners towards each other’s skills based on their client selection and found that therapists working with disadvantaged clients were seen as less skilled.

Bernice Lott (2002) believes that therapists collude in maintaining classism by distancing themselves cognitively and behaviorally. Javier and Herron (2002) write:

In contrast, therapists have no interest in being poor, and despite social conscience, do not seek to identify with the poor. In essence, the poor patient is so unlike the therapist in most instances that regardless of the theoretical frame that influences the analytic technique, the potential for disruptive countertransference is high and prone to override egalitarian and altruistic desires as well.

The general consensus of this body of research is that the poor are not selected into long-term therapy on the basis of inherent clinician bias.

Enter the Matthew Effect

As mentioned earlier, the Matthew Effect studies the gap between the haves and the have nots. In the case of treatment selection, this phenomenon was studied by Link and Milcarek (1980). They examined two basic models of treatment allocation, a mental hygiene model where those who need the most intensive therapies receive them and a social selection model saying those most able to compete receive the most desirable therapies. Ultimately, they postulated the social selection model was at play in the treatment selection process to a greater degree than the mental hygiene model. They write “From this viewpoint, different forms of treatment, particularly the more desirable ones, are seen as social products for which people compete. The most effective competitors are the most successful in obtaining professional help.”

Are There Additional Explanations?

Social Pain Theory

This researcher would like to propose additional possibilities for a bias in treatment selection contributing to a widening gap described by the Matthew Effect. Recent neurobiological research has shown that a person’s experience of social exclusion

creates a pain affect akin to social pain. This affect stimulates the same regions of the brain that are stimulated by physical pain (Eisenberger & Lieberman, 2005). This is an evolutionary process that has been connected to competition for resources, as well as financial stability and attachment relationships. Chen (2008) demonstrated that social pain can be “relived and pre-lived” to a greater degree even than physical pain. Other researchers have augmented social pain theory by attempting to show that financial security or even “thoughts of money” act as a buffer against social pain (Zhou, Vohs, & Baumeister, 2009).

This researcher proposes that buffering from the pain affect of social pain happens on a nonconscious level that creates a competition for relationship and, on the same continuum, a distancing effect between therapist and client in order to avoid pain, leading to a selecting out of clients who are poor.

Integration with traditional psychodynamic theory.

Along with social pain theory, this writing attempts to integrate psychodynamic theory, particularly countertransference, with social pain theory.

Countertransference research, particularly with respect to working with clients who are poor, tells us that the therapist has a special role to play and specific barriers to overcome if they are to be clear about their own biases and motivations when working with an “othered” population (Dimen, 1994; Javier & Herron, 2002; Whitman-Raymond, 2009; Foster, 1998; Rosenberger, 2002). Current psychoanalytic research is also attempting to utilize neurobiological processes as an adjunct or even “cause” of countertransference (Pincus, Freedman, Modell, 2007; Stone, 2006; Ochsner et al, 2008; Schore, 2003).

In combination, this writer believes these theories can explain ontogenetic causes for the Matthew Effect at work in treatment selection, at least on a micro level.

Why is treatment selection equity important?

It is this writer's belief that the forces acting on the treatment selection process occur at both a macro and micro level. For the purposes of this writing, the research focuses on the micro (clinical) level. However, it is not possible to be fully conscious of bias without examining and understanding the greater social context and pressures.

The social work Code of Ethics says in its introduction "A historic and defining feature of social work is the profession's focus on individual well being in a social context and the well being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living." In that spirit, this writing hopes to integrate an understanding of the sociological (the Matthew Effect) as it impacts or is impacted by the personal (social pain theory and countertransference in clinical practice).

It is important that social work clinicians understand the processes at work in treatment selection. Not only is it possible that we select or "deselect" clients based on a nonconscious process that is unfairly biased, it is also possible that we marginalize the poor in development of theoretical thinking, practice and technique for the same reasons, which is in clear violation of the code of ethics of our profession.

Inequality, in all its forms, has many detrimental outcomes. Daniels, Kennedy, & Kawachi, 2000, demonstrated that overall societal inequality affects individual health, even for those who are better off. In other words, one doesn't have to be poor to suffer from inequity, one just needs to perceive themselves as worse off than others. This

knowledge has been extrapolated to and demonstrated in multiple countries with multiple populations. The United States, with its disparate levels of stratification, fares worse than most (Wilkinson, 1999).

Social workers are called to understand inequality and its impacts on the people they work with. Social justice is a core component of the Code of Ethics. Knowing this, what is the impact of this understanding on clinicians? Karon and Vandenbos (1977), in talking about countertransference say,

It is understandably painful for therapists to empathize with poor patients living under circumstances the therapist would not willingly (and perhaps could not) endure. The easiest way to avoid such painful fantasies is to not accept such patients, to unconsciously maneuver the patient into dropping out of treatment, or to not do real therapy but only aid with a misery-abatement plan or escape plan... Whether to help the patient adapt to being lower class or to escape, is ideology, not therapy. The therapist must help the patient evaluate the alternatives in the light of his reality and psychodynamics, and then to act.

Javier and Herron (2002), when talking about the indefensibility of classist positioning by therapists say, “The underlying message is that their internal world, their fantasies, dreams, thoughts, emotions, and wishes are not only irrelevant but also unimportant and unnecessary. But aren’t these the very components that characterize human from nonhuman?”

One of the ethical principles of the social work discipline is to help people in need and address social problems by alleviating oppressive conditions for marginalized populations. The poor have, from the beginning of the profession, been a marginalized group that social work has endeavored to serve. As clinical social workers move more and more to the fore of the depth therapy field, we need to be mindful of our client selection process to ensure that we continue to honor the ethical mandates of our

profession and continue to serve the poor in the best possible way. We have a professional responsibility for good supervision and self awareness.

The question waiting to be answered is whether or not therapists' nonconscious or unconscious activations bias treatment selection when working with an "othered" population such as the urban poor. Specifically, does a clinician's nonconscious processes, in the form of social pain and countertransference, impact treatment selection and referral to psychotherapy for the urban poor as described by the Matthew Effect? This writing will explore both theories through the lens of the Matthew Effect with the hope of determining whether the theories are explanatory, as well as exclusory or complementary.

Summary

This introduction has outlined the basic phenomena and theories to be explored in this writing. This writer has attempted to illustrate the gaps in existing understanding about the phenomena of the Matthew Effect, as well as potential integration with social pain theory and theories of countertransference. All this work is undertaken with the hope of improving mental health care for marginalized populations but specifically the urban poor. This population is historically underserved and stigmatized. In this light, this writer advocates for a greater responsibility to this collection of people than almost any other. The next chapter will discuss the conceptual basis and methodology used in the writing of this paper, and the ways this writing is intended to examine the issue at hand.

CHAPTER 2

METHODOLOGY

This paper examines the impact of the Matthew Effect at work in the treatment selection for urban poor clients in psychotherapy. It is this writer's assertion that there are many potential explanations for the underrepresentation of urban poor clients in depth-oriented psychotherapy. Over the years, there have been many possibilities set forth as an explanatory theory. In this paper, I will focus on how psychoanalytic ideas of countertransference and neurobiology may contribute to the Matthew Effect.

The Matthew Effect, to be thoroughly explicated in the following chapter, was originated in the field of sociology. Merton proposed that the Matthew Effect describes how the rich get richer and the poor get poorer. In this case, it describes how the rich get psychoanalysis and the poor do not. This paper asserts that social pain theory and psychoanalytic theory of countertransference may provide possible contributions and/or explanations for how the Matthew Effect is propagated in the treatment selection process.

Conceptual Framework

In recent years, the fields of neurobiology and psychoanalysis have been coming together. Through the work of Allan Schore, Jaak Panksepp, Peter Fonagy, Eric Kandel and others, the field is starting to be able to describe analytic concepts in terms of neurobiological processes. Diffusely separated fields are developing common language and common means of communicating similar ideas. There has been considerable work

done in affective neurobiology that links the older idea of countertransference to biological and “bodily” responses (Pincus, Freeman, Modell, 2007).

Is it possible to link Social Pain Theory (a neurobiological theory) with countertransference as a means of explaining an individual’s drive toward inclusion and the pain and avoidance of exclusion? We now have technology, such as fMRI, that allows us to look inside the “mind” of individuals as they experience social exclusion or reminders of social exclusion. This technology counterbalanced against the “older,” creative and metaphorical language of psychoanalysis allows us to conceptualize these experiences in a richer and more unified way.

Blending these theories may help bridge the concepts of individual experience with the greater sociological processes underlying the Matthew Effect. The Matthew Effect has been linked across many disciplines and shown to be at work in many different arenas. The literature on health and treatment selection is sparse but available. Drawing on this literature will link the neurobiological to the individual to the social.

Definitions of Classism

The man who washes cars does not own one. The clerk who files cancelled checks at the bank has \$2.02 in her own account. The woman who copyedits medical textbooks has not been to a dentist in a decade. This is the forgotten America... Millions live in the shadow of prosperity, in the twilight between poverty and well being. Whether you're rich, poor, or middle-class, you encounter them every day. They serve you Big Macs and help you find merchandise at Wal-Mart. They harvest your food, clean your offices, and sew your clothes.
~~Shipler, 2004

Because this paper focuses on issues of class difference between therapist and client, it is important to define some of the terms used. Providing a comprehensive yet

accurate definition of social class is a near impossibility. Dimen writes about class constructs in psychoanalysis very directly. She says:

In the most general sense, class refers to the material aspect of society and the way it divides and joins people along a ladder of economic and political power. By definition, class is hierarchical; the relation between classes is determined by their economic and political superiority or inferiority to one another. To put it more crudely, class distinctions are about money and its unequal distribution in society. Conversely, money represents the veritable or potential differences in power among individuals and among groups. (Dimen, 1994).

