

# Psychologists' Experiences Working with Clients in Poverty: A Qualitative Descriptive Study

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**BOSTON COLLEGE**

*LYNCH SCHOOL OF EDUCATION*

**Department of Counseling, Developmental and Educational Psychology**

PSYCHOLOGISTS' EXPERIENCES WORKING WITH CLIENTS IN  
POVERTY: A QUALITATIVE DESCRIPTIVE STUDY

Dissertation

by

ANGELA M. BORGES

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Psychologists Experiences Working with Clients in Poverty: A Qualitative Descriptive  
Study

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Dissertation Chair: Lisa A. Goodman, Ph.D.

Abstract

Those in poverty face myriad stressors, traumatic events, and ongoing hardships; and not surprisingly, struggle with a range of mental health issues. Yet, they are less likely to access mental health services than their middle-income counterparts, and when they do, they are more likely to drop out of treatment prematurely. Although researchers have found that when interventions are tailored to address poverty-related stressors outcomes are dramatically improved, the perspectives of those providing such treatment is rarely described. This qualitative descriptive study of twelve experienced psychologists working with clients in poverty aimed to fill this gap. The study explored the extent to which psychologists develop unique practices for working with low-income clients, as well as the personal and contextual factors that support or hinder these efforts. Findings can be distilled into three categories: Practices unique to working with low-income clients include strategies for addressing power dynamics, managing boundaries, and addressing external stressors as part of the therapeutic process. Therapist attributes key to working with low-income clients include possessing a values-based commitment to working with marginalized groups; possessing experience with, knowledge of, and empathy for the realities of living in poverty; possessing a high degree of self-awareness related to poverty; and possessing a willingness to be deeply affected by the work and cope with negative feelings. Contextual obstacles to working with low-income clients include agency-level

and social service system-level challenges. Perhaps the most striking finding was participants' understanding of how conceptualizations of appropriate boundaries need to change in the context of work with this population. Many participants described, for example, giving food to their clients when they were hungry or giving them small amounts of money to help them take care of their most basic needs. The discussion section explores these findings in the context of ecological and feminist theoretical models and current research and describes the implications of the results for research, training, and practice.

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bestowed upon me the great responsibility of representing their words fairly and accurately and making meaning of the messages contained in a chorus of quite different voices. My hope is that I've done well by their measure in that regard.

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## Table of Contents

Chapter 1: Introduction.....	1
Rationale.....	3
Conceptual and Theoretical Frameworks.....	4
Methodology.....	8
Chapter 2: Literature Review.....	13
Overview of Poverty in the United States .....	16
Poverty Related Stressors and Mental Health.....	19
Mental Health Outcomes Associated with Poverty.....	25
Mental Health Treatment and the Poor.....	26
Psychologist’s Attitudes, Social Class Privilege, and Training for Work with the Poor .....	42
Current Study: Conceptual Basis .....	56
Summary.....	67
Chapter 3: Methodology.....	70
Methodology: Qualitative Description.....	70
Sampling.....	71
Data Collection.....	74
Data Analysis.....	77
Rigor and Validity.....	79
Chapter 4: Results.....	85
Category A: Practices.....	87
Category B: Attributes.....	136

Category C: Obstacles.....	165
Chapter 5: Discussion.....	174
Results in the Context of Theory and Existing Literature.....	174
Summary.....	206
Limitations.....	209
Implications for Practice.....	210
Implications for Training.....	214
Implications for Research.....	217
Conclusion.....	214
References.....	221
Appendices.....	242
Figure 1: Results in the Context of Organizing Framework: Ecological Model .....	250
Table 1: Sample.....	251
Appendix A: Interview Protocol.....	253
Appendix B: Interview Consent Form.....	261
Appendix C: Sample Coding Document.....	264

Psychologists' Experiences Working with Clients in Poverty: A Qualitative Descriptive  
Study

**Chapter One: Introduction**

“I woke up at three a.m. praying for a miracle for my client. I did not wish for self-esteem, release from the terrors of a lifetime of trauma or a flash of insight. I prayed for cash-filthy lucre, dead presidents and gold bars. She has heart, vision and a tenacious spirit. What she lacks is cash to finance her dreams and her basic survival needs.” (Quote from a therapist, Jackson, 2011, p. 1).

As of 2013, 45.3 million Americans were living below the poverty line – a number that has not changed over the last three years (U.S. Census Bureau, 2014). This high number of U.S. citizens living below the poverty line is a serious problem with grave implications for public health. It is well documented that living in poverty is associated with many physical health and mental health problems (Adler, Boyce Chesney, Folkman, & Syme, 1993; Bruce, Takeuchi, & Leaf, 1991; Fiscella & Williams, 2004; Hudson, 2005; Seeman et al., 2004); and that SES predicts health status, rather than the reverse (Williams & Collins, 1995). Poverty has a profound effect on mental health in particular, as studies show that the poor suffer disproportionately from depression (Bruce, Takeuchi, & Leaf, 1991; Siefert, Bowman, Heflin, Danziger, & Williams, 2000), posttraumatic stress (Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshal, 2001), substance abuse (James et al., 2003; Zilberman, Tavares, Blume, & Nady, 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999).

In addition to diagnosable mental health problems, low-income individuals also suffer disproportionately from a range of hardships that contribute to psychological distress. They are disproportionately vulnerable to a range of traumatic experiences, including neighborhood and community crime and violence, infant mortality, and

intimate partner and sexual violence (Bassuk et al., 1998; Bausman & Goe, 2004; Belle, Doucet, Harris, Miller & Tan, 2000; Cunradi, Caetano, & Schafer, 2002; Grief, 2005; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Vest, Catlin, Chen, & Brownson, 2002). And many struggle on a daily basis with the chronic stress that accompanies lack of transportation, discrimination, inadequate income to pay bills, insufficient resources to provide for children, hunger and food insecurity, unemployment, and unstable housing (Burnham, 2002; Evans & English, 2002; Siefert, Heflin, Corcoran, & Williams, 2001).

Despite the relatively high rates of mental health difficulties and oppressive circumstances faced by low-income individuals, literature on their access to mental health treatment and the effects of that treatment are mixed at best. On the one hand, research indicates that low-income adults are less likely to access mental health services given a range of obstacles to doing so (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Diamond & Factor, 1994; Greeno, Anderson, Shear, & Mike, 1999; Maynard, Ehreth, Cox, Peterson, & McGann, 1997); that when they do, they are more likely to stop treatment early (Garfield, 1994; Miranda, Azocar, Komaromy, & Golding, 1998; Nadeem, Lange, & Miranda, 2008; Siefert et al., 2000); and that they show less improvement in therapy when compared with middle-income clients (Falconnier, 2004). On the other hand, some researchers have found that mental health interventions are indeed effective for treating poor clients, especially when they are specifically tailored to address poverty-related stressors (e.g., Ammerman et al., 2005; Grote et al., 2007; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung, et al., 2003). These latter findings suggest that mental health interventions can be altered to better meet the needs of the poor.

## **Rationale**

While the literature on poverty, mental health, and mental health treatment provides valuable information for guiding treatment of the poor, the perspectives of those providing such treatment is rarely described. This represents an important gap: Working with the poor presents unique difficulties that may challenge psychologists in ways that hinder their effectiveness. First, those in poverty often struggle with extreme hardship imposed by external (as opposed to internal or intrapsychic) circumstances, as noted above (Burnham, 2002; Evans & English, 2002; Siefert, Heflin, Corcoran, & Williams, 2001). A treatment provider who is trained to respond mainly to intrapsychic problems may feel overwhelmed by these difficulties; and the theories and techniques she or he has learned may feel insufficient to tackle them (Smith, 2009). This situation may lead to the psychologist's own experiences of powerlessness. Further, even those therapists who might have had first hand experience with poverty are not currently facing those circumstances given their current educational and income privilege. (Nelson, Englar-Carlson, Tierney, & Hau, 2006). Therefore, it may be difficult for them to fully comprehend the reality of poor clients' lives. At the same time, coming face to face with the realities of poverty may bring up feelings of discomfort about the relative ease of the psychologist's own life (Smith, 2009). Third, the psychologist may face a range of workplace and larger institutional barriers to working with the poor the way she or he wants, leading to frustration and burnout. At this point, it is entirely unclear how psychologists think about and respond to these challenges and complexities. As elaborated below, only by exploring how psychologists who provide treatment to low-income clients understand their work can we hope to improve practice, training, and



policy related to mental health intervention with poor clients.

This study had three specific aims, corresponding to three levels of the ecological framework (described below): a) To explore the personal and professional attributes that psychologists describe as key to working with low-income clients (individual-level), b) To explore whether and how psychologists develop unique practices for working with clients in poverty (micro-level), and c) To identify agency and system level factors that hinder or facilitate psychologists' work with low-income clients (exo-level).

We hope that this exploration will contribute to the improvement of mental health practice in a number of ways: First, the identification of individual level factors key to working with clients in poverty could enable better training and teaching methods to support the development of these attributes. Second, exploration of the unique practices psychologists use to navigate work with low-income clients, could contribute to the development of more effective interventions for this vulnerable population. Third, a better understanding of the systemic (exo-level) obstacles that stand in the way of psychologists' work could help us to address them. As researchers, practitioners, and policy-makers work to reduce mental health disparities and improve treatment for impoverished individuals, it is tempting to ask, "Where should we go from here?" But, it is difficult to respond to that question without further attention to this one: "Where are we starting from?" This study aimed to answer this question.

### **Conceptual and Theoretical Frameworks**

This study made use of a qualitative methodology called qualitative description to render an in-depth understanding of psychologists' experiences providing therapy to low-income clients. To establish a conceptual basis for the interview questions, I drew on

several strands of literature.

First, this study employed developmental psychologist Uri Bronfenbrenner's (1979, 1986) ecological model to consider a range of potential contributors to psychologists' experiences of working with low-income clients. Specifically, I asked questions about influences on the psychologist across three ecological levels – the individual, micro, and exo system levels. According to Bronfenbrenner (1979, 1986), the *individual-system* represents one's internal biological and psychological makeup. However, in the context of the current study, the individual level represents the psychologists' own personal and professional attributes needed to do the work. The *micro-system* represents interactions between an individual and those people in his or her immediate contexts; in this case, that would mean the psychologist's interactions with her or his clients, and in the context of therapy, how the psychologist navigates the interpersonal challenges associated with that relationship by adapting existing practices or creating new ones. Finally, the *exo-system* represents the impact on the individual of larger social settings and structures; in this case, that would mean agency and social service level factors that hinder or facilitate psychologists' work with low-income clients and the strategies psychologists use to navigate obstacles. This model is sufficiently flexible that it does not impose expectations on the study, but instead offers a framework for considering the multiple and interacting influences on the psychologist working with clients in poverty. Please see Figure 1 for a visual representation of this ecological model.

Second, I built on the concept of cultural competence to raise questions about psychologists' perspectives on how well prepared they are to do therapy with low-income clients and what would help them to do better work. D.W. Sue (2001) has described

cultural competencies as existing along a three part continuum of a) beliefs and attitudes b) knowledge, and c) skills. Competency regarding beliefs and attitudes involves acknowledging and confronting one's own biases and stereotypes about marginalized groups, acknowledging and appreciating the diversity of clients, and developing a positive orientation toward multiculturalism. Competency regarding knowledge requires counselors to understand their own worldviews and develop specific knowledge of the cultural groups with which they work. Finally, competency regarding skills involves counselors acquiring specific skills and strategies for working with oppressed groups (D.W. Sue, 2001). Drawing on this tripartite model, I aimed to raise questions about participants' attitudes, knowledge, and skills in relation to low-income clients in particular.

Third, I drew upon feminist theoretical frameworks (Brown, 2009; Evans, Kincase, Marbely & Seem, 2005) to examine how psychologists understand and work with the oppressive social conditions with which clients struggle. Typically, psychologists are trained to promote change largely by focusing on the individual client as the agent of change. For example, in traditional psychodynamic therapy, the therapist explores the roots of distress in the clients' early experiences and difficult relationships (e.g., St. Clair & Wigren, 2004) and in traditional cognitive behavioral therapy (CBT), the therapist explores what are seen as problematic thoughts in the client that then shape their behavior in maladaptive ways (e.g. Beck, 1995). However, because clients in poverty are faced with many problems that are external to them, some may experience these approaches as frustrating, irrelevant, and/or disempowering when applied without equal attention to external hardships. In response, feminist therapists, among others,

encourage therapists to look outside the individual to explore and address oppressive social, political, and historical factors that may contribute to clients' distress (e.g. Brown, 2009; Evans, Kincase, Marbely & Seem, 2005). This study therefore explored how psychologists view their role with respect to addressing contextual issues.