For the sake of brevity and clarity, this writer has settled on the work of Liu, et al (2004) for a subjective definition of classism. Liu's work has been focused on classism and class issues within the counseling field. Liu's research has found social class to be a subjective term and resists defining it narrowly. In their 2004 review of counseling journals Liu, et al, 2004, "found over 400 words that had been used to describe social class phenomena." They go on to say:

Adding to the confusion over subjectivity and social class in counseling is the consistent use of "objective" indices rather than subjective criteria to understand social class and classism. Typically, these indices of income, education, and occupation are used to place people into a hierarchical framework or stratification. (Liu, Ali et al, 2004).

It is important to keep an eye on the complexity and variation of issues of class.

Nuances exist whether one resides in a major urban center or rural farming community.

Liu tells us:

Classism also reflects an individual's underlying social class worldview, which is situated in his or her economic culture. The assumption is that many economic cultures exist; that is, "middle class" varies from region to region, and the expectations for a middle-class person vary even if, objectively, a person in Manhattan, New York, has the same educational level, occupation, and income as someone in Manhattan, Kansas. The economic culture establishes certain expectations for people if they are to maintain their social class, and to maintain their social class, individuals behave in classist ways. Social class, therefore, is defined as beliefs and attitudes that help the individual to understand the demands

of his or her economic culture, to develop the behaviors necessary to meet the economic culture demands, and to recognize how classism functions in his or her life. (Liu, Ali, et al., 2004)

To summarize these definitions, Liu adds “But as with all forms of oppression and privilege, classism needs to be understood as complex and constantly negotiated.”

Liu, Ali et al (2004) describes classism as “prejudice and discrimination based on social class resulting from individuals from different perceived social classes. Typically, classism has been discussed as a unidirectional occurrence... yet classism can occur in potentially any direction and can operate simultaneously in any direction.” Therapists may benefit from classism when it is focused from the top down such as gaining materially by benefit of their accumulated social capital. However, they can be targets of upwardly focused classism. Liu et al (2004) gives this description:

One way to understand upward classism is when an individual who perceives others to be of a "higher social class" than he or she is refers to these others as "elitists" or "snobs."

Along with the definitions of classism, it is important to discuss the term urban poor that is used throughout this writing. This paper focuses on urban citizens, those living in major metropolitan areas, regardless of their location within that area. With regard to poor, this writer prefers to use the term “people who are poor” rather than poor people to avoid classifying people who are poor into one homogenous group. Liu (2006) says “people who are poor vary in how they interpret their situations and in their views on social mobility.” For the purposes of this paper, we define urban poor as citizens of a major metropolitan area that do not have the required resources to meet basic needs.

Plan of Analysis

In order to adequately analyze and bridge these distinct theories, the paper will present a history and current literature review of social pain theory and countertransference with respect to work with the urban poor. It is important to focus the review on literature pertaining to work with the poor as this will concentrate theoretical concepts around the population in question.

This paper will also present a thorough review of the philosophy and background of the Matthew Effect and how it applies to sociological phenomenon such as treatment selection for a specific population. The available literature on the Matthew Effect will be extrapolated to the nature of the treatment selection process and how individual/group behaviors may propagate the sociological process.

Along with the literature review, the theoretical chapters will contain clear and explicit definitions of key terms and concepts in each of the theories. These definitions may not be universally accepted, but they will form the basis for the synthesis of the theories.

Research is not conducted within a vacuum and theoretical research is no different. Throughout the analysis, contextual understanding will be critical to maintaining an objective view of the applicability of the theories to the phenomenon of the Matthew Effect. Because this paper is attempting to blend diverse theoretical approaches with a sociological phenomenon, social constructs such as class, society, relationship, health, etc. will invariably weigh heavily with respect to bias. It will be this researcher's goal to retain contextual understanding in an effort to eliminate subjective bias.

This thesis is intended to be hypothesis-generating and analytical in nature. It would be a positive outcome of the research to produce a descriptive or explanatory model, but that is not the primary goal of this paper.

The majority of the data and resources used for this study will be peer-reviewed journals from the fields of psychology, sociology, and social work. However, as the theories are integrated and synthetic in and of themselves, there will be literature drawn from a wide variety of fields. However, this writer will endeavor to keep the resources limited to methodologically sound and peer-reviewed research. The sources will be as representative of the population in question as possible.

The data collection will occur primarily through utilization of cataloged journal articles and again, limited to peer-reviewed journals.

After presenting a thorough review of the theories, the discussion chapter will focus on analyzing and synthesizing the theory through an overall discussion of the theories. The analysis will look at the major influences in each theory and compare them to the other with an eye to understanding how sociological concepts may be driven by individual and/or dyadic processes.

The analysis of the literature will be primarily qualitative, though there will be some discussion of the quantitative nature of the reviewed research, as well as its efficacy, reliability, validity, generalizability, and bias.

The interpretation of the review will be primarily analytic in nature with the understanding of the importance of sufficient and relevant grounds for any conclusions drawn from the analysis.

Methodological Biases

There are several opportunities for bias to enter the theoretical discussion in this paper. First and foremost is the writer's own bias about the relevance of long-term psychotherapy to mental health treatment, particularly for people who are poor. This writer is in a psychodynamically-oriented training program and has positive personal experience with long-term therapy – all of which combine to create opportunity for positive contribution bias.

The second opportunity for bias falls within the reviewed literature itself. The literature review will examine the inherent biases in the research and explicate any potential difficulties these biases may present for the analysis of this research question.

The third opportunity for bias presents itself in the available literature. There is little quantitative research available in recent years in the area of treatment selection. Also, the trend of evidence-based practice and the decline of long-term oriented therapies has created a decline in available research in these areas. This trend is reversing itself, but for the purposes of this writing it is still a potential area of consideration.

The next chapter will examine the phenomenon of the Matthew Effect. Its development as a theory, its impact on the population in question, and its applicability and impact with respect to treatment selection for the urban poor.

CHAPTER 3

THE MATTHEW EFFECT

For to all those who have, more will be given, and they will have an abundance; but from those who have nothing, even what they have will be taken away. ~~
Matthew 25:29, New Revised Standard Version.

The Matthew Effect is an identified sociological phenomenon that demonstrates empirically that the rich do indeed get richer while the poor get poorer. Its stated purpose is to examine the ever-widening gap between those who have and those who don't.

The original thinking didn't particularly concern itself with how this gap came into being, but it does examine why the gap remains and continues to widen over time. "Matthew effects are not consigned to the economic sphere, however; they have been observed across a broad spectrum of social institutions. Thus the principle is essential to understanding the social dynamics of inequality in general." (Rigney, 2010).

The Matthew Effect provides an interesting conceptual framework for understanding the disparities in treatment selection across social class. This chapter will examine the history of the Matthew Effect and review the research linking it to treatment selection for the urban poor.

History of the Matthew Effect

The Matthew Effect is a term originally coined by Thomas Merton an acclaimed sociologist from Columbia University, borrowing from the biblical verse in the book of Matthew. His work spanned from approximately the 1930s to the 1990s. Merton

originally noted this effect in the science arena, where he found that scientists with noted acclaim tended to receive even more notoriety while scientists with nearly identical work but less fame did not receive the same level of attention. In his recent book on the Matthew Effect, Rigney discusses the origin of the theory. "Merton found that in certain social systems, initial advantages are self-amplifying... Scholarly literature on Matthew effects turns up in a remarkably diverse range of fields of study, including sociology and other social sciences, educational psychology, legal and policy studies, and even biology."

Definition

Merton (1988) himself, in a 1988 revision to his theory, described it in this manner, "the ways in which initial comparative advantage of trained capacity, structural location, and available resources make for successive increments of advantage such that the gaps between the haves and the have-nots... widen" (p. 606). In a refinement of this definition, Dannefer (2003) offers this definition of cumulative advantage/disadvantage (CAD), "More formally, cumulative advantage/disadvantage can be defined as the systemic tendency for inter-individual divergence in a given characteristic (e.g. money, health, or status) with the passage of time," or success breed success.

The Matthew Effect has been examined across disciplines. Vanwesenbeeck (1994) used it to conceptualize the barriers to leaving prostitution; Dannefer (1987) used it a framework for studying differentiation in aging, as well as cumulative advantage/disadvantage across the life course (2003); Mildestvedt and Meland (2007) examined the rehabilitation process of heart patients through this theoretical lens; Gal (1998) uses it to examine the intersection of the middle classes and the welfare state;

Sloman and Dunham (2004) looked at potential evolutionary causes of the Matthew Effect; Joseph (1998) studied its effect on health development. Bothner et al (2010) also reference several studies that utilized the Matthew Effect as a theoretical lens including:

political legitimacy (Richards 1968), intraorganizational power (Kanter 1977), career attainment (Allison and Stewart 1974; Broughton and Mills 1980), education (Walberg and Tsai 1983), litigation (Cooney 1994), textbook publishing (Levitt and Nass 1989), internet publishing (Fleming, Simcoe, and Waguespack 2008), household income (Dasgupta 1995), workers' productivity (Weiss 1984), certification contests (Rao 1994), organizational growth (Podolny and Phillips 1996), and economic development (Yang 1990).

Constraints to Theory

Merton (1988) notes, however, that the Matthew Effect cannot be applied exponentially or without constraint. There are also several variations of possibility. The Matthew Effect can be applied in the sense that the rich get richer while the poor get poorer. This implies a zero-sum game in which resources are finite. Rigney (2010) also explains that the Matthew Effect can be applied either absolutely, as in the zero-sum game, or applied in a relative manner in which the rich get richer and the poor get richer, just not equally so.

Rigney (2010) also tells us that Merton recognized that social systems are byproducts of accretions of purposeful and unintended consequences. There is manifest and latent intentions, as well as functional and dysfunctional consequences. Merton did not ascribe cause or meaning to outcomes.

Because Merton is widely recognized as a leading exemplar of structural-functionalism, this focus on inequality-generating processes was more than a little ironic. His analysis of the Matthew effect clearly showed CAD to be a process that treats individuals unfairly and partially, that creates interindividual inequality and invidious sentiments, and thus, at least implicitly, raises questions of social legitimacy of established social practices. (Dannefer, 2003)

Merton, with his belief in structural functionalism, did not intend the Matthew Effect to be applied as a good or an evil, just an “is.” For example Merton deconstructs the idea that belief in a just world leads to the belief that people get what they deserve. Merton did not intend the Matthew Effect to imply this and was specific about focusing the theoretical application only on the measurable widening gap and not the genetic cause of the gap. He wished no external moral judgments to be applied, either good or bad.

Another important piece of theoretical cornerstone is that of feedback loops. In his discussion of the potential outcomes of the Matthew effect, Rigney (2010) provides us with this explanation: “Matthew effects...typically amplify deviations from set points and thereby destabilize systems -- in this instance, by producing ever greater social inequalities.” This is an important concept to bear in mind as the discussion of application of this theory continues, particularly with respect to the discussion of the impact of inequality and social class gradients.

The Matthew Effect theory, with its emphasis on individual contributions to larger social actions makes room for the complicated nature of systems impacting treatment selection for the urban poor and offers an opportunity to synthesize and integrate the domains of sociology, psychology, and biology.

Next, this writing will turn to a review of the literature of the Matthew Effect, specifically as it relates to the dispensation of psychotherapy and mental health care.

Bias in Treatment Selection

The now classic text by Hollingshead and Redlich (1958) demonstrated the link between psychiatric treatment selection and social class. This study divided 1989 "neurotic patients" into five social classes, with “1” being the highest and “5” being the

lowest. These patients had all been well-documented and admitted to some form of psychiatric care in the New Haven, Connecticut area. Please note that the clients studied by Hollingshead and Redlich were already admitted to psychiatric care. This will be true of all of the studies we examine. This is important as it controls for the variable of client selection versus therapist selection. We do not want to conflate those who seek therapy with those who actually receive it. We are narrowing in on the mental health system's decision-making process about providing care rather than the client's decision-making process about seeking care.

Hollingshead and Redlich looked at paths to psychiatric treatment based on class but also how the treatment played out after being admitted to care. Just looking at treatment for neurotic patients admitted to a psychiatric institution, they found that 97% of Class I received psychotherapy, which scaled down to 59% of class V. Class V patients received electroshock or drugs 5 times more often than Class I patients. Also, custodial care was limited largely to Class V patients. They demonstrated clear correlations between class and the types of services clients received.

When examining 1442 patients diagnosed with psychosis, they found that social class was a major determinant in where, how, and for how long a patient was treated. This text includes a huge amount of data. In the summary of chapter 9, they write “The data presented lead to the conclusion that treatment for mental illness depends not only on medical and psychological considerations, but also on powerful social variables to which psychiatrists have so far given little attention... Psychotherapeutic methods and particularly insight therapy are applied in disproportionately high degrees to higher status neurotic patients.”

This study spurred a decade of follow-up research. It seems the psychiatric community fell in love with research around the issue of social class. This was a time of relative affluence in America, but also a time of upheaval with respect to race issues. Class issues were relatively unaddressed in the wider world, but the mental health field was abuzz.

A decade later, Myers and Bean (1968) published a follow-up study to Hollingshead and Redlich's work. This study followed the patients of the original study to look at how follow-up care would be affected by class. Myers and Bean found that the poorest of patients were treated primarily by state hospitals, held there considerably longer and more likely to be readmitted. At the time, state hospitals were seen as holding camps for the poor. The prevalence of poor people with the diagnosis of psychosis in these institutions was due to class factors as upper class patients were treated privately and rarely saw the doors, let alone the inside, of a state hospital. The follow-up study demonstrated clear evidence that after-care continued the cycle of discrimination based on social class, which drastically impacted the quality and level of care received both in-hospital and after hospitalization.

Both of these studies were corroborated by other contemporary researchers including Brill and Storrow (1960), Schaeffer and Myers (1954), and Imber, Nash, and Stone (1955). It should be noted that in all of these studies, the researchers were very clear on one point: the patients were undertreated due to perceived differences on the part of the intake process and lack of homophily with the treating psychiatrists and therapists, not due to an inability to sustain transference, a lack of psychological mindedness, or lessened capacity for insight.

More recently, research has demonstrated a bias in treatment selection with respect to psychotherapy. Though they found no statistically significant bias in psychiatric care, there was a definite bias in referral for insight-oriented therapies. These studies elucidated a clear link between social class and chosen treatment modality: lower-class clients are selected into relational and short-term therapies, while upper-class clients are moved into insight-oriented and longer term therapies. To make this point, Garb (1997) references several studies and writes,

Though social class bias was absent when clinicians made decisions about need for psychiatric hospitalization, it was present when clinicians made decisions about psychotherapy. Middle-class individuals were more likely to be recommended for psychotherapy and were expected to do better in psychotherapy than were lower-class individuals, and when psychotherapy was recommended, the lower-class individuals were more likely to be referred for supportive psychotherapy and the middle-class individuals were more likely to be referred for insight-oriented therapy (Franklin, 1985; Levy & Kahn, 1970; Neumann, Salganik, Rabinowitz, Bauer, & Kastner, 1990; Rabinowitz & Lukoff, 1995; Routh & King, 1972; Rowden, Michel, Dillehay, & Martin, 1970; Sutton & Kessler, 1986; Umbenhauer & DeWitte, 1978).

And Sutton and Kessler, in 1986 wrote this in their research discussion:

The results converge with previous studies: Regardless of sample size, geographical area, or type of mental health professional involved, lower social class consistently affects clinical judgment negatively. This study suggests that negative evaluation is severest for those at the lowest social class level (Class V) and supports Lorion's (1973) contention that Class V members should be treated separately when designing clinical research.

Although these studies did not conceptualize these disparities as related to the Matthew Effect, they can be seen as instrumental in developing an understanding about the potential for bias in treatment selection based on class discrimination allowing us to extrapolate this phenomena to the Matthew Effect.

The Matthew Effect and Psychotherapy

In the literature review for this study, only one article was found that connected the Matthew Effect to treatment selection. In 1980, Link and Milcarek directly examined selection factors for therapy. They found that all mental health needs aside, social factors seemed to play a major part in the type and length of treatment patients received after being admitted to a psychiatric institution. They started with the hypothesis that therapists select clients based on social characteristics that appeal to the therapist. Schofield (1964) presented us with the idea of the “YAVIS patient,” which stands for young, attractive, verbal, intelligent, and successful. Levinson (1969) talks about clinicians preferring patients that are motivated.

“These studies indicate that therapists tend to want a certain kind of patient and that if a competitive process is at work in the allocation of treatment, it is likely to favor young, competent, motivated, successful people.” (Link, Milcarek 1980)

Link and Milcarek proposed that social selection and the Matthew Effect are at work due to the social structure of the delivery system itself. “In particular, it is likely that the way in which rewards are meted out to service providers in terms of recognition, respect, and ultimately prestige and money influences their choice of patients and thus the patterns we observe.” The connection to reward is important to hold in mind when we come to the discussion of social pain theory and reminders of money as a buffer or cause of social pain.

This research supported the idea of competition and social selection in allocation of resources, to quote, “Factors of initial advantage tend to increase an individual’s likelihood of being given attention by the mental health system. The Matthew Effect appears to be at work.”

Summary

The Matthew Effect is a sociological phenomena that illuminates the ever-present impact of cumulative advantage/disadvantage in a wide spectrum of arenas. In common terms, the rich get richer and the poor get poorer.

Though the Matthew Effect is not explanatory in the sense that it doesn’t tell us why this bias occurs in treatment selection for the urban poor, it does give a sound quantitative and theoretical lens from which to explain the phenomena.

The Matthew Effect also does not provide us an entry to intervention. It does not provide a means to an end or even a means to a beginning with respect to changing the course of cumulative advantage/disadvantage. Though Merton felt that the Matthew Effect was an example of unfair and unjust social movements, as a structural-functionalist, he believed it was a phenomena that led to the greater good, at least in his chosen field of study, which was reward in the field of science.

Because the Matthew Effect is not explanatory and provides no ontogenetic causes, much of the research utilizing its framework has attempted to find explanations. This paper is no different. It is this writer’s contention that treatment selection is a complicated process involving the relational mix of therapist and client, as well as the extenuating social pressures and structural context in which the therapist and client are embedded. The Matthew Effect helps us to describe the inequities; the remainder of this

paper will attempt to examine potential root causes for the phenomena from a diverse range of fields including social psychology, psychoanalysis, and sociology.

CHAPTER 4

SOCIAL PAIN THEORY

People are afraid of themselves, of their own reality; their feelings most of all. People talk about how great love is, but that's bullshit. Love hurts. Feelings are disturbing. People are taught that pain is evil and dangerous. How can they deal with love if they're afraid to feel? Pain is meant to wake us up. People try to hide their pain. But they're wrong. Pain is something to carry, like a radio. You feel your strength in the experience of pain. It's all how you carry it. That's what matters. Pain is a feeling. Your feelings are a part of you. Your own reality. If you feel ashamed of them, and hide them, you're letting society destroy your reality. You should stand up for the right to feel your pain." ~ Jim Morrison

Social Pain Theory (SPT) is a relative newcomer to the field of social psychology and the social neurosciences. The basic premise of SPT states the experience of social exclusion activates the same regions of the brain as pain affect. It is believed that, evolutionarily speaking, social exclusion piggybacked on the already existing neural pathways for physical pain as a means of inducing proximity and attachment-related behaviors and avoiding exclusion. In the distant past, social ostracism quite meant death for the excluded individual. This chapter will examine the history, trends and orientation of SPT, summarize the empirical literature, and provide a basis for understanding the importance of SPT in the context of clinical and countertransference processes and issues, particularly as they relate to working with the urban poor.