Finally, I also drew on feminist theory (Brown, 2009; Jordan, 2000) to explore how psychologists negotiate power with their clients. While power is always a part of the therapeutic relationship, power dynamics may become even more salient when working with clients in poverty, who may feel that the therapy process is a reminder or re-living of previous disempowering experiences with "helpers" who are in fact gatekeepers to resources (e.g. case workers at social service agencies from which they need help such as food stamps or other public assistance) (Abrams, Dornig, & Curran, 2009). Feminist theorists highlight boundary negotiations as an especially important dimension of power in the therapeutic relationship. Regarding boundaries around self-disclosure, for example, the traditional notion is that therapists should not engage in personal disclosure so that the client can see her as neutral or objective (Wachtel, 1993). This may not be an issue for those who are less sensitized to the experience of powerlessness, but it may leave the low-income client feeling tremendously exposed without the possibility of mutuality or reciprocity (Jordan, 2000). Some feminist therapists therefore posit that more flexible and mutually agreed upon boundaries around self-disclosure may be useful, particularly when working with oppressed populations (Jordan, 2000). The same concern could be extended to a host of boundary-related issues, including length and location of sessions, and the role of the therapist (e.g. whether or not the therapist extends herself beyond the session to advocate for the client). Although some therapists have written

about the need for flexibility around these issues when working with the poor (Brown, 2009; Jordan, 2000; J. Smith, 2000), there is little writing about how psychologists actually manage the process of setting and negotiating boundaries with low-income clients. I therefore raised questions about how psychologists handle issues of power in their relationships with clients. The feminist theoretical frameworks will mainly be employed in asking questions at the micro level of the ecological model – where the psychologist manages the power dynamics, boundary setting, and role negotiation inherent in the therapeutic relationship with clients in poverty.

### **Methodology**

This study made use of a specific qualitative methodology called qualitative description. Unlike other qualitative approaches, such as phenomenology or grounded theory, qualitative description does not provide a high-level of interpretation (Sandelowski, 2010; Sandelowski, 2000). Because psychologists' experiences of their practice with clients in poverty have not been researched, it is necessary to gather preliminary, low inference data to explain their perspectives directly.

My target population was psychologists who are three years post-doctoral training and are currently conducting at least five hours per week of individual adult psychotherapy with clients in poverty. Among therapists, the perspective of psychologists seems particularly important to consider: Because they receive extensive doctoral level training, there may be a presumption in the field that they are well-prepared to work effectively with the poor. Yet, this assumption has not been tested. This study explored the experiences of psychologists doing this work in order to help guide thinking in the field about how better to meet the needs of this underserved population.

Therefore, the sole eligibility criterion for this study was that the participant self-identified as a psychologist who has worked with low-income clients for 5 years or more.

**Sampling.** To develop the sample, this study made use of maximum variation purposive sampling, where demographically varied cases are sought. Miles and Huberman (1994) note that when using multiple-case sampling and data with high complexity and richness, coding can become unwieldy after 15 cases. The ultimate number depends, however, on when the researcher reaches saturation; that is, when no additional data can be found that develops properties of the conceptual categories (developed from coding). This study reached saturation after 12 interviews

To recruit potential participants, I made use of the informal connections that I had with local community mental health centers. Using snowball sampling, I also asked participants if they would be willing to recommend colleagues who might like to be interviewed. Having recruited participants, I allowed them to set the time and place of the audio taped interview and paid them a \$30 stipend for their time.

**Procedure.** Each 60-120 minute interview took place at a location that was easiest for participants, in either their workplace or home. I offered for participants to meet with me in an office at Boston College if preferred, but no participants chose that option. The semi-structured interviews were based on the interview guide presented in Appendix A, which provides a list of demographic questions followed by general, open-ended questions and probes. Questions covered the following areas, corresponding to the aims of the study: 1) personal and professional attributes important for psychologists working with low-income clients, including skills, knowledge, and attitudes that shape their work (individual-level); 2) psychologists' perspectives on their interpersonal

interactions with clients living in poverty - compared to their interactions with higher-income clients. This includes how they understand and respond to clients' poverty related stressors, as well as their use of power and boundary setting and unique practices they develop for work with this population (micro-level); and 3) psychologists' perspectives on how agency and institutional level factors that hinder or facilitate their work with low-income clients (exo-level).

**Data analysis.** The study used a method called qualitative content analysis to code the data (Hsieh & Shannon, 2005). This method enables the creation of a "comprehensive summary" of the phenomenon of interest in "everyday terms" (Sandelowski, 2000, p. 336). It is a low-inference method that enables the voices of participants to be heard without the imposition of the author's conceptualizations of the data. This is appropriate given that little is known about the topic; the goal is to paint a straightforward picture of the processes occurring. Specifically, this method calls for three levels of coding. In vivo coding involves using the exact words of participants when they seem to express an important concept or an often-repeated idea, which are organized into "chunks" of data (Hsieh & Shannon, 2005). Second level coding involves looking for patterns and commonalities across the interviews and collapsing the in-vivo codes where possible, to create categories. Third level coding involves sorting the second level codes into "clusters" which capture the relationships between categories (Patton, 2002). Please see Appendix C for sample of coding.

**Rigor and validity.** Qualitative research must demonstrate both rigor and validity in order to make a contribution to the field. Rigor is the extent to which the findings of the study are the result of a thorough, precise, and well-documented process of data

collection and analysis. Validity is the extent to which the findings can be considered authentic, trustworthy, and reliable (Guba & Lincoln, 2005). This study used memo-writing, reflexivity, peer review, and member checking to ensure reliability and validity. Memo-writing involved taking detailed notes throughout the process to document what stood out in each interview and how interviews are similar or different across participants. Reflexivity, the process of recognizing the researcher as an integral part of the research (Munhall, 2007), involved keeping memos that recorded my reactions to participants, my assumptions about the topic, and my emerging impressions of the data. Peer review meant bringing in outside reviewers (e.g. my dissertation chair) at every step of the process – to check the validity of codes and to ensure that I had bracketed my own subjectivity. Member checking, done to ensure the accuracy of the data, meant sending results to participants to give them the opportunity to provide feedback on results.

**Conclusion.** The quote from a therapist at the start of this chapter illustrates the dilemma often faced by psychologists working with low-income clients. We work hard in training for many years, hopefully to become compassionate and highly skilled clinicians. We have practiced the art of sitting with and exploring clients' deep emotions, uncovering and interpreting longstanding intrapsychic conflicts, examining and challenging their patterns of thought, and analyzing their patterns of behavior. We are often told to “consider the context,” but our counseling theories and strategies don't often lead us in that direction, or point the way to what to do with that context. When we encounter clients with the unimaginable and seemingly unworkable stress of poverty as a “contextual factor,” we are often left with the sentiment that the therapist quoted above expresses. We want to help, but our tools seem limited. We feel powerless, and



sometimes our efforts may even be misdirected. The present study asked psychologists to articulate the tensions that arise for them when confronted with a client's poverty, how well prepared they feel to deal with it, how far they are willing to go to address the very real external stressors associated with poverty directly, what the influences of their own context are on the work, and what would help them to do better. We owe it to hard working psychologists, and perhaps more so, to the clients they work with, to understand these processes better. That was the aim of the present study.

## Chapter 2: Literature Review

### Introduction

As of 2013, 45.3 million Americans were living below the poverty line. It is well documented that living in poverty is associated with many physical health and mental health problems (Adler, Boyce Chesney, Folkman, & Syme, 1993; Bruce, Takeuchi, & Leaf, 1991; Fiscella & Williams, 2004; Hudson, 2005; Seeman et al., 2004); and that SES predicts health status, rather than the reverse (Williams & Collins, 1995).

Poverty has a profound effect on mental health in particular, as studies show that the poor suffer disproportionately from depression (Bruce, Takeuchi, & Leaf, 1991; Siefert, Bowman, Heflin, Danziger, & Williams, 2000), posttraumatic stress (Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshal, 2001), substance abuse (James et al., 2003; Zilberman, Tavares, Blume, & Nady, 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999). In addition to diagnosable mental health problems, low-income individuals also suffer disproportionately from other hardships and factors related to psychological distress, including chronic stress, losses, traumatic events, disparities between an individual's goals and achievement, and lower reported quality of life (Falconnier & Elkin, 2008; Ferriss, 2006; Lafave, de Souza, Prince, & Atchison, 1995; Park, Turnbull, & Turnbull, 2002; Smith, Sim, Scharf, & Phillipson, 2004; Wong, 2005).

Although the poor are more likely than those with middle to upper incomes to suffer from mental health difficulties, literature on their access to mental health treatment and the effects of that treatment are mixed at best. On the one hand, research indicates that the poor are less likely to access mental health services; that when they do, they are more likely to stop treatment early (Garfield, 1994; Miranda, Azocar, Komaromy, &

Golding, 1998; Nadeem, Lange, & Miranda, 2008; Siefert et al., 2000); and that they show less improvement in therapy when compared with middle-income clients (Falconnier, 2004). On the other hand, some researchers have found that mental health interventions are indeed effective for treating poor clients, especially when they are specifically tailored to address poverty-related stressors (e.g., Ammerman et al., 2005; Grote et al., 2007; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung, et al., 2003). These latter findings suggest that mental health interventions can be altered to better meet the needs of the poor.

While the literature on poverty, mental health, and mental health treatment provides valuable information for guiding mental health intervention with poor clients, the perspective of those providing such treatment is noticeably missing from the literature. This is an important gap because working with the poor presents unique difficulties that may challenge psychologists in numerous ways. First, those in poverty often struggle with extreme hardship imposed from without, as noted above. A treatment provider who is trained to respond mainly to intrapsychic problems may feel overwhelmed by these difficulties; and the theories and techniques she or he has learned may feel insufficient to tackle them. This situation may lead to the psychologist's own experiences of powerlessness. Second, even those therapists who might have had first hand experience with poverty are not currently facing those circumstances because of educational and income privilege. (Nelson, Englar-Carlson, Tierney, & Hau, 2006). Therefore, it may be difficult for them to fully comprehend the reality of poor clients' lives – a task that is necessary for a therapist to be effective. At the same time, coming face to face with the realities of poverty may bring up feelings of discomfort about the

relative ease of the psychologist's own life. Third, the psychologist may face a range of workplace and larger institutional barriers to working with the poor the way she or he wants, leading to frustration and burnout. At this point, it is entirely unclear how psychologists think about and respond to these challenges and complexities. Only by exploring how psychologists who provide treatment to low-income clients understand their work can we hope to improve training for providers and treatment for clients. Specifically, we need to understand more about how those who provide therapy to poor clients conceptualize their goals and strategies, whether psychologists feel they have the knowledge and skills they need to work with low-income clients; how their own attitudes about class and poverty affect their work; what conceptual tools they use to think about and work with clients' internal psychological and external poverty-related difficulties; how they manage power dynamics related to poverty; and what kinds of adaptations they make for this population. As researchers, practitioners, and policy-makers work to reduce mental health disparities and improve treatment for the poor, it is tempting to ask, "Where should we go from here"? But, an important first question is, "Where are we starting from?" Beginning to answer these questions about the process of conducting therapy with the poor will help answer that first question.

This chapter begins with an overview of poverty in the United States. Second, it discusses some of the poverty-related stressors the poor contend with and the mental health difficulties that result from these stressors. Third, this chapter provides a review of the scholarship on historical responses to the poor, current access to mental health treatment for the poor, as well as research on the experience and effectiveness of therapy for this population. Fourth, psychologist's approaches to and training for working with

the poor are discussed. Finally, the chapter concludes with a description of how ecological models, models of multicultural competence, and feminist theoretical approaches to addressing power in therapy help frame the proposed study.

### **Overview of Poverty in the United States**

As of 2013, 45.3 million Americans were living below the poverty line – a number that was not statistically different from the previous year’s estimate for the third consecutive year (U.S. Census Bureau, 2014). In addition to these already devastatingly high numbers, one must also consider the many poor and working class Americans not counted here, as the U.S. government’s poverty guidelines tend to underestimate how many families are in serious economic trouble because they exclude many living just above the poverty line, and the current cost of living far exceeds that cutoff (Boushey, 2002; Opinion Dynamics Corporation, 2001; Thibos et al., 2007). For example, the 2014 Census guidelines require a family of four to earn less than \$23,850 per year in order to be considered to be living below the poverty line (U.S. Department of Health and Human Services, 2014). Those making more than that amount, even by one dollar, are not counted in the figures reported above. Furthermore, Smith (2010) points out that according to the Living Wage Calculator created by Penn State University, a basic living wage for a family of four living anywhere in the country is much higher than the poverty line indicates. Therefore, for the purposes of the present study I followed Smith’s (2010) recommendation for defining poverty. When I refer to those living in poverty, this includes those who live below, at, or near the poverty line and therefore do not have sufficient income to meet their basic needs such as food, shelter, and clothing.

While the numbers of people unable to meet their basic needs because of poverty

is increasing, the gap between the wealthiest and the poorest Americans has also increased considerably, a gap that some scholars have gone so far as to label economic apartheid (Bernstein, McNichol, Mishel, & Zahradnik, 2000; Collins & Yeskel, 2005). Between the years of 1979 and 2005, the average income of the poorest fifth of Americans increased 9%, whereas the average income of the wealthiest 1% of Americans increased by 201% (Collins & Yeskel, 2005). Smith (2010) notes that in 2001, as a result of trends such as these, around 10% of Americans owned 70% of all wealth in the U.S., and of those, 1% owned 40% of wealth. The popular saying that ‘the rich get richer while the poor get poorer’ appears to be true in the U.S., as we are the nation with the greatest income inequality in the developed world (Fischer, Hout, & Stiles, 2006; Sen, 2008). And, this economic inequality is compounded by other aspects of inequality experienced by some in the U.S., such as racism and sexism.