Social Pain Theory Origins

Social Pain Theory is widely credited to have its beginning in Jaak Panksepp's work on affective processing and separation distress (MacDonald, Kingsbury, & Shaw, 2006, Eisenberger & Lieberman, 2005). He originally asserted, "the social attachment

system may have co-opted the opiate substrates of the physical pain system to maintain proximity with others, eliciting distress upon separation and comfort upon reunion (Panksepp, Nelson, Bekkedal, 1997).” Panksepp (1998) also said: “This affirms that separation distress is related to perceptions of physical pain... the PAG (periaqueductal gray) receives nociceptive information but is also responsible for affective pain processing.” For clarity in definition, nociceptive pain is "understandable" pain that is the result of an injury. Based on this work, social psychologists and neuroscientists began to look at the overlap between social exclusion, ostracism and physical pain, paralleling some of the work done by Bowlby (1969) and others regarding attachment systems and theories.

Definitions

There are varying definitions of social pain. MacDonald and Leary (2005) state it as “a specific emotional reaction to the perception that one is being excluded from desired relationships or being devalued by desired relationship partners or groups.” Eisenberger and Lieberman (2005) use this definition: “Social pain is the distressing experience arising from actual or potential psychological distance from close others or from the social group.”

The key in both of these definitions is to understand that the social pain is an affective experience not a nociceptive quantification (Price, 2000). Price states:

The affective dimension of pain is made up of feelings of unpleasantness and emotions associated with future implications, termed secondary affect. Experimental and clinical studies show serial interactions between pain sensation intensity, pain unpleasantness, and secondary affect...Both direct and corticolimbic pathways converge on the same anterior cingulate cortical and subcortical structures whose function may be to establish emotional valence and response priorities.

It is also important to note that social pain can occur from the threat or perception of exclusion. An individual does not have to experience an “actual” ostracism or rejection, they only need perceive the threat of it, which could be triggered by watching an exclusory experience by a third party (Eisenberger et al, 2006) (Krill & Platek, 2009), reading non-conscious social cues that predict rejection (Lloyd, 2009), or even being excluded by a computer (Zadro, Williams & Richardson, 2004). This writer agrees with Lott's contention that cognitive and psychological distancing contribute to experiences of rejection, ostracism and exclusion (Lott, 2002). In fact, Zadro et al (2004) conclude, “The amassed evidence suggests that at all levels of measurement, humans detect and suffer from the most minimal cues of ostracism, supporting our view that ostracism is such a powerful social signal that it produces widespread intrapsychic reactions that serve to mobilize coping responses.”

Social pain researchers prefaced much of their understanding of the evolution of social pain on the attachment work of Bowlby and Panskepp. Bowlby's theories of attachment are much written about and widely understood with no need for further elaboration here. However, worth mentioning is Baumeister and Leary's 1995 review of literature on the need to belong. In their conclusion, “Again and again, we found evidence of a basic desire to form social attachments. People form social bonds readily, even under seemingly adverse conditions... Moreover, people resist losing attachments and breaking social bonds, even if there is no material or pragmatic reason to maintain the bond and even if maintaining it would be difficult.”

Social pain theorists have postulated that the need to belong is related to the idea that social belonging means survival. Pain mechanisms were co-opted to ensure that we

attach and stay attached else we suffer quick and certain consequences that are impossible to ignore (MacDonald, Kingsbury, & Shaw, 2005). We know that social exclusion activates the threat response system by increasing plasma cortisol and blood pressure (Stroud, Tanosky-Kraff, Wilfley, & Salovey, 2000); interferes with higher order cognitive processing while not affecting more base mental tasks (Baumeister & DeWall, 2005); hinders self-regulation (Baumeister and DeWall, 2005); automatically primes anger (Williams, Case & Govan, 2003); and promotes aggression (Buckley, Winkle & Leary, 2005). Unlike attachment processes, which are predicted to fade as a child becomes more capable, social pain persists throughout the life span (Eisenberger and Lieberman, 2005). MacDonald and Leary (2005) stated, “Social animals require a system that punishes individuals who do not avoid social exclusion and motivates quick responses to signs of exclusion.”

From a social-evolutionary perspective, recruitment of pain processing systems when perceiving another experiencing pain would be adaptive both because it would help us understand their internal state and might move use to aid and assist them, and because it could serve as a platform for vicarious learning about painful experiences that we should avoid. (Ochsner, Zaki, Hanelin, et al, 2008)

So given the evolutionary why, how exactly do these systems overlap?

The dACC (dorsal anterior cingulated cortex) and the PAG (periaqueductal gray)

The dACC and PAG are the two major brain areas implicated in the overlap of physical pain affect and the social pain of exclusion or ostracism. Developmentally, the anterior cingulate is known to contribute to maternal behavior (Schore, 2003). The mother’s cingulate and right orbitofrontal cortex respond to both pain and separation cries of an infant. Eisenberger (2006) states, “With regard to physical pain, the dACC seems to be involved in the affective as opposed to the sensory component of pain.” MacDonald

and Leary (2005) say, “The ACC has been well established as an important site for processing physical pain signals. Specifically, pain affect, but not pain intensity appears to be associated with activation in the ACC.” Eisenberger (2006) goes on to say,

The PAG is a small brainstem structure involved in pain processing, maternal behavior and distress vocalizations in nonhuman mammals. In addition, the PAG receives dense projections from the dACC and insular cortex, both of which are activated in response to physical and social pain in humans.

Along with this, the periaqueductal gray (PAG) has also been shown to have a role in pain processing. MacDonald and Leary (2006) say “The PAG receives input from the body’s injury detection mechanism, the nociceptive system and has been shown to be active in connection with physical pain.” Eisenberger, Lieberman and Williams (2003) found,

a pattern of activations very similar to those found in studies of physical pain emerged during social exclusion, providing evidence that the experience and regulation of social and physical pain share a common neuroanatomical basis. Activity in the dorsal ACC, previously linked to the experience of pain distress, was associated with increased distress after social exclusion.

Social Pain Studies

The majority of social pain research efforts have been done utilizing fMRI studies of brain activation patterns and blood flow connected to participants watching or experiencing some version of social exclusion. In 2003, Eisenberger, Lieberman, and Williams completed their first fMRI study demonstrating the pain of social exclusion. Participants were scanned while playing a virtual ball tossing game (cyberball). Through a series of ingenious experiments, participants were initially included in the ball tossing game but eventually stopped receiving the ball. Though they were told they were playing with other participants, they were actually playing with a computer. The scans

demonstrated that their dACC was more active during exclusion than during inclusion and positively correlated with distress. They also found that the dACC was similarly activated when the participants imagined exclusion when exposed to an emulated version of the game.

Krill and Platek (2009) expanded on this work by varying the physical appearance of the “group” participants. Participants were excluded by others that looked like them, looked similar to them, or were of an “other race.” Their results

indicated that activation in the ACC varies as a function of resemblance to the participant when individuals are excluded. Activation in the ACC increased during exclusion conditions as the other player’s facial resemblance to the participants increased... We also found that individuals are not only affected neurologically but participants also reported a decrease in satisfaction of four basic needs (belonging, control, self-esteem, and meaningful existence) when excluded.

Wirth and Williams (2009) conducted similar studies based on group membership. They found that “participants perceived vast differences in their treatment when included, compared to being ostracized and they had greater identification with a permanent group compared to a temporary group... regardless of attributions, the reflexive response to ostracism was painful.”

Social Pain Theory and Money

Along with social pain theory has come some interesting research looking at pain buffering, postulating that money (or having money) can act as a pain buffer in the face of social exclusion.

In a series of experimental research with students in China, Zhou, Vohs and Baumeister (2009) found that “Handling money (compared with handling paper) reduced distress over social exclusion and diminished the physical pain of immersion in hot water.

Being reminded of having spent money, however, intensified both social distress and physical pain.” These researchers have concluded that

Money enables people to move the social system to confer benefits. As social animals, humans are deeply sensitive to social acceptance and rejection, but as cultural animals, they are also sensitive to symbolic resources that might enable even rejected or unpopular persons to get what they need from the social system. The present findings indicate that the mere idea of money has considerable psychological power, enough to alter reactions to social exclusion and even to physical pain.

Critiques

The most cogent critique of the social pain literature comes from Panskepp (2005). He addresses some shortcomings in the analysis of the SPT research. Primarily, the ACC activates under other experiences, such as romantic love and cognitive conflicts. Panskepp also points out some of the deficiencies in fMRI scanning: It does not illuminate the full trajectory of social pain systems, it is not especially sensitive to changes in slowly firing neural circuits, and most importantly,

there are no modules in the subneocortical regions of the brain humans share with other mammals, only dynamically interactive systems, where our instinctual action tendencies and our feelings aroused during those urges are often so interpenetrant and interactive with multiple feed-backward and feed-forward loops that no major concept can be completely unambiguous and independent of others.

SPT is new in the world of research, with the earliest fMRI study dating to 2003.

There are many nuances and variables yet to be isolated in the coming years. Also, as other means of brain scanning become available or cost-effective, researchers will uncover novel information that may validate or change the direction of the current theoretical thinking.

Summary

Social Pain Theory is a new and interesting area of study in the field of social psychology and the social neurosciences, as well as affective neuroscience. It is demonstrating that we have an evolutionary-based neural substrate that has co-opted the physical pain pathways as a means of preventing (or at least drawing attention to the danger of) social exclusion.

SPT tells us that the areas of the brain responsible for processing the affective physical pain experience also become active during times of social exclusion – hence, rejection, ostracism and exclusion are painful. This pain alerts us, as social beings, to the potential danger of being isolated and alone and motivates us to draw back into the safety and protection of the fold.

SPT research also pays attention to the developmental models of affective neuroscience, as well as the attachment-based models first proposed by Bowlby. It has the potential to integrate theory across several disciplines and hopefully into the clinical and interventional domains.

The next chapter will review psychoanalytic theory, specifically transference and countertransference, as it relates to working with urban poor clients.

CHAPTER 5

COUNTERTRANSFERENCE

What is to be found among us in the way of another view of sexual life is confined to the uncultivated, lower strata of society; among the higher and more refined classes it is concealed, since it is considered culturally inferior, and it ventures to put itself into practice only in the face of a bad conscience. ~
Sigmund Freud

Psychoanalysis and psychoanalytic theory proper have well-grounded roots in the early work of Sigmund Freud and his contemporaries. Though a thorough history and analysis of psychoanalytic theory is out of the scope of this writing, this chapter will briefly examine the origins of psychoanalytic theory, particularly as it relates to transference and countertransference issues while working with the urban poor. The chapter will also provide some brief definitions of transference and countertransference and look at research, theory, and critique of analytic transference ideas.

Psychoanalytic History, Social Justice, and Clinical Practice

In the beginning days of psychoanalysis, the theoreticians were widely concerned with social justice. Elizabeth Danto (2005) outlines the history of early psychoanalysis and the free clinics started under the tutelage of Freud and his contemporaries. She says:

In 1918, just two months before the Armistice, Freud had rallied the psychoanalysts assembled in Budapest for their fifth international congress to started these “institutions or out-patient clinics... where treatment shall be free. The poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery.

Freud and his contemporaries firmly believed in the importance of mental health treatment for everyone, regardless of class status or ability to pay, especially since they were seeking a unifying theory of psychology. Danto (2005) goes on to say:

As late as 1935 Freud still wrote that “out of their own funds, local societies (psychoanalytic) support ... outpatient clinics in which experienced analysts, as well as students give free treatment to patients of limited means.” The intervening decades saw the practice of analysis unfold in plain offices, case by case, on couches where theory hovered invisibly over clinical encounters. Between 1918 and 1938 psychoanalysis was neither impractical for working people, nor rigidly structured, nor luxurious in length... This made psychoanalysis accessible to students, artists, craftsmen, laborers, factory workers, office clerks, unemployed people, farmers, domestic servants, and public school teachers. Freud’s idea so influenced trainees and medical students that they sought to subsidize their education by agreeing to treat patients at no cost.

At this time, there were more than 20 free clinics dispersed through the psychoanalytic centers of Europe; however, the trend of this social justice focus, though wide-ranging, was not to last. The surfacing of Nazism and Hitler’s rise to power was to disperse the thinkers of the time and community-oriented psychoanalysis would never regain its footing in quite the same manner. Danto (2005) tells us:

The Neue Deutsche Seelenheilkunde would replace insight-oriented treatment with a psychology of pragmatic resilience and civic fitness. On a larger scale, the Nazis used the Poliklinik itself to rid Germany of social influences they considered degenerate, modern, Jewish, democratic, and communist.

As the brilliant minds of the early psychoanalytic clinics dispersed to other parts of the world and brought their work to the shores of America, the social justice work lost ground as clinicians concentrated on legitimizing and professionalizing psychoanalysis (Danto, 2005; Ponder, 2007). Psychoanalysis became a normative force and one available (seemingly) only to wealthier clients (Ponder, 2007). Psychoanalysis also became known as elitist and exclusionary. Since then, even insight-oriented therapy has come to be seen

as not applicable to urban poor populations (Auld, Myers 1954; Jones, 1974.) Now community mental health centers, faced with evidence-based practices and the constraints of state funding and insurance requirements struggle to provide even six sessions a year to needy clients.

Next, let's turn attention to definitions of countertransference as it may be triggered when working with urban poor clients.

Definitions of Countertransference

Transference and countertransference work is central to the success of insight-oriented and analytically-based therapy. The subject is vast and again, beyond the scope of this writing. Instead, the definitions here will be focused around issues of social class and their impact on the therapeutic relationship, utilizing current research and thinking of clinicians/researchers working with urban poor populations.

Generically speaking, it is difficult to define countertransference. The word comes with heavy baggage and years of discussion and disagreement over its role (or actuality) in therapy (Pincus, 2007). Surprisingly, Freud had little to say on the subject of countertransference.

In Freud's view, countertransference was essentially an obstacle to be overcome. The doctor unconsciously experiences the patient as someone from the doctor's past. In this regard, countertransference could be conceptualized as the analyst's transference to the patient. This Freudian view is commonly referred to as the narrow perspective, and it is still espoused by some modern classical analysts. (Gabbard, 2001)

Since the time of Freud, countertransference has been written about and discussed at great length. Its definition has undergone many transformations and continues to be

redefined as current theoreticians and clinicians continue to evolve theory and technique (Ponder, 2007; Jacobs, 1999).

A more modern and perhaps more encompassing definition is proposed by Gabbard, 2001:

... psychoanalytic theorists from diverse persuasions have converged on the idea that, to some extent, countertransference is always a joint creation involving contributions from both clinician and patient. The relative emphasis given to each of these contributions may vary with the theory, but there is a remarkable degree of agreement that what the patient projects onto the clinician and what the clinician brings to the situation are both relevant to the end result of countertransference. There also is widespread agreement that the patient will inevitably attempt to transform the therapist into a transference object. The therapist must then work diligently to find a way out of the transference-countertransference enactment or projected role that the patient thrusts upon him or her.

This definition, though decidedly conventional and analytically-oriented, provides a broad base from which to begin conceptualizing countertransference while working with urban poor clients.

Countertransference with Urban Poor Clients

“Money questions will be treated by cultured people in the same manner as sexual matters, with the same inconsistency, prudishness, and hypocrisy. The analyst is therefore determined from the first not to fall in with this attitude, but, in his dealings with his patients, to treat of money matters with the same matter-of-course frankness to which he wishes to educate them in things relating to sexual life” ~~ Freud 1913, p. 131

This section proposes to take the broad concept of countertransference and distill it down to conceptualizing therapy with clients who are poor. First, a word about stereotype and bias prior to countertransference:

In an attitude that may bespeak the prejudice that many psychodynamically oriented clinicians harbor toward those who are different from themselves, questions have been raised within the clinical literature about the value of even using insight-oriented therapies with minority patients. This recommendation,

while usually cloaked within the practical exigencies of ethnic clients' concrete service needs, emerges from a far more dangerous and pernicious bias: That people from racial minority and immigrant groups lack the capacity for insight and the ability to explore the meaning of their experiences. (Foster, 1998)

Clinicians need examine their biases about working with urban poor populations before they can begin to work with and assimilate countertransference issues. If left unexamined, these biases may transmit to selecting out clients who are poor.

Siassi and Messer (1976) echo Foster's beliefs. They say:

There are those who claim that psychotherapy for the lower classes is ill advised and a waste of resources, because the emotional problems of the poor are a result of their economic deprivation. Without realizing it, such well-meaning antagonists of psychotherapy for the lower classes introduce the very type of stereotyping of the lower classes which is responsible for the injustices they are trying to prevent.

Beyond bias and stereotype, Javier and Herron (2002) have done considerable work with clients who are poor and issues of countertransference. They write:

Most therapists are middle class, so it might be argued that they are too separated from upper class patients to understand them sufficiently, but that is unlikely. Middle-class people frequently wish for more, and often try to achieve it... In contrast, therapists have no interest in being poor, and despite social conscience, do not seek to identify with the poor. In essence... the potential for disruptive countertransference is high and prone to override egalitarian and altruistic desires as well." Regardless of class of origin, therapists are typically upwardly-mobile and quite likely uncomfortable with being in poverty or identifying with people who are poor.

And if therapists are feeling uncomfortable about working with someone who is poor, one can rest assured the poor are feeling equally uncomfortable. Research tells us that people from a perceived lower social class have been shown to communicate very differently with people from a perceived upper class. Garcia, Hallahan and Rosenthal, in 2007, encapsulate it in this way:

It is a well established finding that people in low status roles perceive their high status interaction partners more accurately and in more detail than do people in

high status roles interacting with a low status partner (e.g., Fiske, 1993; Garcia, Darley, & Robinson, 2001; Keltner & Robinson, 1996, 1997; LaFrance & Henley, 1994; Neuberg & Fiske, 1987; Robinson & Keltner, 1996). Some explanations have considered perceivers' motivation to attend to someone with a different level of social power (e.g., LaFrance & Henley, 1994), but there is stronger evidence that this finding is explained by differences in expressive behavior. Specifically, people in low status roles interacting with people in higher status roles behave in ways that are more difficult for their partners to "read." In other words, their behavior conveys less clear information about themselves and their affective state (Hall, Rosip, Smith LeBeau, Horgan, & Carter, 2006; Snodgrass, Hecht, & Ploutz-Snyder, 1998)... Lower-class individuals, aware of their class stigma, thus reported that they would intentionally change their behavior with upper-class interaction partners. This within-subjects design is particularly compelling because it suggests that lower-class individuals were deliberate in their expressing themselves differently in cross-class interactions. Upper-class individuals, on the other hand, reported that they would act the same regardless of whether their counterpart is lower- or upper-class.

Their research found that there are distinct attempts to mask emotion and expression when speaking across class. From the earliest attempts at communication, the therapeutic dyad is already facing clear difficulties in achieving attunement and connection.

To further these thoughts, Dimen (1994) writes eloquently about the therapist's fear of falling from grace as it were and the role of money and class in creating anxiety and a sense of dishonesty in the therapist. She writes:

For one thing, members of this class know that their power, privilege and authority can make their clients envy, resent, and hate them (and, analysts would add, idealize them). ... because they do not produce anything visible or tangible, they do not actually do anything real; as such, not only does their work seem worthless, it also cannot match their own or their clients' idealization.

She goes on to say that therapists fear sliding into "homelessness and indignity" similar to the fear that Melanie Klein elucidated as being "orphaned or beggared as a punishment for their unconscious aggression... Rooted in the very work of professionals, then, this anxiety about felt fraudulence and looming loss is actually built into the role of

analyst in a class-structured society.” (Dimen, 1994). Before opening the door to a client, therapists struggle with their class identities and fear of loss of prestige, security, and constancy imbued by their class status.