**Poverty, race, and gender.** While it is clear that poverty is widespread, not all Americans are affected by poverty equally. Poverty affects racial and ethnic minorities and women disproportionately. According to the U.S. Census (2014) people of color are hardest hit by poverty. Twenty seven percent of African Americans, 23.5% of Hispanics, and 10.5% of Asians and Pacific Islanders meet American poverty standards, whereas only 9.6% of White Americans do. Lui, Robles, Leondar-Ross, Brewer, & Adamsom (2006) explain this historical discrepancy by taking into account wealth in addition to income. By considering how the asset-building histories of generations of people of color are affected by historical oppression, they explain why for each dollar owned by the average white family in the U.S., the average family of color owns less than ten cents (Lui et al., 2006). In addition, people of color are more likely to live in neighborhoods

with high concentrations of poverty, which limits their access to opportunities for education and recreation (Evans, 2004). This lack of access to quality education for children of color as compared to white children can then translate into lack of employment in adulthood (Shapiro, 2004). These factors serve to perpetuate poverty for those already battling other oppressive forces, such as racism. In this way, poverty is part of the systematic oppression of people of color.

Race clearly intersects with social class in important ways, and these two aspects of identity and social status also intersect with gender (Smith, 2010). According to the U.S. Census (2014), women are also disproportionately affected by poverty. Women are 35% more likely to be poor than men in the U.S. (Legal Momentum, 2014). Additionally, as of 2010, more than one third (31.6%) of families with a female single head of household were living below the poverty line (National Poverty Center, 2014). Therefore, although the U.S. is one of the wealthiest industrialized nations, this country also has the greatest gender gap in poverty rates. Some of this can be attributed to the fact that many forms of employment are segregated by gender and correspondingly, work performed primarily by women is compensated at lower pay scales (England, 2008).

However, it is important to note that considering race or gender alone is an oversimplification of the nature of oppression as it occurs in people's actual lives. One form of oppression compounds another. When the intersection of race, class and gender are considered altogether, one can see that women of color are the hardest hit – nearly 40% of single African American and Latina mothers live in poverty (Thibos et al., 2007). As Smith (2010) points out, the race/class/gender intersection reveals some of the highest poverty rates in America. And the oppressive nature of life in poverty takes a serious toll

on those experiencing it, with poverty-related stressors compounding already difficult to impossible circumstances, and oftentimes, leading to mental health difficulties.

### **Poverty Related Stressors and Mental Health**

Given high rates of poverty in general and especially for populations experiencing multiple forms of oppression (e.g. racism, sexism, etc.), it is important to understand how poverty shapes everyday experiences and how that in turn, affects mental health. This section reviews research on the major stressors associated with living in poverty, including traumatic life events, chronic stress, stigma, social isolation, and powerlessness.

**Traumatic life events.** While traumatic events can happen to anyone, research demonstrates that the poor are dealing with more frequent, more dangerous, and more uncontrollable life events than the general population, including just about every type of trauma imaginable - neighborhood and community crime and violence, substance abuse and addiction in their families and communities, discrimination, unstable or nonexistent employment, unstable housing, greater physical health problems, infant mortality, marital problems, intimate partner violence (IPV), and sexual violence (Bassuk et al., 1998; Bausman & Goe, 2004; Belle, Doucet, Harris, Miller & Tan, 2000; Cunradi, Caetano, & Schafer, 2002; Grief, 2005; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Vest, Catlin, Chen, & Brownson, 2002). These traumatic events may be one-time occurrences or may be ongoing (as in the case of persistent IPV), but in either case those in poverty feel the threat consistently, on a day-to-day basis. Therefore, they are sources of both acute and chronic stress (Goodman, Smyth, Borges & Singer, 2009). The poor must constantly manage this stress and many use adaptive and persistent strategies to alleviate



the difficulties they face (Efin & Lein, 1997). Yet, managing the effects of persistent stress and traumatic events without the necessary resources to do so often leads to feelings of powerlessness, anger, hostility, fear, anxiety, and low self-esteem, as well as cognitive and behavioral reactions such as isolation, attributions of negative intent, and chronic vigilance (Chen & Mathews; Gallo & Mathews, 2003; Goodman et al., 2009). While these are understandable responses to such overwhelming and chronic stress, they take a psychological toll. They result in more mental health problems for the poor, including higher levels of depression, anxiety, posttraumatic stress, and other mental health problems (Bachman & Satzman, 1995; Bassuk, Buckner, Perloff, & Bassuk, 1998; Bell & Goodman, 2001; Gill et al., 2009; Dunn & Hayes, 2000; McLeod & Kessler, 1990; Stafford, Chandola & Marmot, 2007; Vest et al., 2000; Vogel & Marshall, 2001).

**Stressful life conditions.** The disproportionate number of traumatic life events experienced by those in poverty are just one aspect of the web of stress the poor are caught in everyday (Banyard, 1995). To be poor is to deal with ongoing deprivation in many areas of one's life, which has obvious psychological effects. In addition, the poor must contend with sources of worry and stress associated with many aspects of daily life that others take for granted, such as lack of transportation, inadequate income to pay bills, insufficient resources to provide for children, hunger and food insecurity, and difficulties dealing with social services in order to try to meet these needs (Burnham, 2002; Evans & English, 2002; Siefert, Heflin, Corcoran, & Williams, 2001). Finally, homelessness, unstable, or substandard housing is a typical concern for the poor, and this has been

linked to increased rates of depression and anxiety (American Psychological Association [APA], 2007; Evans, Wells, & Moch, 2003; U.S. Census, 2001).

The stress of not being able to take for granted one's safety and survival demands that the poor dedicate a great deal of cognitive and psychological resources to simply navigating daily life (Goodman et al., 2009). One mistake, which may be a mere inconvenience for those with more resources could mean a catastrophe for those in poverty (Goodman et al., 2009). For example, missing one bus ride may mean losing a job or missing one piece of paperwork may mean losing public benefits that are necessary for survival (Goodman et al., 2009; Goodman & Epstein, 2008; Riger, Raja & Camacho, 2002). J. Smith (2000) puts it this way, "The severity of poor people's circumstances makes life a tightrope without a safety net. There is little margin of error. Spend twenty dollars the wrong way, and everyone is hungry." (p. 79). Moreover, those in poverty must contend with what tend to be long, complex, and intrusive processes in order to obtain government resources in order to survive (Bullock, 1995; Goodman et al., 2009; Laughon, 2007; Lott, 2002). Engaging in these processes may also involve being spoken down to, shamed, or insulted by government workers (Bullock, 1995; Goodman et al., 2009; Laughon, 2007; Lott, 2002). It is difficult to imagine for those who take for granted their daily needs will be met just how demanding it is, both physically and psychologically, for the poor to obtain the most basic resources of food, shelter, transportation, etc.

It is not surprising given these stressful conditions that the poor are also more likely than other populations to experience the stress of chronic health problems such as osteoarthritis, hypertension, cancer, coronary heart disease, and AIDS/HIV infection,

(Adler & Coriell, 1997). The higher one's SES, the lower their risk of chronic diseases and mortality (Adler & Coriell, 1997). Furthermore, higher SES is associated with fewer risk factors (e.g. cigarette smoking, hypertension, cholesterol, diet, etc.) for the number one killer of Americans: cardiovascular disease (Adler & Coriell, 1997). Adding to the stress, the poor are less likely than other populations to have health insurance and are therefore less likely to receive proper treatment (Kaiser Family Foundation, 2004). Dealing with chronic health problems without adequate resources then becomes yet another stressful life condition. The disadvantages of having low income may be cumulative, reflecting more health-risking behaviors as well as less screening and early detection, and less access to care and treatment (Adler & Coriell, 1997). Thus, stressful life conditions and lack of access to resources to deal with those conditions have a cumulative effect on the wellbeing of those in poverty.

**Stigma and discrimination.** If coping with the trauma and stress associated with poverty and the resulting mental and physical health difficulties were not enough, the poor must contend with all of those challenges in a cultural climate that consistently disparages, condemns, and blames the poor for their problems. In U.S. society, where economic failure is often attributed to individual characteristics without accounting for oppressive societal structures, poverty may be considered a sign of personal weakness and failure, and is deeply discrediting (Belle & Doucet, 2003). Illustrating this point, Cozzarelli, Wilkinson, and Tagler (2001) conducted a study of undergraduates' beliefs about the poor vs. the middle class and found that college students were likely to describe the poor as uneducated, unmotivated, unpleasant, dirty, angry, stupid, criminal, violent, immoral, alcoholic, and abusive. In particular, the study showed that among the poor,

those who receive public assistance are condemned. Another study found that welfare recipients were the only group of 17 stereotyped groups to be labeled both disliked and disrespected (Fiske, Xu, Cuddy, & Glick, 1999). As with other oppressed groups, negative perceptions and stereotypes are often internalized, so that the poor not only have to contend with negative treatment by others, but also negative views of themselves, leaving them feeling alone, guilty, and ashamed (Moane, 2003).

**Social isolation.** Social support refers to instrumental and/or emotional assistance exchanged within the context of interpersonal relationships (Goodman, et al., 2009). Instrumental support is material or practical aid whereas emotional support involves encouragement, validation, empathy, listening, and giving advice (Kocot & Goodman, 2003). The presence of social support in one's life plays an important role in coping with stress and is important for physical and psychological well being (Groh, 2007; Mickelson & Kubansky, 2003). Unfortunately, while the poor are in great need of social support, poverty complicates the usefulness of networks of support because of what is known as the "contagion of stress" (Belle & Doucet, 2003; Wilkins, 1974). The social networks that those in poverty rely on likely contain these same stressors they themselves are dealing with, and can therefore serve as conduits of stress (Riley & Eckenrode, 1986). In other words, because the social networks of the poor are often made up of others with similarly challenging life circumstances who are also in poverty, receiving help means that one will likely be asked for help later, and this expectation of reciprocity adds yet another burden to an already full plate (Edin & Lein, 1997). Rather than having to reciprocate, some in poverty would rather not receive help in the first place (Goodman et al., 2008; Mickelson & Kubansky, 2003). Not surprisingly, this can lead to social

isolation and low levels of support, which is a risk factor for depression (Coiro, 2010; Smyth, 2009). In addition to the social isolation created by the contagion of stress, Smith (2009) points out that the poor are largely excluded from full participation in many mainstream social experiences because of stigma and lack of resources. In fact, Smith (2009) asserts that social isolation and exclusion is actually a defining feature of poverty.

**Powerlessness.** Trauma, chronic stress, stigma, and social isolation interact in the lives of the poor, creating both an actual and a psychological prison of powerlessness and lack of control (Lachman & Weaver, 1998). Powerlessness is a lack of choice or decision-making power within one's life (Goodman et al., 2010; Young, 2000). In fact, the poor have fewer opportunities for choice, control, and agency than other groups (Lachman & Weaver, 1998). When efforts are made to address poverty related stressors through state assistance, the poor are forced to deal with bureaucratic institutions which place even further demands and stressors on them (Dodson, 1998). For example, imagine a single mother with limited education who is living in poverty and trying to gain enough income to provide for her children. If she is lucky, she may be able to obtain a minimum wage job, which will barely cover her rent and would not cover childcare. She cannot leave her children alone at home, and yet, if she stays home with them she cannot pay her rent. This type of double bind is a common experience for the poor. In fact, the poor may be facing many of these double binds all at once.

Over time, facing impossible dilemmas and double binds and the inevitable feeling of failure no matter what one does results in both actual experiences of powerlessness and perceived powerlessness (Goodman et al., 2007). It is easy to see how this could then lead to affective responses such as fear, hopelessness, anger, and shame

and how these responses can become internalized over time, leading to a lack of self-worth (Chen & Matthews, 2003; Gallo & Matthews, 2003; Moane, 2003). In this way, it is clear how the life conditions of poverty and resultant powerlessness can lead to mental health problems such as depression for even the most resilient among the poor (Monroe & Hadjiyannakis, 2002; Sapolsky, 2004).

### **Mental Health Outcomes Associated with Poverty**

According to data from National Institute of Mental Health (NIMH), poverty is detrimental to psychological well being. Low-income Americans are two to five times more likely to have a diagnosable mental disorder than those with the highest socioeconomic status (Bourdon, Rae, Narrow, Manderschild, & Regier, 1994, as cited in APA, 2007; Regier et al., 1993, as cited in APA, 2007). Studies show that the poor suffer disproportionately from depression (Siefert, Bowman, Heflin, Danziger, & Williams, 2000), posttraumatic stress (Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshal, 2001), substance abuse (James et al., 2003; Zilberman, Tavares, Blume, & Nady, 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999). In fact, all but three of the mental health diagnoses in Axes 1 and II of the DSM-IV have been found to be associated with lower SES (Sareen, Afifi, McMillan & Asmundson, 2011). And, unfortunately mental health disparities for low-income individuals appear to be increasing with time - mental health problems increased from 21% in 1998 to 43% in 2004 (Ganong et al., 2008). These mental health problems, while harmful in and of themselves, also serve as another barrier for the poor in seeking assistance for improving life circumstances such as public assistance, psychotherapy, or vocational training (Levy & O'Hara, 2010). Therefore, the mental health outcomes associated with poverty can

further entrap people in poverty, creating a vicious cycle.

### **Mental Health Treatment and the Poor**

Although many low-income men and women seek help to address their mental health concerns, the interventions provided are only sometimes helpful. The following sections describe the mental health field's response to the poor, historically and today.