In Dimen’s perspective, countertransference and “money anxiety” is inevitable in analysis and/or psychotherapy regardless of the client’s status. One can only imagine how many times magnified this anxiety becomes when faced with a client of much lower means than the therapist.

The point is critical: the way analysts talk, behave, and feel in relation to money is replete with uneasiness, an uneasiness that is the surface manifestation of a deep, psychocultural contradiction that cannot be thought, willed, or wished away. In the marrow of our culture, this contradiction is embedded in the matrix of our work. It inhabits our souls. And it will not disappear until the very bones of our society change...(Dimen, 1994).

The analytic ideas of orphanage suggested by Klein may be enacted in the therapy in tangible and visible ways larger than a simple exercise in analysis. Karon and Vandenbos (1977), in talking about countertransference say:

It is understandably painful for therapists to empathize with poor patients living under circumstances the therapist would not willingly (and perhaps could not) endure. The easiest way to avoid such painful fantasies is to not accept such patients, to unconsciously maneuver the patient into dropping out of treatment, or to not do real therapy but only aid with a misery-abatement plan or escape plan.

Perhaps it is this idea of escape that is at the heart of countertransference issues when dealing with people who are poor. Karon and Vandenbos (1977) caution against this. “Whether to help the patient adapt to being lower class or to escape, is ideology, not therapy. The therapist must help the patient evaluate the alternatives in the light of his reality and psychodynamics, and then to act.” They suggest that having a client who is

poor is no excuse for pushing that client to “escape” their reality though the therapist may feel that is the only way to healing.

Countertransference is a controversial concept in and of itself. When confounded with issues of social class and classism, it becomes even more troublesome a nettle for psychotherapists to untangle. Critiques of psychoanalytic theory abound, as do critiques of constructivist ideas of class. The next section will expound on some counterpoints to countertransferential research.

Empirical Studies

This writer was unable to uncover any empirical studies that researched countertransference with respect to working with poor populations. However, there are a considerable number of empirical studies examining countertransference and its impact on the therapeutic relationship.

In a 1951 foundational study, “Fiedler (1951) used a Q-sort method to examine discrepancies between therapists’ perceptions of their real and ideal selves and how these related to perceptions of clients.” (Hayes, 2004) reportedly in an attempt to quantify countertransference. Since then, empirical work has examined a therapist’s tendency to avoid client material that is similar to their own “blind spots.” This specific type of avoidance is a key finding of early countertransference research. Later, researchers found that the countertransferential response to a client was dependent on the subjective perceived threat by the therapist. In other words, the greater the perceived threat (by the therapist), the greater the countertransferential reaction (Hayes, 2004).

More recent research has shown that countertransference reactions are also dependent on therapist variables such as empathy, self-insight and conceptual ability,

self-integration, and anxiety management (Hayes, 2004). A therapist's ability to attend to and moderate their anxiety facilitates management of countertransference reactions.

These researchers also learned that over 80% of therapist's studied experienced countertransferential reactions at every session. This was contrary to the then-held opinion that countertransference was an uncommon reaction to the transference of the client.

Neurobiology and countertransference

The latest work in countertransference is with respect to the neurobiological basis of this phenomenon. Schore (2003) writes extensively about the neurochemical underpinnings of the therapeutic relationship. He has this to say:

...the therapist is consciously attending to the patient's verbalizations in order to objectively diagnose and rationalize the patient's dysregulating, symptomatology. But he/she is also listening and interacting at another level, an experience-near subjective level, one that processes socioemotional information at levels beneath awareness... The therapist's detection of his/her countertransferential interoceptive responses that resonate with the patient's autonomic responses to threatening stimuli is especially important to the reception of defensive projective identifications.

There are many levels of awareness at play in social communication that contribute to countertransference.

Psychophysiological studies of emotion communication demonstrate that human vocal affect expression of anger elicit electromyographically detectable changes in the receiver's facial affect expressions (Hietanen, Surakka & Linnankoski, 1998), and hence the therapist's face briefly mimics the state changes induced by the patient's negative communication... But in addition, neurobiological research demonstrates that aberrant early social experiences alter the ability to efficiently process facial expressions of emotion... The interaction of these two nonconscious mechanisms may account for the synergistic effects of the therapist's transient countertransferential "mindblindedness" and the patient's negatively biased transference expectation – the cocreation of an enactment. (Schore, 2003, p. 86).

It is with this newer research in mind that we will turn to a critique of the theory of countertransference and the implications for this research.

Critiques

Rosenberger and Hayes tell us, "...despite nearly a century of musings and debate about CT, a comprehensive and testable theory that might help integrate, as well as stimulate, research has been absent until recently." (Rosenberger & Hayes, 2002).

Because of the difficulty in isolating and operationalizing countertransference research, there is still much room left for the understanding of this complex phenomenon. Measurement continues to be the single, greatest challenge to this line of research. Also, research needs to be undertaken not just on the origins of countertransference but on the manifestation of these feelings.

With respect to countertransference and the urban poor, it will be important to study the context and triggers of countertransference, as well as the various ways in which the countertransference is actually manifested in the therapy. Again, this is out of the scope of this paper, but what is important to the issue at hand is understanding how these processes may contribute to treatment selection for the urban poor to begin with. Have countertransference reactions to working with the poor set psychotherapy on a track that isolates and selects out urban poor clients from receiving long-term, depth-oriented therapy? And on an even deeper level, how is this bias impacting research and theoretical development?

Summary

Countertransference is a key issue in analytically-oriented therapy. Though it is an integral part of analytic thinking it can be extrapolated to other theoretical orientations,

and it is an understudied phenomenon, but a potentially crucial one to understanding work with the urban poor.

This chapter has reviewed psychoanalytic history with respect to social justice and countertransference issues in working with the urban poor. In the upcoming discussion chapter, this paper will elucidate the connections between neurobiology, countertransference, and the Matthew Effect -- all forces at work in treatment selection for the urban poor.

CHAPTER 6

DISCUSSION

A scientist's aim in a discussion with his colleagues is not to persuade, but to clarify. ~~ Leo Szilard

Synthesis

The aim for this section of this writing is to analyze and synthesize an understanding of social pain theory and countertransference as they relate to the Matthew Effect. Is it possible to use these theories to explain the disparity of treatment allocation across social class lines?

Macro Versus Micro

The first difficulty to set aside is that of macro versus micro level of effect. It is this writer's belief that treatment selection decisions are complex and involve multiple layers of influence from wide societal constructs to the very personal attunement that happens in intimate relationships. Treatment decisions come under the influence of wider social structures such as social class and the Matthew Effect, as well as the most intimate of personal interactions. In fact, it is the wider social conditioning and construction that sets the stage for the more relational decisions. If it weren't for the co-constructed idea of social class and the larger sociological theory of the Matthew Effect, there would be no need for this discussion to begin with. From the top of the analysis, social constructions play a primary role and influence. This influence is integral to the research question.

When it comes to the actual treatment allocation decision, however, this writer will attempt to narrow analysis down to the clinical level of micro-attunements and interactions. Though it is ever important to hold the construct of social class and the zero-sum game in the frame, the actual decision moment happens between two people in a mostly one-on-one encounter. It is this moment that this writer seeks to explicate most clearly, hoping to seek intervention at a clinical rather than macro level.

The Absolute Matthew Effect

The chapter on the phenomena of the Matthew Effect showed how the Matthew Effect could be applied either absolutely or relationally. In the case of treatment selection for the poor, this writer contends we are working with an absolute Matthew Effect due to the limited resource availability of psychotherapy for people who are poor. Because this population of clients are working either with insurance (if they are fortunate enough to be insured) or the reality of public funding. In either case, they will be faced with a limited resource. There will be a limited number of sessions available, as well as a limited number of therapists available to see them. If these clients work through an agency rather than an inpatient setting, there will be waiting lists and language barriers, inconvenient locations, and difficult to arrange appointment times. In the best of situations, a client who is poor can expect to be faced with a number of obstacles and a finite resource pool. As the research tells us (Link and Milcarek, 1980), those most able to compete for the resources will receive them.

Since competition is central to the Matthew Effect, what exactly is it that allows some to better compete than others? What exactly is motivating therapists to select some

clients and not others? Have these micro-level decisions generalized to the greater collective understanding of who is most suitable for psychotherapy?

Connecting Social Pain Theory to Countertransference

Human beings are inveterate mindreaders. We routinely (and for the most part unconsciously) represent the mental states to the people around us (thus employing metarepresentations – representations of representational states). We attribute to them perceptions, feelings, goals, intentions, knowledge, and beliefs, and we form our expectations accordingly. (Carruthers, 2009)

Class differences separate us but in what way? Smith (2005) describes it like this:

I do not imply that this avoidance is conscious. Like the authors cited earlier, who suggested that this distancing is the result of unconscious fear of identification with the poor and negative stereotyping, I believe that we avert our gaze from the poor as an unconscious way of preserving our ability to enjoy our relative good fortune amid an unequal distribution of resources. When we from the middle-class go into poor neighborhoods to work, we must admit into consciousness a vivid comprehension of the disparity between our lives and theirs. Once we have done so, it is difficult to conjure up the oblivion that previously sheltered us from this awareness, and any unexamined assumptions that may have reassured us—that the poor lead contented, uncomplicated lives or that people are poor because they do not wish to work or that each of us has what we deserve—are suddenly exposed to daylight and lose their power.

Smith's description gives us a visceral way of thinking about classism and the ways in which it might penetrate our thinking and our decision-making process. It is an anecdotal means of describing a phenomena akin to a countertransferential reaction but on a more sociological level.

Social Pain Theory (SPT) tells us that experiencing exclusion causes emotional pain but more importantly physical pain. Seemingly, our pain pathways have been co-opted in an effort to help us avoid exclusion heightening affiliation, ultimately ensuring our survival. But how to make the connection between SPT and countertransference?