**Historical responses to the poor.** For the past 50 years, mental health practitioners' interest in and attention to mental health treatment for the poor has waxed and waned (Smith, 2010). It has long been acknowledged and well documented in the field that poverty has negative physical and mental health effects, as described above. However, the dialogue around treatment of mental illness for the poor has shifted over time based on the attitudes and circumstances of various historical periods. In the 1950s and sixties, the predominant view was that the poor were not suitable for therapy because it was believed that they did not possess the necessary skills, a view that was assumed based on the fact that they tended to end treatment quickly (Graff, Kenig, & Radoff, 1971; Heitler, 1973). At that time, the poor were largely viewed negatively by therapists, who considered clients in poverty to be hostile and crude (Hollingshead & Redlich, 1958; Affleck & Garfield, 1961). This may explain why those in the field did not invest in exploring other reasons why the poor may have been ending treatment prematurely.

In the next decade, mental health problems in general became more widely recognized nationally, and in the 1970's the Community Mental Health Center (CMHC) movement began to bring more attention to the mental health needs of all Americans, including the poor (Smith, 2010). The opening of CMHC's coincided with a shift in the field regarding therapists' views of the poor. Lorion (1973) and Siassi and Messer (1976)

began writing about the possibility that therapist's negative views could in fact be contributing to the high attrition rates of poor clients and suggested that therapists use supervision to acknowledge their negative biases rather than looking only at the client when trying to explain problems with treatment. During the 1970s, therapists responded positively to these suggestions, and the predominant view evolved (Smith, 2010). The new belief was that when therapists had the awareness and the skills to work with the poor, there is no reason whatsoever that treatment should not be successful (Karon & VandenBos, 1977).

However, in the 1980's there was another shift, referred to by some as the counterrevolution (Albee, 1996). Mental health professionals at that time began to focus on genetics and biology as the source of mental distress, which took the focus off of cultural and social causes. This change coincided with a change in leadership of the U.S. as President Reagan's administration reduced funding for CMHCs (Smith, 2010). Between 1981 and 2000, only 18% of articles in major counseling journals examined social class, and if so, it was likely considered only as a demographic variable in the methods section (Liu et al., 2004). Those who did examine treatment with low income clients during this time found that not much had changed in terms of outcomes since the 1950s and 60s – the poor were still less likely than other groups to initiate treatment and more likely to stop treatment prematurely (e.g., Greeno, Anderson, Shear, & Mike, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

While the 1980's and 1990's marked a near absence of discourse on poverty and mental health in the field of psychology generally, some subgroups, including feminist and family systems practitioners and researchers, continued to explore the consequences



of poverty and encourage mental health practitioners to examine their own biases, acknowledge systemic oppression, and better serve the poor (Smith, 2010). Unfortunately however, even at the turn of the millennium, the mainstream psychological community continued not to pay poverty much attention, with little research being done on the most important topics related to poverty and mental health (Furnham, 2003; Lott, 2002; Saris & Johnston-Robledo, 2000; Sue & Lam, 2002).

Yet, during the 2000's another shift took place, with poverty becoming recognized once again as an important topic. This shift began in 2000, when the American Psychological Association (APA) began to recognize the glaring absence of attention to poverty in the field and responded by adopting a Resolution on Poverty and Socioeconomic Status, which acknowledged the detrimental effects of poverty on mental health and charged psychologists with addressing the needs of the poor, including conducting scholarship on poverty and classism, improving practitioner competence and training, and doing work for the poor in public policy (APA, 2000). Those in some subfields of psychology, such as counseling, had already begun doing some of this work, even if peripherally. For example, counseling psychology as a specialty made significant contributions to answering the APA's call when it began to consider social justice as a goal for practitioners and researchers, calling for its members to go beyond individual explanations for problems and individual solutions and to adopt a more systemic approach (Fouad et al., 2004; Sue, 2001).

**Current responses to the poor.** Building on the recent work of counseling and other applied fields in psychology, a small body of recent research exists on the topic of mental health practice with low-income clients. The following sections discuss this work,

specifically highlighting the proportion of the poor who seek mental health treatment, barriers to treatment, and treatment outcomes.

**Access.** It is well established that lower income populations have lower rates of mental health service use than those with middle or upper incomes (Angold et al., 2002; Edlund et al., 2002; Olfson, Marcus, Druss, Pincus & Weissman, 2003; Sturm & Sherbourne, 2000). In fact, one large-scale study focusing on low-income women found that of 1,893 participants with mental health problems, only ten percent sought mental health treatment of any kind (Nadeem et al., 2008). This is not surprising given that those in poverty face many barriers to treatment, and the effectiveness of mainstream approaches for this population is unclear. The next section describes some of the difficulties those in poverty face when seeking treatment for mental health problems.

**Barriers to treatment.** Poverty poses obstacles for getting help for those with mental health issues (McGrath, Keita, Strickland, & Russo, 1990, as cited in APA, 2007). In part, the lesser use of mental health services among the poor can be explained by lack of resources in lower income communities and the practical challenges that result – lack of finances, loss of pay from missing work, cost of not being insured, lack of transportation, inaccessible clinic locations, limited clinic hours, and lack of affordable child care (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Diamond & Factor, 1994; Greeno, Anderson, Shear, & Mike, 1999; Maynard, Ehreth, Cox, Peterson, & McGann, 1997). In addition, those with low incomes face so many daily difficulties that seeking treatment might seem like just one more burden given the extraordinary difficulties they are already facing (Hall, 2001; Kazdin, 2000; Owens et al., 2002; Verhulst & van der Ende, 1997). For example, Jesse, Dolbier and Blanchard (2008)

conducted a study of rural women in poverty and found that participants identified the need to manage acute stressors as more important than addressing ongoing mental health needs.

If those in poverty are able to overcome this first layer of practical barriers, they will likely have more to face, as those in poverty are less likely to be able to find providers willing to treat them at lower rates of reimbursement and are more likely to be asked to wait for first appointments (Lieberman, Adalist-Estrin, Erinle, & Sloan, 2006). Waiting for an appointment may be a major deterrent, as those who are asked to wait are more likely to withdraw from treatment (Barrett, Chua, & Thompson, 2007; Saporito, Barrett, McCarthy, Iacoviello, & Barber, 2003). In fact, a recent study shows that even those who are not necessarily in poverty have difficulty obtaining first appointments with psychiatrists given the many barriers to care in the current mental health system (Malowney, Keltz, Fischer, & Boyd, 2014). And, even if a client is seen quickly, many mental health treatment options require lengthy intake appointments, sometimes not even with the treating clinician, before treatment can begin (Lieberman et al., 2006). While this could be a deterrent for anyone, it may be especially disheartening for those in poverty who have overcome so much to get to that point.

In addition to practical barriers to access, there are also psychological barriers, such as perceived stigma. Corrigan et al. (2000) write that people with depression or mental illness are often portrayed in popular cultures as incompetent, crazy, and violent, but also responsible for causing their condition. Scholle, Hasket, Hanusa, Pincus, and Kupfer (2003) found that in a sample of depressed, economically disadvantaged women, 51 percent reported worrying about what their family and friends would think about their

depression, 40 percent were too embarrassed to discuss it, and 26 percent did not believe they could be helped by mental health professionals. In addition to stigma, those in poverty may experience other psychological barriers to seeking treatment, including negative attitudes and beliefs about treatment based on previous experience with providers in position of authority (Abrams, Dornig, & Curran, 2009; Dodson, 1998). As a result, they may be sensitive to any sign of disrespect, lack of empathy, or lack of understanding of the conditions of poverty he or she is dealing with (Abrams, Dornig, & Curran, 2009; Dodson, 1998).

Against the odds, some of those in poverty with mental health problems are able to overcome the innumerable practical and psychological barriers to treatment and begin therapy. The following section describes what happens when they do.

**Outcomes.** Findings on outcomes of psychotherapy with the poor are mixed, and somewhat difficult to interpret altogether. This is in part because the construct of poverty has been inconsistently defined (Falconnier, 2004, 2009; Levy & O'Hara, 2010). Socioeconomic status is typically evaluated by measuring income, education, occupation, or some combination (Falconnier, 2004). Due to this inconsistency in measurement, different investigators have found different results, and therefore findings in the literature are inconsistent. The most frequently used combination measure of SES is the Hollingshead Index of Social Position, which uses both education and occupation ratings to assign participants to one of five social classes ranging from wealthy/highly educated to unskilled laborers who have not completed high school (ISP; Hollingshead, 1971; Hollingshead & Redlich, 1958). Falconnier (2004) notes that findings from studies using this measure are more consistent than findings based on only one aspect of poverty (e.g.

education, not income or occupation or vice versa), which are more often mixed.

In addition to poverty being inconsistently defined, another difficulty in interpreting outcome studies with the poor is the varying definitions of “outcome.” For example, many studies use attrition rates (prematurely ending therapy) as a proxy for outcome, typically finding that as income decreases, attrition increases (e.g., Falconnier, 2009; Garfield, 1994; Wierzbicki & Pekarik, 1993). Particularly at earlier times in the history of the field, attrition as an outcome of therapy for the poor was widely known and consistently demonstrated. For example, Garfield (1986) reviewed a number of studies from the 1960s on therapy with low-income clients. On the whole, this body of evidence from that era suggests that low-income clients were likely to drop out of treatment prematurely. There is evidence from some studies that this trend continues today. Miranda et al. (2003) conducted a study of 267 low-income minority women with depression who were assigned to one of three conditions: medication, CBT, or community referral. They found that antidepressant medication and CBT significantly decreased depression, whereas a community referral did not. Still, they report that only 36% of those assigned to psychotherapy attended 6 or more sessions revealing that a vast majority of their sample did not continue with treatment. However, while findings on attrition rates among the poor are robust across many studies over the last 50 years, these studies offer no explanation for why this is the case. In addition, high attrition rates do not shed any light on what happens when the poor do remain in therapy. Therefore, it is necessary to turn our attention to outcomes other than attrition.

Unfortunately, there are only a small number of studies examining these outcomes, and they have found remarkably different results. One body of research

investigates the outcomes of mainstream psychotherapy practices for those in poverty. There are two sets of findings generated by these studies – the first finds that those with lower incomes have poorer outcomes in therapy, while another set of studies finds no relationship between income and therapeutic outcomes. While these divergent results are difficult to make sense of as a whole, they do shed some light on the many possible experiences of poor clients in therapy. Another body of research asks a different type of question – whether the poor can benefit positively from therapy that has been adapted specifically with their needs in mind. These studies find that when treatment is altered to meet the specific needs of the poor, therapy can be effective for this population.

Turning first to research on mainstream psychotherapy practices, Falconnier (2004, 2009) conducted a study examining the relationship between SES and improvement, as well as SES and attrition in therapy for those experiencing depression. In this study, 239 predominantly white adults with depression were classified using the Hollingshead Index of Social Position (ISP; Hollingshead, 1971) according to five social classes and were then randomly assigned to three treatment conditions: CBT, interpersonal therapy, or pharmacotherapy (Falconnier, 2009). The results showed that lower SES was associated with less improvement (gains in overall function and reductions in depressive symptomology) across all three treatments. Yet, contrary to previous findings, lower SES was not associated with attrition in her study. Falconnier (2009) interprets her findings to mean that mental health clinicians should be aware that empirically validated treatments may not be effective with low SES groups.

While Falconnier's findings reveal poorer outcomes for low-SES clients, other studies have found no relationship at all between income and treatment outcome. For

example, Rounsaville, Weissman, and Prusoff (1981) found no relationship between post-treatment symptoms and SES with the use of interpersonal therapy for treatment of depression. Later, Mynors-Wallis & Grath (1997) also failed to find a relationship between SES and treatment outcome when medication and problem-solving interventions were used to treat depression. In more recent years, McLeod, Johnston and Griffin (2000) found little difference between groups of white poor and non-poor clients in their perceptions of the effectiveness of time-limited psychotherapy. Similar to Falconnier (2009), Mcleod, Johnston, and Griffin (2000) also failed to find evidence of higher rates of attrition among the poor (a previously robust finding), further complicating the picture. Finally, Hamilton and Dobson (2002) reviewed the literature on predictors of cognitive therapy outcomes and found no relationship between occupation or education and treatment outcome. Thus, the findings on the effectiveness of mainstream psychotherapy practices for the poor as compared to the non-poor appear to be mixed.

Another body of research explores the impact of therapy approaches modified to address clients' poverty related stressors directly. This research does not compare low-income and middle-income clients; but instead investigates changes among poor clients before and after treatment that is tailored to their unique needs (e.g. Ammerman et al., 2005; Azocar, Miranda, & Dwyer, 1996; Grote et al., 2009; Miranda, et al., 2003).

For example, one simple modification to traditional treatment involves having the therapist directly acknowledge economic stressors in the context of traditional therapy. Falconnier and Elkin (2008) conducted a study exploring the extent to which this straightforward modification affected therapy outcomes with a sample of mostly white and female clients with depression, some of whom were middle income, and some who

were low-income. Their findings were that therapists' direct exploration of clients' economic stressors was significantly related to decreased depressive symptoms and increase Global Assessments of Functioning (GAF) regardless of treatment condition (CBT or interpersonal therapy) and regardless of income level. In other words, all clients, regardless of income level or treatment condition, benefited from exploring the effect of economic stressors on their mental health. This finding is important in light of that fact that many therapists avoid discussing economic stressors because of their own lack of training and/or discomfort with the material (Falconnier & Elkin, 2008; Parnell & Vanderkloot, 1994; Smith, 2009).

Others have explored the effects of more dramatic modifications. For example, Azocar, Miranda and Dwyer (1996) modified group cognitive behavioral therapy (CBT) to meet the special needs of poor clients. They found that some low-income minority women respond well to short-term, directive, problem-solving psychotherapy and are more amenable to psycho-educational approaches because they can think of the group as a "class" instead of as therapy, thereby reducing the stigma associated with it. They also note that group therapy is often preferred because of the social support it provides participants, which individual therapy is lacking, and may be especially important for those in poverty who are more likely to experience social isolation. In modifying CBT to better meet the needs of low-income women, the group therapists specifically ask the women what they believe the cause of their depression to be. Therapists also engage in self-disclosure about themselves and their background in initial sessions, and encourage the women to do the same, which allows a more personal orientation in group members' relationships. In addition, therapists engage with clients in multiple ways with clients,



acting as psychotherapist, case manager, translator, and advocate. Therapists also provide referral and consultation with other agencies and crisis management. In this way, therapists step outside what is typically expected of a CBT therapist in order to adapt treatment to meet the specific needs of low income minority women.

Miranda, Azocar and colleagues (2003) evaluated this modified CBT approach by measuring dropout rate and treatment outcome for 200 ethnically diverse low-income individuals, who were randomly assigned to traditional CBT or the modified CBT approach they developed. Those attending the modified treatment attended more sessions and were less likely to end treatment prematurely. Also, six months after treatment, those in the modified group reported less depressive symptomology and higher levels of social adjustment than those in the typical CBT group. However, Falconnier (2009) points out that even despite these more positive outcomes with the modified treatment, even the group receiving modified CBT did not receive as much benefit as middle class clients typically do in therapy.

In a similar approach to modifying treatment for poor clients, Ammerman et al. (2005) developed what is known as In-Home Cognitive Behavioral Therapy, which is an innovative approach designed to reach low income mothers with postpartum depression who would otherwise not receive consistent and effective mental health treatment because of lack of access to resources (Ammerman et. al., 2005). CBT is an empirically validated mental health treatment for depression and because it is delivered in the homes of the mothers, they are not required to obtain childcare and transportation to a mental health facility. Ammerman et al. (2005) found in one case study of a depressed mother living in public housing that a substantial reduction in depression was observed from pre

to post-treatment using this approach. Ammerman et al. (2007) conducted a larger study of the effects of In-Home CBT on 26 mothers with depression and found that depressive symptoms and levels of functional impairment were reduced in the sample.

Improvements were noted in areas of functioning such as coping with stress and use of interpersonal support.

Similarly, McKay and Gonzales (1996) and McKay et al. (2004) also modified a traditional treatment approach in order to address possible barriers to care for low income and minority women, in this case by developing a pre-therapy telephone engagement intervention and a combined-engagement intervention (telephone interview and first treatment interview). They found that the additional outreach prior to treatment did increase attendance at the first therapy appointment after referral (McKay & Gonzales, 1996; McKay et al., 2004).

Grote, Zuckoff, Swartz, Bledsoe, and Geibel (2007) attempted to overcome some of the barriers to treatment in an even more holistic way, attempting to address the barriers directly at multiple levels. In their study of treatment with poor and minority women with depression, they adapted the treatment by engaging clients in a process of identifying and problem solving these barriers, including practical (e.g. transportation, childcare, etc.), psychological (e.g. attitudes about mental health system based on previous experiences) and cultural (e.g. issues related to race or ethnicity and poverty) barriers. They did so by including elements of ethnographic interviewing, which facilitates empowerment by encouraging the client to a) be the expert on their own experience of depression, b) identify culturally relevant supports, and c) to express what they might want from treatment. The authors combined this Ethnographic Interviewing

approach with Motivational Interviewing, which addresses clients' ambivalence about treatment directly. Ethnographic and Motivational Interviewing strategies were combined in a pre-treatment intervention called an engagement interview, where clinician biases and assumptions about "healthy" behavior are suspended, and the clinician relinquishes the role of the expert, except to provide psycho-education about depression and treatment options. In addition, clinicians use open-ended questions, encourage the client to tell her own story, affirm the client's strengths, and accept ambivalence as a normal part of the treatment process, working with it directly and straightforwardly with respect for the clients' own choices and decisions. Additionally, the clinician pays attention to race, culture, and gender, being sure to broach these topics and ask several times about how they are interacting with treatment. The authors found that of the 25 women in their study who participated in the engagement interview, 24 (96%) attended an initial treatment session whereas only 36 percent of those in the standard treatment condition did so. In addition, 68% of those receiving the engagement interview vs. 7% in the standard condition completed a standard depression treatment (Grote, et al., 2007).

In a more recent study by the same research team, Grote et al., (2009) compared the effectiveness of two types of treatment, both modified and enhanced to overcome barriers to treatment for the poor – enhanced usual care and enhanced brief interpersonal psychotherapy. The study was conducted with 53 African-American and White pregnant women with depression who were living in poverty. The brief interpersonal psychotherapy group included an initial engagement session, eight therapy sessions, and bi-weekly or monthly sessions following the birth of their child for up to six months. The enhanced interpersonal psychotherapy approach included the elements described above –

addressing practical, psychological, and cultural barriers to care, the use of techniques from motivational interviewing, and the willingness of the clinician to act as an advocate for the clients' practical needs. Both groups' treatment was 'enhanced' with free transportation and childcare for appointments. Although both groups received this practical support, the brief interpersonal psychotherapy group participants showed significantly higher rates of treatment engagement, lower attrition, and greater reported symptom reduction and improvements in social functioning.

In addition to those described in these studies, other practical strategies used to overcome barriers to treatment with the poor which have been found to be effective in the literature are conducting therapy sessions over the phone (Simon et al., 2004); providing mental health care in primary care clinics in order to reduce stigma and improve convenience (Miranda, Azocar et al., 2003), and using appointment reminders by letter or phone (Shivack & Sullivan, 1989). It seems that when traditional therapy is supplemented with these additional supports and when poverty related stressors are taken into account as part of the treatment, outpatient therapy can have more positive outcomes on the poor.

Finally, although it is not an outcome study specifically, a recent study by Pugach and Goodman (under review) helps shed light on what effective therapy looks like from the perspective of poor clients themselves – in this case, low-income women. The qualitative study sought to explore low-income women's subjective experience of traditional outpatient psychotherapy, focusing specifically on what aspects of practice were most effective. They found that participants experience therapy as meaningful and effective when the therapist: 1) was aware of poverty-related stressors, 2) had personal or

professional experience with poverty, 3) demonstrated flexibility, 4) provided instrumental support, 5) emphasized building strengths, 6) listened without judgment, 7) attempted to share power, and 8) demonstrated authenticity. These results provide further evidence that for traditional therapy to be effective for those in poverty, modifications such as those identified by participants in this study are required.

The idea that mainstream approaches and treatment-as-usual alone may not work well for the poor is also echoed by feminist and social justice oriented scholars in psychology. Goodman, Smyth & Glenn (2010) posit that the mental health needs of those with low incomes are not met by the narrow framework of traditional outpatient psychotherapy, which locates the source of distress inside the person somehow – biologically, cognitively, or emotionally. Given the myriad chronic and acute stressors and other extreme difficulties faced by the poor, focusing mainly on intra-psyche issues or the internal experience of these stressors may be insufficient. For example, Simons, Gordon, Monroe & Thase (1995) found that those who have experienced severe and stressful life events but do not hold dysfunctional attitudes about those events do not benefit from CBT treatment. In this case, depression may be a reasonable response. Although this research was conducted with stressed but not necessarily poor clients, it is reasonable to hypothesize that the results may apply to those in poverty, who are undoubtedly under tremendous stress, and more so than other socioeconomic groups (e.g., Bausman & Goe, 2004; Belle et al., 2000; Cunradi et al., 2002; Greif, 2005; Tolman & Rosen, 2001).

In sum, those in poverty face higher rates of mental health difficulties, due in large part to the traumatic life events, chronic stress, stigma, social isolation, and

powerlessness associated with poverty. Yet, they also face many barriers to treatment and access treatment at lower rates than those from other socioeconomic groups. When the poor do seek treatment, many decades of previous research show that they tend to drop out of treatment more quickly, while more recent studies show that this may not always be the case, particularly when treatment approaches are modified to address poverty related stressors. A small number of studies have explored treatment outcomes beyond attrition, and those that do have found mixed results. While some studies find therapy with the poor to be ineffective, others find no correlation between SES and outcome at all. A handful of recent studies show that when interventions are modified in various ways to address poverty-related stressors both inside and outside the therapy session, therapists enable their clients to focus more fully on their psychological functioning, thereby increasing their ability to benefit from traditional psychotherapy (Grote et al., 2007; Levy & O'Hara, 2010; Miranda, Chung et al., 2003). Levy and O'Hara (2010) conducted an extensive review of the literature on therapy with low-income women, and found that the most effective approaches were those that addressed the practical, psychological, and cultural barriers to seeking mental health care for the poor. This is in line with suggestions from some scholars that traditional therapy misses the mark for the poor, who are facing tremendous external stressors that go unaddressed when the focus of therapy is entirely intrapsychic.

While this review of literature paints a picture of the extensive difficulties faced by the poor and the possible gaps between effective mental health treatment and the needs of the poor, little to no research has focused on how those involved – clients in poverty and the therapists working with them - actually experience psychotherapy. Some

have begun exploring the former (Balmforth, 2009; Chalifoux, 1996; Pugach & Goodman, under review; Ware, Tugenberg, & Dickey, 2004), but almost nothing is known about the latter. Psychologists are on the front lines of working with those in poverty who have mental health problems, and given the questions being raised about traditional therapy's usefulness for the poor and the mixed results on effectiveness, it is unclear how well equipped psychologists feel to deal with the challenges they face and how they experience their work. In line with the recent calls in the field for more attention to poverty (APA, 2007), a handful of theorists and researchers have gone beyond examining the effectiveness of specific types of therapies and have begun writing about the importance of what the therapist brings to the work. The following pages describe that body of work.

### **Psychologist's Attitudes, Social Class Privilege, and Training for Work with the Poor**

When considering the effectiveness of therapy for the poor, one must consider *who* is delivering the treatment and what their attitudes are toward the poor, in addition to the specific type of therapy being offered. Many factors affect psychologists' attitudes toward the poor, most of which can be grouped into two main categories: background and training. First, psychologists come from many varied backgrounds, including class backgrounds, and hold multiple intersecting identities, but all psychologists have some degree of class privilege based on their level of education and current career standing. Psychologists' own class identity and the level of class privilege they enjoy can impact attitudes about working with the poor, and these attitudes have a direct impact on the therapy. Second, psychologists' attitudes about the poor may be affected by their training

experience and whether it included attention to the experience of poverty.

The following pages describe literature on therapists' attitudes toward the poor clients they work with and the effect of those attitudes on the therapy. I also outline some of the challenges faced by therapists doing this work. Finally, I explore the influence of social class privilege and poverty-related training on therapists' attitudes about class and working with the poor.

**Attitudes about poverty.** Turning first to therapists' attitudes about the poor, it is important to understand that practitioner attitudes are inevitably influenced by larger societal attitudes about poverty. At certain moments in history, the U.S. has turned its attention to issues facing those in poverty. For example, Hurricane Katrina brought the issue of poverty into the spotlight. In a similar way, the recent economic recession in the U.S. brought many middle class Americans closer to the poverty line, and in 2012, protests held as part of the Occupy movement across the country drew attention to poverty and economic injustice nationally (NY Times, 2012). Although these events may signal a shift in the American consciousness regarding poverty, stigma against the poor and a general lack of understanding of the experience of poverty remain the norm (Smith, 2009). Therapists are not immune to such stigmatizing attitudes and lack of understanding, and this inevitably affects the treatment process, as detailed next.

Flanagan, Miller, and Davidson (2009) write about the stigma attached to mental illness even within mental health settings, which suggests that the beliefs, attitudes, and practices of mental health providers themselves may become obstacles to clients seeking help. Although their qualitative study explored the attitudes of therapists towards clients with mental health problems generally, not just low SES clients, there was evidence of



stigma against the poor in the data they present (Flanagan, Miller, & Davidson, 2009). For example, one mental health clinician described clients as having “difficulty with very simple things like job, working, going to school, supporting themselves, supporting their families” (Flanagan, Miller, & Davidson, 2009, p. 60). This comment and others described in the study, reveal some of the difficulty that therapists might have truly understanding the context of clients’ lives, as for those in poverty these are not ‘simple things.’ One participant reported,

The lives these people live are not the lives that we imagine and sometimes the stories they tell are so bizarre. It’s like when Freud decided that there was no such thing as incest, it could not be this common - these women must all be making it up. It’s like that. It requires a lot in order to make the space to really let the client unfold so that you can see where things are at” (Flanagan, Miller, & Davidson, 2009, p. 62).

This quote illustrates the difficulty of fully understanding the complexity of poor clients’ lives even when one is aware of the tendency to minimize or disbelieve the level of difficulty the client is experiencing. Indeed, as Katz (1995) points out, the non-poor rarely recognize the daily challenges that living in poverty creates.