First, it is important to understand how SPT is related to a felt, shared experience, Ochsner et al, 2008, tell us:

There is increasing evidence for the recruitment of shared representations during pain perception as well (Jackson et al., 2006b). Several functional imaging studies have examined overlapping patterns of activation associated with experiencing pain directly and perceiving that someone else is experiencing pain. All have shown recruitment of dorsal anterior cingulate (dACC) and AI when participants receive a shock themselves and when they see a cue indicating that someone else is receiving a mildly painful electrical shock (Singer et al, 2004, 2006)... Common recruitment of dACC and AI for pain perception in self and other is thought to reflect the roles these regions play in the emotional and physical distress that accompanies painful stimulation (Singer et al., 2004). The mid ACC and mid/posterior dorsal insula receive ascending nociceptive spino-thalamo-cortical projections, return afferents to the spinal cord via the peri-aqueductal gray (Craig, 2002, 2003), and both are commonly activated by the direct experience of a variety of painful stimuli (Wager and Feldman Barrett, 2004; Vogt, 2005). In general, the dACC is thought to function as an all-purpose 'alarm' that signals when ongoing behavior has hit a snag (Botvinick et al., 2001, 2004; Ochsner et al., 2001; Eisenberger and Lieberman, 2004). Physical pain provides perhaps the most primitive signal of this sort (Eisenberger and Lieberman, 2004), and the ACC is critical to assessing the salience and affective quality of pain (Downar et al., 2002, 2003).

Note the same areas of brain activation mentioned here are the same mentioned in SPT. In fact, if one takes close notice of the referenced literature above, the SPT literature is directly quoted. From this extensive list of research, it becomes clear that physical pain can be and most likely is a shared experience.

Can this idea of a shared physical pain experience translate to countertransference experiences and ultimately treatment selection bias? In 2006, Stone attempted to frame shared/felt experience as a type of countertransference. This research talks about the therapist's perception of the client with respect to an actual physical response in the therapist's body, embodied countertransference. She quotes research completed in 1985.

In a research project into the countertransference responses of 30 psychotherapists, Samuels (1985a) found that in 46% of the cases the countertransference could be described as 'embodied'. His paper develops Fordham's concept of 'syntonic' countertransference into two connected but

separate types of usable countertransference, 'reflective' and 'embodied', and he defines the latter as 'intended to suggest a physical, actual, material, sensual expression in the analyst of something in the patient's inner world, a drawing together and solidification of this. (p. 52)

Allan Schore has been at the forefront of integration regarding the right brain's role in co-regulation and affect regulation particularly as it can be linked to analytic ideas. He has talked about how a clinician's physiologic response to a client can be explained by right brain processes and conceptualized as a kind of countertransference. In 2003, p. 82, he writes

The therapist's detection of his/her countertransference interoceptive responses that resonate with the patient's autonomic responses to threatening stimuli is especially important... These are registered in the therapist's right brain... It is established that "a primary role for the right ventral medial prefrontal cortex may be the integration of internal physiological states with salient environmental cues, to guide behavior in an optimally cautious or adaptive manner in situations of perceived threat or conflict." (Sullivan & Gratton, 2002a, p. 77)... The clinician's implicit countertransference reactions to the patient's communicating self system are thus registered in his/her right brain, because this hemisphere, dominant for the corporeal self (Devinsky, 2000), contains the most comprehensive and integrated map of the body state available to the brain (Damasio, 1994), processes the autonomic correlates of emotional arousal (Witting & Roschmann, 1993), plays a special role in the perception of the affective qualities of somatic signals coming from the body (Galín, 1974), decodes emotional stimuli by "actual felt [somatic] emotional reactions to the stimuli, that is, by a form of empathic responding" (Day & Wong, 1996, p. 651), and is dominant for attentional processes (Heilman et al., 1977; Coule et al., 1996).

Schore goes on to speak more explicitly about this somatic countertransference as a version of empathy or at least physiologic evidence of empathy; however, this empathy is also an attunement to a client's fear states and anxiety.

This bears upon the matter of "somatic countertransference" (Dosamentes-Beaudry, 1997). Clinical observers have noted that "perhaps the most striking evidence of successful empathy is the occurrence in our bodies of sensations that the patient has described in his or hers" (Havens, 1979, p. 42), and that psychotherapeutic resonance is expressed in "specific sensations and/or feelings kinesthetically perceived by the therapist" (Larson, 1987, p. 322).

Schore talks about the difficulty of this type of countertransference and its impact on the therapeutic relationship, p. 84.

This task is difficult because the experience of traumatic pain is stored in bodily based implicit-procedural memory in the right brain (Schore, 2001d), not in the verbal articulation of a discrete subjective state.

Schore and the other researchers referenced are talking about a physical "pain" reaction based on a nonconscious interpretation of the client's state. Connect this back to what we know from SPT research and the triggering of pain pathways when experiencing exclusion, witnessing exclusion, and/or being reminded of exclusory experiences. It is possible that the countertransferential reaction Schore and others describe is the same or similar reaction that SPT describes.

This writer does not intend this connection to be read as the "only" connection. In fact, even within this narrow realm of discovery, there seems to be multiple points of entry: the mutual experience of exclusion based on class difference, in line with an us versus other dichotomy; and that of reminders of money (clearly an issue in social class difference) as exacerbating or buffering nonconscious pain reactions.

A third possible mode of entry is the difference in nonverbal communications across class lines. We know from earlier discussion that cross-class communications are particularly troubled and fraught with danger from both sides of the dyad. The poor consciously "cover" their expression of emotion and attempt to "disguise" their social class when speaking with someone they perceive as being from an upper class (Garcia, Hallahan, Rosenthal, 2007).

The poor, from this vantage point, are unable to adequately compete for resources, in this case the therapist's positive regard and desire for affiliation. To make this point, Garcia, Hallahan and Rosenthal also write:

The present analysis also sheds light on the formation of social capital (e.g., Putnam, 2000), which refers to the material and inherent value of social networks. Our analysis underscores the unique difficulty that lower-class individuals face in building social capital. Lower-class individuals must work especially hard to make social connections with upper-class counterparts and their networks, as they pay an extra tax associated with expressing themselves differently – a slightly uncomfortable and perhaps even cognitively depleting interaction (Lord & Saenz, 1985).

From the beginning of the relationship, each side is fearing exclusion and defending against pain, social or otherwise. The lower-class client is fearing rejection from the privileged world of the therapist and the therapist is defending against their own fear of exclusion based on the possibility of falling into (or back into) the frightening world of being poor. Perhaps, though not elucidated in the research clearly, the lower-class clients are expressing a form of nonconscious resistance against a socially inequitable relationship. We know from the research of Zhao and Gao that reminders of money and/or lack of become triggers for fears of exclusion and that having money can be seen as a buffer against this pain. The complicated dynamics of social class find another entry into the relationship. It becomes entirely possible that the client and therapist have entered into a feedback loop that reinforces itself through nonconscious communications and metacognition.

We know from the SPT research that one does not have to "experience" exclusion, one only has to be reminded of its possibility. Just this triggering can set off a wave of pain response that one is not likely aware of but reacting to nonetheless. Is it

social pain or countertransference or is it possible that they become one in the same in that moment?

Completing the Loop

Now it is time to complete the entire feedback loop and return to the Matthew Effect. There is no research in this area, making this link. This thesis has attempted, step by step, to make connections by integrating disparate fields and theories. It becomes possible to see how individual interactions generalize, magnify and feed into a large social system leading to a widely based discrimination of the poor. This really isn't new or news. Sociologists and psychologists, social workers and epidemiologists have been in agreement from the beginning that individual interactions can and do lead to wider social consequences. What is relatively new is the attempt to show how a countertransference process can be linked to a neurobiological and even physical response leading to a heightened and more exquisite sensitization to implicit bias.

It is important to bring the Matthew Effect and the sociological impact of inequity to the individual level with respect to developing interventions. If we know that clients are being underserved by psychotherapy, we need to create interventions to address that inequity. Our social work ethics demand that of us.

Summary

This writing has attempted to explicate the impact of the Matthew Effect at work in the treatment selection for the urban poor. The poor are simply unable to compete for the mental health resources they need, and those resources are indeed limited. There have been many postulations about how and why this might be. This paper attempted to

explain the phenomena through an integration of social pain theory and countertransference, seeking an interventional entry on the micro level.

We examined social pain theory and discussed how money and reminders of money (the most salient "difference" between social classes) can trigger the experience of exclusion or buffer against it depending on the condition. Once social pain is triggered, it can be acted upon in a manner similar to what psychoanalytic theory talks about as countertransference

Countertransference while working with the poor was examined in depth and linked back to the embodied experience explicated in social pain theory. In this way a link was made between the two very different theories.

Caught in the middle are the poor -- the very group that social work has historically sought to serve. Our clients who are poor find themselves unable to communicate to us their pain and distress. They have learned to mask their social class while communicating, which has the effect of furthering the relational distance. If they are somehow able to freely express the depth of their experience and exclusion as a person who is poor, they risk triggering a reaction in the therapist and that reaction, left unexamined, leads to treatment decisions based upon fear reactions and rationalizations. In the end, the poor are left out of therapy entirely.

As professionals, it is our responsibility to examine our nonconscious processes and understand the interface between the biological and the psychological as we are embedded in a social context, located in a given space and time. Without this awareness, we may be led to make decisions or explicate rationales that are not helpful or accurate with respect to the needs and capabilities of the people we work with.

REFERENCES

- Auld, F., & MYERS, J. (1954). Contributions to a theory for selecting psychotherapy patients. *Journal of Clinical Psychology*, 10 (1), 56-60.
- Beckham, E. (1992). Predicting patient dropout in psychotherapy. *Psychotherapy*, 29 (2), 177-182.
- Bothner, M., Haynes, R., & Lee, W. (2010, Jan 1). When Do Matthew Effects Occur? *Journal of Mathematical Sociology*, 34:80–114.
- Bowlby, J. (1969). *Attachment and Loss (Volume 1)*. London, UK: Hogarth.
- Brill, N. &. (1960). Social class and psychiatric treatment. *Archives of General Psychiatry*, 3, 340-344.
- Brody, B. (1976). "Freud's Case-Load" and social class: A rejoinder. *Psychotherapy: Theory, research and practice*, 13, 196-197.
- Chen, Z. (2008, Jan 1). Psychological impact of social pain: The pain that doesn't heal. *ETD Collection for Purdue University*.
- Daniels, N. K. (2000). *Is Inequality Bad for our Health?* Boston, MA: Beacon.
- Dannefer, D. (1987). Aging as intracohort differentiation: Accentuation, the Matthew effect, and the life course. *Sociological Forum*. 2(2), 211-236.
- Dannefer, D. (2003, Jan 1). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *Journals of Gerontology*. 58B(6), S227-S237.
- Danto, E. (2005). *Freud's Free Clinics: Psychoanalysis and social justice, 1918-1938*. New York, NY: Columbia University Press.
- Dimen, M. (1994). Money, love, and hate: Contradiction and paradox in psychoanalysis. *Psychoanalytic Dialogues*, 4 (1), 69-100.
- Eisenberger, N. (2006). Identifying the neural correlates underlying social pain: Implications for developmental processes. *Human Development*, 49 (5), 273-293.
- Eisenberger, N. L. (2003). Does rejection hurt: An fMRI study of social exclusion. *Science*, 302, 290-292.
- Eisenberger, N., & Lieberman, M. (2005). Why it hurts to be left out: The neurocognitive overlap between physical and social pain. *The social outcast: Ostracism, social exclusion, rejection, and bullying*, 109–127.

- Eisenberger, N., Jarcho, J., Lieberman, M., & Naliboff, B. (2006). An experimental study of shared sensitivity to physical pain and social rejection. *Pain, 126* (1-3), 132-138.
- Foster, R. (1998). The clinician's cultural countertransference: The psychodynamics of culturally competent practice. *Clinical Social Work Journal, 26* (3), 253-270.
- Freud, S. (1913). *On beginning the treatment (Further recommendations on the technique of psychoanalysis I)*. (Vol. 12).
- Gabbard, G. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 57* (8), 983-991.
- Gal, J. (1998). Formulating the Matthew Principle: on the role of the middle classes in the welfare state. *Scandinavian Journal of Social Welfare, 7* (1), 42-55.
- Garb, H. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4* (2), 99-120.
- Garcia, S., Hallahan, M., & Rosenthal, R. (2007). Poor expression: concealing social class stigma. *Basic and applied social psychology, 29* (2), 99-107.
- Hayes, J. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy research, 14* (1), 21-36.
- Hollingshead, A. &. (1958). *Social Class and Mental Illness*. New York, NY: John Wiley and Sons, Inc.
- Imber, S. N. (1955). Social class and duration of psychotherapy. *Journal of Clinical Psychiatry, II*, 281-284.
- Jacobs, T. (1999). Countertransference past and present: A review of the concept. *International Journal of Psycho-Analysis, 80* (3), 575-594.
- Javier, R., & Herron, W. (2002). Psychoanalysis and the disenfranchised: Countertransference issues. *Psychoanalytic Psychology, 19* (1), 149-166.
- Jones, E. (1974). Social class and psychotherapy: A critical review of research. *Psychiatry, 37* (4), 307-320.
- Joseph, K. (1989, Jan 1). The Matthew effect in health development. *British Medical Journal* .
- Karon, B., & Vandenbos, G. (n.d.). Psychotherapeutic technique and the economically poor patient.

- Krill, A., & Platek, S. (2009). In-group and out-group membership mediates anterior cingulate activation to social exclusion. *Frontiers in Evolutionary Neuroscience*, 1(1), 1-7.
- Link, B. (1983). Reward system of psychotherapy: implications for inequities in service delivery. *Journal of Health and Social Behavior*, 24 (1), 61-69.
- Link, B., & Milcarek, B. (1980). Selection factors in the dispensation of therapy: The Matthew effect in the allocation of mental health resources. *Journal of Health and Social Behavior*, 21 (3), 279-290.
- Liu, W. (2006). Classism is much more complex: Comment. *American Psychologist*, 61 (4), 337-338.
- Liu, W., Soleck, G., Hopps, J., Dunston, K., & Pickett, T. (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.
- Lloyd, D. (2009). The space between us: A neurophilosophical framework for the investigation of human interpersonal space. *Neuroscience and Biobehavioral Reviews*, 33 (3), 297-304.
- Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, 57 (2), 100-110.
- MacDonald, G. K. (2005). Adding insult to injury: Social pain theory and response to social exclusion. In K. F. Williams, *The Social Outcast: Ostracism, social exclusion, rejection, & bullying*. New York, NY: Psychology Press.
- MacDonald, G., & Kingsbury, R. (2006). Does physical pain augment anxious attachment? *Journal of Social and Personal Relationships*, 23 (2), 291.
- MacDonald, G., & Leary, M. (2005). Why does social exclusion hurt? The relationship between social and physical pain. *Psychological Bulletin*, 131, 202-223.
- Merton, R. (1998). The Matthew Effect in Science: Cumulative advantage and the symbolism of intellectual property. *ISIS*, 79 (4), 606-623.
- Mildestvedt, T., & Meland, E. (2007). Examining the “Matthew Effect” on the motivation and ability to make lifestyle changes in 217 heart rehabilitation patients. *Scandinavian Journal of Public Health*, 35 (2), 140-147.
- Minuchin, S. et al. (1967). *Families of the Slums: An exploration of their structure and treatment*. New York, NY: Basic Books.

- Myers, J. &. (1968). *A Decade Later: A followup of Social Class and Mental Illness*. New York, NY: John Wiley and Sons, Inc.
- Myers, J., & Schaffer, L. (1954). Social stratification and psychiatric practice: A study of an out-patient clinic. *American Sociological Review*, 307-310.
- National Association of Social Workers. (2008). *Code of Ethics*.
- Ochsner, K., Zaki, J., Hanelin, J., Ludlow, D., Knierim, K., Ramachandran, T., et al. (2008). Your pain or mine? Common and distinct neural systems supporting the perception of pain in self and other. *Social Cognitive and Affective Neuroscience*, 3, 144-160.
- Panksepp, J. (1998). *Affective Neuroscience: The foundations of human and animal emotions*. New York, NY: Oxford University Press.
- Panksepp, J. N. (1997). Brain systems for the mediation of social separation-distress and social reward: Evolutionary antecedents and neuropeptide intermediaries. *New York Academy of Sciences*, 807, 87-100.
- Panksepp, J. (2005). Why does separation distress hurt? Comment on MacDonald and Leary (2005). *Psychological Bulletin*, 131, 224-230.
- Pincus, D., Freeman, W., & Modell, A. (2007). A neurobiological model of perception: Considerations for transference. *Psychoanalytic Psychology*, 24 (4), 623-640.
- Ponder, J. (2007). Elitism in psychoanalysis in the USA: narcissistic defense against cumulative traumas of prejudice and exclusion. *International Journal of Applied Psychoanalytic Studies*, 4 (1), 15.
- Price, D. (2000). Psychological and neural mechanisms of the affective dimension of pain. *Science*, 288 (5472), 1769.
- Rigney, D. (2010). *The Matthew Effect: How advantage begets further advantage*. New York, NY: Columbia University Press.
- Rosenberger, E., & Hayes, J. (2002). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling & Development*, 80 (3), 264-270.
- Schofield, W. *Psychotherapy: The purchase of friendship*. New York, NY: Prentice-Hall.
- Schore, A. (2003). *Affect Regulation and the Repair of the Self*. New York, NY: W.W. Norton.
- Siassi, I., & Messer, S. (1976). Psychotherapy with patients from lower socioeconomic groups. *American Journal of Psychotherapy*, 30 (1), 29-40.

- Sloman, L., & Dunham, D. (2004, May 24). The Matthew Effect: Evolutionary implications. *Evolutionary Psychology* 2, 92-104.
- Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, 60 (7), 687.
- Stern, M. (1977). Social class and psychiatric treatment of adults in the mental health center. *Journal of Health and Social Behavior*, 18 (3), 317-325.
- Stone, M. (2006). The analyst's body as tuning fork: embodied resonance in countertransference. *Journal of Analytical Psychology*, 51 (1), 109-124.
- Stroud, L. T.-K. (2000). Stressor (YIPS): Affective, physiological and behavioral responses to a novel interpersonal rejection paradigm. *Annals of Behavioral Medicine*, 204-213.
- Terestman, N., Miller, J., & Weber, J. (1974). Blue-collar patients at a psychoanalytic clinic. *American Journal of Psychiatry*, 131 (3), 261.
- Vanwesenbeeck, I. (1994). *Prostitutes' Well-being and Risk*. Amsterdam, Denmark: Amsterdam University Press.
- Wachtel, P. (2002). Psychoanalysis and the disenfranchised: From therapy to justice. *Psychoanalytic Psychology*, 19 (1), 199-215.
- Whitman-Raymond, L. (2009, Jan 1). The influence of class in the therapeutic dyad. wawhite.org.
- Wilkinson, M. (2006). The dreaming mind-brain: a Jungian perspective. *Journal of Analytical Psychology*, 51 (1), 43-59.
- Wirth, J., & Williams, K. (2009). They Don't Like Our Kind': Consequences of Being Ostracized While Possessing a Group Membership. *Group Processes & Intergroup Relations*, 12 (1), 111.
- Zadro, L., Williams, K., & Richardson, R. (2004). How low can you go? Ostracism by a computer is sufficient to lower self-reported levels of belonging, control, self-esteem, and meaningful existence. *Journal of Experimental Social Psychology*, 40 (4), 560-567.
- Zhou, X., Vohs, K., & Baumeister, R. (2009). The symbolic power of money. *Psychological Science*, 20, 700-6.