Not fully understanding the challenges faced by one’s clients can have a powerful impact on the therapeutic relationship. Kearney (2003) provides a poignant example of how stigmatizing class-based assumptions and frames of reference enter the therapy room in sometimes subtle but important ways. For example, illustrating a bias that most people have cars, a middle class counselor might reflect back the words of a working class client but absentmindedly add the phrase “in the car.” If the working class client does not have

a car, he or she might feel embarrassed, and may feel ill equipped to challenge the counselor or correct the statement. The client may feel unseen, and shamed by the counselor, and the therapeutic relationship may be ruptured. Taking this one step further, that same middle class assumption that most people have reliable transportation such as a car could have even further detrimental impact if that counselor is trying to understand a client's difficulty making it to sessions. The counselor who assumes being late or missing sessions is therapeutic resistance and tries to process that with the working class client could be making a grave error - one that could keep that client from seeking further treatment for a mental health difficulty.

One reason that a therapist's attitudes and beliefs about clients have such a powerful impact on the experience of low-income clients is that the therapist is in a position of power. Practitioners in Flanagan and colleagues' (2009) study described the substantial effects of the power they hold over clients. One participant was quite straightforward, explaining,

If you're telling me that you want a certain medication and you'd rather have such and such, I might call you 'drug seeking'...If you get angry with me because I answer a phone call while you're in my office, during an appointment, I might say you have some kind of personality disorder...If you happen to think my treatment approach is not working and you let me know that, I might label you in some other way. So, basically, it's the power of the pen. The practitioner has the power to make these diagnoses. Once you put these diagnoses in someone's chart, they can follow them for their whole lives (p. 61).

This quote illustrates the enormity of the power that clinicians have over their

clients. If clinicians are holding stigmatizing attitudes about the poor as described earlier, and they hold this level of power over their poor clients, the likelihood of therapy being experienced by the poor as oppressive is high. On the other hand, it is heartening that this participant was aware of the importance of power in the therapeutic relationship, as this may not be the norm – those who belong to a powerful group often do not question the system that maintains them in that position (Kearney, 1996).

In one of few studies on how therapist power and classist attitudes affect the psychotherapy process, Balmforth (2009) explored qualitatively the psychotherapy process from the perspective of six clients who identified as working class and who were working with middle class counselors. Findings revealed that participants felt misunderstood by or distanced from their therapists; that they felt uncomfortable and powerless because of perceived class differences between themselves and the therapist; and that the unequal balance of power between therapist and client caused great psychological disconnection between them. Participants talked about how therapists lacked understanding of their different life experiences, different access to opportunities, and restricted life choices based on a lack of resources. In addition, participants felt that the responsibility for voicing differences in class lay with the therapist, as it was too risky to raise this issue themselves. Balmforth's (2009) findings also highlight that class is communicated in so many ways that a counselor or client may absorb the message of a different class indirectly – based on the part of town the office is located in, possessions on display in the counselor's office, the counselor's clothing, etc.

It is noteworthy that Balmforth's (2009) study was conducted with clients who themselves were also therapists or therapists in training, which indicates that while they

self-identified as working class, they had some class privilege at the time of the study based on their current career. Yet, they still reported experiencing disconnections between themselves and their middle class therapists based on class difference. While these findings suggest that class difference may play an important role in the counseling relationship, the limitations of the study are important to note: the researcher used a small sample of only six participants, which is less than ideal even for a qualitative study and certainly does not allow for generalizability; all participants were White; and the study was conducted in Britain, where norms around class are different from those in the U.S. Still, Balmorth's (2009) study provides some insight into how class difference and provider attitudes can affect the therapeutic process.

Pugach and Goodman (under review) conducted a similar qualitative study with fewer methodological limitations – their study was conducted with a sample of ten participants, all of whom were mothers living in chronic poverty. They found similar results with regard to the influence of the therapist's attention to power in the therapeutic relationship. For example, participants in their study emphasized the importance of therapists' listening deeply and without judgment and willingness to share power with them (rather than wielding power over them) when handling issues of expertise, decision-making, and the use of psychological or medical jargon. One of their participants noted that as a result of her class location, she sometimes felt devalued in the therapeutic relationship, as though the therapist was taking the role of the expert. She said,

Not being taken seriously in general because of education or financial reasons

and um, and so you're always like, there's always just this kind of like tension, like, "No we're gonna do this my way, I'm the therapist, I know." But you're you and you know yourself. (p. 21).

Participants in the study also noted that therapist's use of some degree of self-disclosure was meaningful and helped to "level the playing field" with regard to power, as well as reducing clients' sense of stigma and isolation. Finally, participants noted how useful and meaningful it was when therapists were able to convey that they truly "got" both the intrapsychic and practical hardships of living in poverty

Although there are few empirical findings studies like Balmforth's (2009) and Pugach and Goodman's (under review), some psychologists have explored their own experience in the field in order to identify problematic attitudes that arise when conducting therapy with the poor. For example, Smith (2009) outlined four distinct attitudinal barriers to class competence that she discovered as a psychologist working with low-income families. The first attitudinal barrier was the belief that the poor need practical instead of emotional or psychological help. Although the poor often do need practical and instrumental support in addition to what is offered by traditional therapy, this does not imply that the poor are incapable of psychological change or unable to benefit from emotional support. The second barrier was the belief that the interventions offered by psychologists are diminished in significance when working with the poor. That is, even when therapy is helpful to clients in poverty, they still need to leave the office and face a life of difficulty which is likely incomprehensible and overwhelming to the psychologist. The intensity of real challenges faced by those in poverty are often untouched by the psychologist from his or her office, which can leave him or her feeling

unproductive, overwhelmed, and disoriented, even if an emotional concern has been successfully addressed in the therapy (Smith, 2009). Smith (2009) noted that these feelings are the psychologists' to work through, and should not be projected onto the client in poverty. The third attitudinal barrier was that working in a poor community takes away from the psychologist the comfort of not knowing how poor people live (Smith, 2009). The comfortable distance that most middle and upper class individuals maintain from the poor allows them to feel good about their own lives and resources without the nagging concern that something isn't fair about the way our society is structured and the way some people are forced to live. Psychologists working with those in poverty are confronted with that discomfort, and this likely brings up feelings of guilt, confusion, and overwhelm. Smith (2009) noted that this effect on the psychologist is not the fault of those in poverty, and should be regarded by the psychologist as a personal reaction to work through, rather than a reason to blame or distance from poor clients. Finally, the fourth attitudinal barrier was the belief that because conventional psychological services are neither familiar to nor widely accepted in the cultures of many poor communities, even the poor who could benefit from treatment will not likely seek it out (Smith, 2009). While it may be true that "the culture of the psychologist's office is the culture of whiteness and class privilege" (Javier & Herron, 2002, p. 88), that does not mean that the poor cannot be helped. It just may be that the psychologist needs to step outside of his or her office, or some of the more comfortable and conventional boundaries of therapy, in order to be helpful.

J. Smith (2000), a social worker who works with low-income clients, also discussed some of the difficulties that arise while working with the poor based on her

own experience, many of which are closely related to the attitudinal barriers outlined by Smith (2009). Similar to Smith (2009), J. Smith (2000) pointed out that therapists are likely to feel horrified by the unfair circumstances of their clients' lives and therefore guilty about their own life circumstances, making it more difficult to maintain a safe psychological distance from the realities of poverty. Part of this lack of comfort comes from knowing more about the intimate details of the lives of those in poverty. This may involve therapists being made uncomfortable by having to listen to illegal acts the client may be committing to ensure his or her own survival (J. Smith, 2000). Also, the therapist may have difficulty communicating across the experiential distance between he or she and the client, finding the right words, and understanding fully what the client is trying to communicate (J. Smith, 2000). This also echoes the findings of Balmforth's (2009) study that the therapist's communication could include class-based language or assumptions. The stress of constantly monitoring one's communication in this way could cause the therapist to develop negative attitudes toward working with the poor. In addition, J. Smith (2000) noted how frustrating it can be for the therapist that clients in poverty may be distrustful of the therapist or of therapy itself.

Finally, J. Smith (2000) discussed how therapists working with the poor may have difficulty distinguishing intrapsychic issues from contextual ones, which can be particularly challenging. She wrote, for example,

Did a woman fail to come to an appointment because she lacked bus fare, or is that her way of saying that you said something during the preceding session that she perceived as critical? Or maybe her boyfriend was so high that she didn't trust him alone with her children. Or maybe she was simply scared of something she

was feeling. The circumstances of people's lives impinge so much that it is a constant challenge to insist on space for the intrapsychic, to honor people's experience while still offering an alternative perspective. While one must do this with all clients, the possibility of behaving insensitively is greater here and, conversely, more inhibiting. (J. Smith, 2000, p. 88).

Jackson (2000), another writer of a firsthand account of doing therapy with the poor, discussed the same difficulty, describing it as, "the dilemma of tackling the oppression versus the depression" (p. 243). She writes, "the challenge is how to render immediate aid while supporting an understanding of the systemic factors that target members of marginalized communities" (p. 243). In fact, advocates of multicultural and class competence have stressed the importance of clarifying the internal and external aspects of clients' presenting problems, and where the two overlap (Hays, 2009), but this is not an easy or straightforward task, and it may require the therapist to rethink basic assumptions about fairness and personal responsibility. The process of making sense of such quandaries and engaging fully with the experiences Smith (2009), J. Smith (2000), and Jackson (2005) described are likely to cause the therapist great discomfort in his or her role.

**Social class privilege.** Another contributing factor to the classist attitudes described above is the social class privilege experienced by psychologists. Privilege is defined as "a special right, benefit, or advantage given to a person, not from work or merit, but by reason of race, social position, religion or gender" (McIntosh, 1995, p. 76). Privilege is usually unconscious, invisible to the person who has it, and exercised unknowingly (Liu, Picket, and Ivey, 2007). Social class privilege, then, refers to those



advantages that a person experiences because of his or her class.

Counselor and client are already in positions of unequal power, with the client often feeling vulnerable, and the counselor feeling in control and in his or her own territory (Balmforth, 2009). This power dynamic is then exaggerated when the counselor is from a more privileged social group, such as being white, male, heterosexual, nondisabled, and/or in a more privileged social class. Even therapists who come from lower social class groups originally are likely no longer living with the day-to-day realities of poverty, because they have succeeded in achieving upward mobility, they hold social class privilege and, moreover, are likely to endorse middle class value systems (Nelson, Englar-Carlson, Tierney, & Hau, 2006).

Psychologists who endorse middle class values such as upward mobility may then see clients in poverty as somehow failing to meet the standards they have set (and met) for themselves and may feel frustrated with clients. Liu, Pickett and Ivey (2007) suggest that counselors should be aware of their upward mobility bias, which assumes that “individuals are constantly interested in upward social mobility, achievement, and success” (p. 197). Counselors could then label those who are not subscribing to that bias as lazy or unmotivated (Liu, Pickett, and Ivey, 2007). On the other hand, idealizing those who are poor is also a risk of having social class privilege. That is, those who are distant from the experience of poverty may have an idealistic view of the life of the poor, a view in which low-income clients are noble victims (Smith, 2005).

**Poverty-related training.** In addition to psychologists’ social class identity and level of privilege, another factor that likely has an effect on attitudes toward treating the poor is the level of training on poverty that the therapist has received. Although therapists

sometimes undergo such training, Balmforth (2009) speculates that it is typically included as a very small part of what is known as multicultural competence training. Rukert (2007) conducted a qualitative phenomenological study of views of the poor among ten doctoral level clinical psychology trainees, exploring among other topics how their doctoral training addressed poverty and social class. Rukert (2007) found that participants reported that although poverty and social class were sometimes covered informally during field training, they were rarely addressed specifically and directly in their academic coursework.

Scholars have pointed to a number of key dimensions of training they believe necessary to ensure effective treatment with low-income clients. First, Liu, Pickett, and Ivey (2007) highlight the importance of therapists becoming aware of their own biases and assumptions around social class in addition to race, ethnicity and other groups. As Balmforth (2009) writes,

There is a risk that any difference between counselor and client which carries a legacy of power imbalance and oppression, whether class, race, gender, disability or sexual orientation, may be carried into the counseling room in a destructive form” (p. 384).

The only way to avoid such destruction is for therapists to explore directly and extensively their own attitudes and behaviors that may serve to perpetuate classism (Liu and Pope-Davis, 2003).

In addition to conducting self-examination, Smith (2009) suggests the need for therapists and therapists-in-training to supplement their own knowledge of poverty, which may mean stepping outside the bounds of traditional psychological theory and

literature to understand more about its history, context, and implications. Likewise, Lott (2002) writes that existing psychological theory highlights perspectives that are not always relevant for clients in poverty. She writes, “psychological theories are pre-occupied with people who are like those who construct theories, that is, those in the middle class (and primarily European Americans) (p. 101). Therefore, psychologists must go beyond even the knowledge base typically provided to them in counselor education and training.

Third, Smith (2009) notes the importance of ongoing supervision to deal with the feelings that arise when working with poor clients. Neil Altman (1995), one of the few psychologists to write about the experience of working with low-income clients, describes the experience as entering the “unfamiliar realm of trauma” (p. 1). Psychologists may be unprepared for the level of trauma, both chronic and acute, faced by the poor clients they are working with. Therefore, part of delivering class competent care to the poor means seeking support, actively processing one’s own reactions, and engaging directly with the overwhelm that may result.

Fourth, Smith (2009) emphasizes the importance of using a social justice framework in clinical supervision of therapists working with the poor. This may be the best way to support a supervisee or trainee who is witnessing first hand the effects of social injustice. She emphasizes the importance of encouraging trainees to see clients’ personal problems as political, rather than considering contextual and political issues to be a digression from clinical work. Finally, in both supervision and in treatment of clients, she advocates flexibility with regard to treatment approach (Smith, 2009). Effective work with clients in poverty may require the therapist to step outside of his or

her tightly defined role or theoretical orientation to counseling, and this flexibility is a must in order to deliver class competent treatment. I return to these elements of training in a section below on class competence.

In sum, there is a high likelihood that psychologists hold attitudes toward working with the poor clients that may interfere with treatment, such as an unquestioning valuing of upward mobility, blaming the poor for their circumstances, idealizing the poor, holding stigmatizing beliefs about the poor, and failing to recognize one's power in the therapeutic relationship with the poor. Psychologists' own class identity and class privilege, as well as lack of training about poverty may contribute to these attitudes.

Despite the importance of these findings, however, the field still lacks systematic research on how psychologists themselves think about therapy with the poor. Among therapists, the perspective of psychologists seems particularly important to consider: Because they receive extensive doctoral level training, there may be a presumption in the field that they are well- prepared to work effectively with the poor. Yet, this assumption has not been tested. Knowing more about the experiences of psychologists doing this work can help guide our thinking about how better to meet the needs of this underserved population. The current proposed study therefore aims to explore psychologists' experiences of providing psychotherapy with the poor. The next section articulates the conceptual basis of the interview questions I have developed, drawing on an ecological heuristic; a multicultural/class competence framework; a feminist perspective on how psychologists think about and act on intrapsychic versus contextual sources of distress; and a feminist perspective on how power is negotiated in the therapeutic relationship.

### **Current Study: Conceptual Basis**

**Ecological model.** This study employed developmental psychologist Uri Bronfenbrenner's model to consider the multiple and interacting variables that contribute to psychologists' experiences of conducting therapy with low-income clients. Bronfenbrenner (1979, 1986) proposed six levels of environmental contexts influencing development – the individual system, micro-system, meso-system, exo-system, and chrono-system. It is important to note, however, that because his framework was geared towards understanding the development of children, some of the contextual levels he proposed do not apply directly to the purposes of the current study. Therefore, I am focusing on three of the six levels he proposed – the individual, micro, and exo system levels – and I am applying them only to the context of the psychologist's work, rather than his or her entire life. According to Bronfenbrenner (1979, 1986), the *individual-system* represents one's internal biological and psychological makeup. However, in the context of the current study, the individual level represents the psychologists' own personal and professional attributes needed to do the work. The *micro-system* represents interactions between an individual and those people in his or her immediate contexts; in this case, that would mean the psychologist's interactions with her or his clients, and in the context of therapy, how the psychologist navigates the interpersonal challenges associated with that relationship by adapting existing or creating new practices – such as conceptualizing the clients' difficulties, addressing power in the relationship, and setting boundaries. Finally, the *exo-system*, according to Bronfenbrenner, represents the impact on the individual's immediate context and experience of larger social settings and structures. He used this level to understand situations like the impact of a parent's loss of

a job, for instance, on the home life of a child. In the present study's context, the *exo-system* represents the impact on the individual of larger social settings and structures; in this case, that would mean agency and social service level factors (e.g. size of large caseloads, available resources, policies, limitations on psychologist freedom to practice as he or she wishes, etc.) that hinder or facilitate psychologists' work with low-income clients and the strategies psychologists use to navigate obstacles.

Also, this model is sufficiently flexible that it did not impose expectations on the study, but instead offered a framework for considering the multiple influences on the psychologist working with clients in poverty. For example, at the *individual-system* level I asked about how the psychologists' own class background, and experience of his or her skills, knowledge, and attitudes related to working with clients in poverty affect the work. At the *micro-system* level I asked about psychologist's interactions with his or her clients in poverty with questions such as, "How do you think about the clients' mental health problems in relation to their poverty and external circumstances?" and "How does the poverty of the client influence the power dynamics between you and your client?". At the *exo-system* level I asked about structural factors affecting the psychologist, including for example, "To what extent do you feel supported in your workplace to work with low-income clients?" and "To what extent do community resources available to your client impact your work?". Please see Figure 1 for a visual representation of this ecological model.

**Cultural and class competence models.** For decades, cultural competence has been discussed as a vital issue facing the profession of psychology (APA, 1993; Constantine & Ladany, 2001; D.W. Sue, 2001). The driving force behind cultural

competence is the fundamental ethical principle for psychologists to “do no harm” or nonmaleficence (APA, 2002; Koocher & Kieth-Spiegel, 1998). In order to do no harm, interventions must be tailored to clients in ways that are respectful of and attentive to every aspect of their humanity and identity, including race, ethnicity, religion, gender, sexual orientation, ability status, age, and social class. Therefore, cultural competence is a vital aspect of all aspects of a psychologist’s work, including doing therapy. Next, I describe a model of cultural competence and how it can be used to frame potentially important elements of class competence, a term that has been used in the literature (e.g. Liu, Corkery, & Thome, 2010), but does not seem to be consistently defined.

D.W. Sue (2001) has described cultural competencies as existing along a three-part continuum of a) beliefs and attitudes b) knowledge, and c) skills. Competency regarding beliefs and attitudes involves acknowledging and confronting one’s own biases and stereotypes about marginalized groups, acknowledging and appreciating the diversity of clients psychologists work with, and developing a positive orientation toward multiculturalism. Competency regarding knowledge requires counselors to understand their own worldviews and develop specific knowledge of the cultural groups with which they work. Finally, competency regarding skills involves counselors acquiring specific skills such as intervention techniques and strategies needed to work with oppressed groups (D.W. Sue, 2001). Although there is some debate as to whether the three-domain model accounts for every component of multicultural competence (e.g. Sadowsky, 1996; Vinson & Neimeyer, 2000), most in the field agree that it is conceptually useful. Similarly, a conceptualization of class competence should take into account the domains of attitudes, knowledge, and skills.

Building on this model, Vera and Speight (2003) outline a three-tiered system for working toward cultural competence, which can also be used to think about class competence. The first tier involves psychologists increasing their awareness of their own values and biases. Regarding class competence specifically, this would mean psychologists exploring their own classist attitudinal barriers (as outlined by Smith, 2009) and assumptions and biases about those in poverty. The second tier requires psychologists to attempt to understand the worldview of their clients in a manner that aims to withhold judgments about areas of difference between themselves and clients. For class competence, psychologists would attempt to understand the client's context fully before passing judgment on his or her experiences or decisions, and would be sure not to rely only on his or her own frames of reference when attempting to understand the client's worldview and situation. The third and final tier involves using intervention techniques that are salient for the client. For class competence, this may mean acknowledging and addressing the systemic factors (e.g. negative cultural norms and beliefs about the poor, lack of access to basic resources, bureaucratic social systems with which the client must interact to get basic needs met, etc.) at play in clients' lives when implementing interventions, rather than looking only at the client's intrapsychic concerns. It may also mean adapting interventions to make them more accessible or salient for the client (for examples, see e.g. Ammerman et al., 2005; Azocar, Miranda, & Dwyer, 1996; Grote et al., 2009; Miranda, et al., 2003). By addressing these three tiers, psychologists can move in the direction of cultural and class competence respectively.

I used the tripartite model of cultural/class competence (attitudes/knowledge/skills) to question psychologists about their experiences in



conducting therapy with low-income clients. For example, in terms of exploring one's own attitudes and those of the client, I asked questions like, "What kinds of opportunities have you had to explore your own attitudes/beliefs about poverty?" and "What did you discover in that exploration?". Regarding knowledge of the client's life experiences, I asked questions like, "What do you think is important to know about working with clients in poverty?", "Do you feel you have enough knowledge of poverty?" and "To the extent that you feel you have knowledge of poverty, how did you find out about it?". And in terms of specific skills and strategies for addressing the group's need, I asked questions such as, "How do you put this knowledge into practice?" and "How are the skills needed to work with clients in poverty different from skills you need to work with other clients?". Importantly, this study did not aim to assess participants' level of class competence; instead it aimed to understand participants' experiences and perceptions with a potential model of class competence in mind.

**How psychologists understand and respond to the client's pain: External versus internal factors.** Typically, psychologists are trained to promote change by focusing on the individual client as the agent of change. For example, in psychodynamic therapy, the therapist explore the roots of distress in the clients early experiences and difficult relationships (e.g., St. Clair & Wigren, 2004) and in cognitive behavioral therapy (CBT), the therapist explores what are seen as problematic thoughts in the client which then shape their behavior in unhealthy ways (e.g. Beck, 1995). However, because clients in poverty are faced with many problems that are external to their own psychology, and largely out of their control, some may experience these approaches as frustrating, irrelevant, and/or disempowering. And, if the client does not find the therapy helpful, he

or she may blame him or herself for it, adding insult to injury. Smyth, Goodman, and Glenn (2006) write about how those who are poor are often treated by clinicians who assume that with the right medication or psychotherapy, their lives will significantly improve. When this does not happen, those in poverty may, “blame themselves for their suffering, and are taught, once again, to feel ashamed of their situations and emotional distress” (p. 492).

In response to this, some have advocated an approach to treatment that emphasizes external oppression as a source of distress in addition to intrapsychic issues. For example feminist therapy encourages therapists to look outside the individual for sources of distress (Goodman et al., 2004). Although traditionally trained clinicians may look at immediate external stressors in a client’s life, feminist therapists expand their lens to examine oppressive social, political, and historical factors as well (e.g. Brown, 2009; Evans, Kincase, Marbely & Seem, 2005).

Examining these factors and discussing them as sources of distress may help the client to better understand the causes of his or her pain, to feel more understood, and perhaps to address directly the sources of the distress. Regarding the latter point, if the therapist sees the client’s problems as stemming from systemic factors, the therapist may be compelled to step outside the traditional therapist role and attempt to address these factors with or for the client, therefore becoming an advocate for the client in addition to a therapist. This may mean making phone-calls on behalf of the client to address a systemic issue such as unfair policies in subsidized housing or public assistance programs. In fact, some have suggested that helping clients interact more effectively with social systems and addressing the environment when problems stem from environmental

stressors is a key aspect of cultural (or class) competence in therapy (Hays, 2009; Smith, 2009).

The present study explored this issue with psychologists' themselves, inquiring as to whether they attend to these broad external stressors (whether or not they take a feminist theoretical approach in their work) either within the therapy session by helping the client see external sources for their problems or outside the session as an advocate for the client attempting to address those external sources directly. In instances when participants reported attending to these external stressors, I went on to explore with participants what that looks like, what tensions arise, and how the psychologist experiences the process. I did so through questions such as, "How do you think about the clients' mental health problems in relation to their poverty and external circumstances?", "Do you work directly with clients' external circumstances related to poverty (i.e. problems with unstable housing and employment, lack of access to resources, etc.)?", and, "How do you integrate the clients' external poverty related stressors and their intrapsychic issues in your conceptualization?"

**Negotiating power and boundaries in the therapeutic relationship.** While power is always a part of the therapeutic relationship, power dynamics may become even more salient when working with clients in poverty. Clients in poverty experience powerlessness – both real and perceived – as a constant in their lives, shaping their views of themselves and the world around them (Goodman et al., 2007; Hagglund & Ahlstrom, 2007). Given this, the poor may come to therapy highly sensitized to how power will be addressed there. At the same time, the role of the psychologist confers upon him or her a great deal of power – the power to define health and disease, the power to label both

observable and nonobservable phenomena, the power to assess reality and its limits, and the power to make treatment decisions (Heller, 1985). One dimension of the power held by the psychologist that may be particularly important for work with the poor is how the psychologist shapes the nature of the therapeutic relationship. As above, feminist theory sheds light on this dimension of therapy.

It is widely acknowledged that the traditional therapeutic relationship and mainstream approaches to therapy prescribe a hierarchical relationship between therapist and client, and this has been discussed at length by feminist therapy theorists (e.g., Balmforth, 2009; Heller, 1985; Miller & Stiver, 1997). Brown (2009) discusses the “expert” position of the therapist, wherein he or she possesses all of the knowledge of the causes of emotional distress and the change process. In addition, Balmforth (2009) notes that the therapist is on his or her own home turf or territory in the therapy office, where he or she knows before the client does what the structure and format of therapy will be. On the contrary, the client may feel very much out of his or her own element, arriving at therapy with a sense of vulnerability and feeling out of control of one or more dimensions of his or her life.

For some clients in poverty, there may be some relief found in the structure of therapy and there may be in fact a desire to turn over some power to the therapist. Heller (1985) notes that this desire could be informed by cultural or spiritual beliefs about the role of a healer. Or, the client could simply be looking to give up the burden of having to be responsible for so much. But, for other poor clients, surrendering power in the therapeutic relationship may be a reminder or a re-living of previous disempowering experiences with “helpers” and gatekeepers to resources such as social service workers

who tell them how to live their lives in order to gain access to a job, housing, public assistance, etc. (Abrams, Dornig, & Curran, 2009). These clients may hope that therapy will be one place where they have a sense of agency and control. For example, in a study of ethnic minority women in therapy, most of whom were impoverished, Ward (2007) found that participants who were actively involved in decision-making in their treatment were more treatment compliant and had better clinical outcomes.

In negotiating power in the therapeutic relationship, the psychologist must be attentive to the process of setting boundaries. Most traditional approaches to therapy call for fairly strict boundaries, with the therapist playing the role of the emotionally neutral, non self-disclosing helper (Brown, 2009). This is rooted in the psychoanalytic notion that the therapist should be a 'blank screen' for the client to project his or her own emotion-laden responses and self-disclosures onto, while the therapist remains 'objective' (Wachtel, 1993). In addition to limiting therapist self-disclosure, traditional therapy boundaries exist around place (e.g. meeting only in the therapy office), time (e.g. the traditional 50-minute hour), and the role of the therapist (e.g. no dual relationships).

Many have critiqued this understanding of boundaries, particularly feminist therapy theorists (e.g. Jordan, 2000; J. Smith, 2000). They point out that this strict enforcement of boundaries defined by the therapist could communicate to the client that he or she is not empowered in the relationship. This is especially difficult for poor clients who are already likely to be feeling disempowered in their lives. With traditional boundaries, the client is asked to make him or herself vulnerable, exposing him or herself to the therapist as much as possible, without any mutuality or reciprocity (Jordan, 2000).

Therefore, feminist therapy theorists posit that more flexible and mutually agreed upon boundaries may be more effective.

This flexibility in boundaries may mean that therapists use more self-disclosure in the therapy relationship, but it also may mean being more flexible with other boundaries. For example, therapists might need to negotiate time boundaries, such as the length of sessions (50 minutes may not be sufficient for someone in constant crisis) and the scheduling of sessions because those in poverty often have hectic schedules, little control over timing of events in their lives, and unreliable transportation.

Therapists may also need to be flexible regarding role boundaries, meaning that the therapist may be required to step outside the traditional therapist role in order to become an advocate for a low-income client, as described in the above section on how therapists handle external sources of distress. For example, if the client's housing is unstable and in jeopardy, the therapist may decide to call the housing authority on behalf of the client or accompany the client to an appointment related to the situation. In this situation, the therapist must decide when and how to be involved, to what extent, and how his or her advocacy involvement fits with the rest of treatment. There is little to no guidance about this in either traditional counseling training programs or in the counseling theories that psychologists are trained to use, so negotiating these boundaries can be incredibly challenging.

Finally, psychologists may need to negotiate physical boundaries, such as where to meet. Some therapists may do home visits, for example. However, some situations may call for even more creative solutions, which stretch boundaries even further. J. Smith (2000) shares a story about a client who calls her on a cold winter night when her

apartment has been sprayed for cockroaches. They typically meet in the client's home for sessions, but in this case the client asks her to meet for a session in a parking lot in her car. While traditional frameworks for therapy would find this request far outside the usual boundaries, Smith decides to agree and the session turns out to be an important one. She describes the decision-making process this way:

It reminds me of a poster I once saw of a frog whose legs become awkwardly tangled as he tried to inch along the bottom of a leaf without falling off. I'm the frog: the more alienated the person I am working with, the more I find myself bending in ways which – at the least – trouble my sense of form, and typically make me look foolish. While most therapy with poor women goes on in my office and uses conventional methods, the work pushes for accommodations (J. Smith, 2000, p. 73).

These types of accommodations, though not often discussed in the literature on treatment for the poor, may in fact be necessary. Because so many of the poor enter therapy already feeling unheard, disempowered, and put under a microscope in order to get the help they need, they are surely especially attuned to the process of boundary setting in therapy. While flexible boundaries, including stepping out of the traditional therapist role and providing advocacy, may be important for work with the poor, and while some therapists have written about the need for such accommodations, there is little to no writing about how therapists actually manage the process of setting and negotiating these boundaries when working with low-income clients. The current study examined the process of setting boundaries with disempowered clients in poverty from the perspective of the psychologist through questions such as, “How are boundaries different when

working with low-income clients than with other populations?” and “How are they different when/if you are addressing external circumstances or stepping out of traditional counselor role?”

In sum, the present study explored psychologists’ experience of conducting therapy with low-income clients using several different overlapping lenses. First, psychologists’ experiences were examined within an ecological framework that acknowledges the multiple systemic factors affecting psychologists, at the individual, micro, and exo, levels. Second, borrowing from multicultural competence theories, this study explored the psychologists’ experiences of the work from the perspective of the psychologist’s skills, attitudes, and knowledge regarding working with clients in poverty. Third, the study examined the extent to which psychologists understand their work from an intrapsychic versus an external contextual perspective and how that affects what they do; And finally, drawing from feminist therapy theory, questions addressed issues of power in the therapeutic relationship, focusing especially on how psychologists navigate boundaries around self-disclosure, time, place and role.

### **Summary**

As poverty in the U.S. continues to affect millions of people (U.S. Census Bureau, 2014), psychologists must increase attention to mental health treatment for the poor. The insidious effects of poverty on mental health are well documented (e.g., Miranda & Green, 1999; Siefert et al., 2000; Vest et al., 2002; Vogel & Marshall, 2001; Ziberman et al., 2003). While some approaches to therapy tailored specifically for low-income clients have been shown to be effective (e.g. Ammerman et al., 2005; Azocar, Miranda, & Dwyer, 1996; Grote et al., 2009; Miranda, et al., 2003), other studies on treatment



outcomes for the poor show mixed results (e.g. Falconnier, 2009; Garfield, 1994; Mynors-Wallis & Grath, 1997; Rounsaville, Weissman, & Prusoff, 1981). Some theorists have posited that this is due to a lack of class competence among therapists working with the poor, who may hold attitudes toward poor clients that interfere with treatment. Therapists' own class identity and class privilege, as well as lack of training in class competence, may contribute to these attitudes.

While a few scholars have theorized about this, the field is lacking qualitative studies that provide accounts from therapists themselves who are conducting therapy with the poor. We know very little about the process of conducting therapy with the poor; how contextual factors affect that process at all levels of the ecological model; how psychologists integrate principles of class competence into their work; how they think understand and address external sources of distress; and how they deal with power in the therapeutic relationship.

The current study aimed to fill this gap by exploring psychologists' experiences of providing psychotherapy with the poor. The study examined the work of psychologists through the lens of an ecological model as well as from both a multicultural competence theoretical framework and a feminist theoretical framework with attention to power. Specifically, it used a qualitative descriptive methodology to explore the phenomenon of outpatient psychotherapy with low-income clients as it is experienced by psychologists.

By asking psychologists about aspects of their experiences of class competence and working with clients' poverty related stressors at each level of the ecological model, this study aimed to provide a greater understanding of the many possible factors affecting psychologists' experience of working with low-income individuals, as well as what helps

and what hinders the work. Once identified, these factors may inform future qualitative and quantitative studies. Findings from this study may also be helpful in explaining some of the previously found mixed results on treatment outcomes with the poor by shedding light on the process from the psychologists' perspective, perhaps illuminating what difficulties are inherent in treatment as usual for the poor. Knowledge gleaned may also help lay the groundwork for the development of subsequent therapeutic interventions that can more effectively address the needs of poor clients and improve class competence. Indeed, those looking to develop trainings to improve class competence for psychologists and/or psychologists in training would benefit from a greater understanding of the experience of doing therapy with the poor. Finally, agencies, funders, and policy makers wishing to improve outcomes for the poor may benefit from the rich experiences of psychologists working day to day with the poor. Ultimately, knowledge gained has important implications for potential changes in training, practice, and policy in order to improve treatment for the poor and therefore possibly reduce health disparities.

## Chapter Three: Methodology

### Methodology: Qualitative Description

The questions posed in this study were most appropriately answered using qualitative description. Qualitative description creates “a comprehensive summary of events in everyday terms of those events” (Sandelowski, 2000). It attempts to answer the “who, what, and where events of experiences, or their basic nature or shape” (Sandelowski, 2000, p. 338). Unlike other qualitative approaches, such as phenomenology or grounded theory, it does not provide a high-level of interpretation (Sandelowski, 2010; Sandelowski, 2000). Sandelowski (2000) suggests that qualitative description is best used when one is searching for straight answers to questions of relevance for practice. In addition, qualitative description is appropriately used when little is known about a topic. Because psychologists’ experiences of their practice with clients in poverty have not been researched extensively, it is necessary to gather preliminary, low inference data to explain their perspectives directly.

Although naturalistic inquiry serves as a general orientation to qualitative description, a qualitative descriptive study can borrow from other qualitative methods and philosophies, referred to as “hues, tones, and textures” (Sandelowski, 2000, p. 337). In particular, one of the philosophical underpinnings of grounded theory –pragmatism – provides a helpful lens through which one can view the process of therapy with clients in poverty. In a pragmatic study, the goals of inquiry are judged in terms of their usefulness for making change (Wuest, 2007). This is relevant for the present study because the purpose of finding out what is involved in psychologists’ work with poor clients is to understand that work more deeply in order to improve training and supervision of

psychologists and psychologists-in-training, and ultimately to improve therapy for those clients. This is a pragmatic, rather than a theoretical goal. Indeed, Sullivan-Bolyai, Bova, and Harper (2005) espouse the benefits of qualitative description as a pragmatic method for assessing, developing, and refining interventions with vulnerable populations. They note that the final product is a clear, straightforward, but rich description of the phenomenon and the results can easily be understood by those who are not directly involved (Sullivan-Bolyai, Bova, & Harper, 2005).

### **Sampling**

My target population was psychologists who are three-years post-doctoral training and are currently conducting at least five hours per week of individual adult psychotherapy with clients in poverty. Self-identification as such was the sole inclusion criterion. I made use of purposeful sampling, which involves selecting participants who can provide information-rich cases that are relevant to the research question (Patton, 2002). Information-rich cases are those with which one can “learn a great deal about issues of central importance to the purpose of the research” (Patton, 2002, p.46). Specifically, I used maximum variation purposive sampling, where demographically varied cases are sought, and looked for diversity in race, gender, and age, as well as setting. Prior to the start of the study, I had conducted one pilot interview with an African American woman psychologist with more than 30 years of experience working with clients in poverty. The dissertation sample included a younger and somewhat less experienced group of psychologists of diverse races.

I interviewed 12 participants. Miles and Huberman (1994) note that when using multiple-case sampling, data with high complexity and richness can become unwieldy

after 15 cases. Based on my pilot interview, I had anticipated many cases with high complexity and richness, so I had planned to sample a range of 12-15 participants, which allowed me some flexibility in the process, as qualitative studies demand “continual refocusing and redrawing of study parameters during fieldwork” (Miles & Huberman, 1994, p. 30). The ultimate number, twelve, depended however, on when I reached saturation (defined below).

**Recruitment.** My current status as a doctoral candidate in Counseling Psychology at Boston College afforded me relatively easy access to psychologists who work in settings that serve clients in poverty in the greater Boston area. Fortunately, the faculty and doctoral students of the Counseling Psychology Program at Boston College are well connected to psychologists at a number of such locations because they train students in our program. Some of these locations include Brookline Community Mental Health, Southern Jamaica Plain Health Center, Martha Eliot Health Center, Fenway Health, South Boston Health Center. In particular, the former practicum director of our program, Dr. Sandra Morse, knew many of these psychologists personally through her work with them over the years. My dissertation chair, Dr. Lisa A. Goodman, and I met with Dr. Morse to discuss her recommendations and she was willing to help connect me to psychologists at these organizations. In addition, another doctoral student on my research team is employed at Brookline Community Mental Health Center and was able to help me obtain permission and access there. If this strategy was not yielding sufficient results, I had previously planned to also cold-call other community mental health centers in the greater Boston area, but that was not necessary. Finally, I had brainstormed another possible recruitment tool, which could be to make use of mental health related listserves

that I already had access to, but this was also not necessary.

Having gained access to one psychologist in a particular organization, I asked participants if they would be willing to recommend colleagues who might like to be interviewed. Having recruited participants, I allowed them to set the time and place of the audio taped interview. I obtained grant funding from the Society for the Psychological Study of Social Issues (SPSSI) for \$400 with matching funding of \$400 from the BC Counseling Department, for a total of \$800. Therefore, I paid a \$30 stipend to participants in the study (with the remainder of funds I paid a small stipend to two graduate assistants who helped me to transcribe the interviews).

**Saturation.** Saturation is a concept used in qualitative research that was originally developed by Glaser & Strauss (1967) in their grounded theory methodology. According to Glaser & Strauss (1967), saturation is reached when no additional data can be found that develops properties of the conceptual categories (developed from coding). In trying to reach saturation, the researcher, “maximizes differences in his (sic) groups in order to maximize the varieties of data bearing on the category, and thereby develops as many diverse properties of the category as possible” (Glaser & Strauss, 1967, p. 62); hence the importance of maximum variation sampling. However, as Bowen (2008) notes, it is difficult to recognize the saturation point without explicit guidelines for determining data or theoretical saturation. Without explicit guidelines, I needed to rely on my own judgment and intimate familiarity with the data (Lofland & Lofland, 2006) and on the strategies I had chosen for maintaining rigor and validity (outlined below) in order to recognize when no new significant explanations for the data were arising from further

observations (Glaser & Strauss, 1967). I also consulted with my dissertation chair throughout the process, including in decisions about saturation in sampling.

### **Data Collection**

**Informed consent.** I obtained Boston College Internal Review Board (IRB) approval before conducting interviews. Before collecting or transcribing data, all researchers involved in the study (i.e., myself, and two graduate research assistants) participated in the computer certification process to become certified by HIPAA (Health Insurance Portability and Accountability Act).

At the start of each individual interview, I discussed the importance of maintaining confidentiality and reviewed the informed consent document with the participant. The informed consent document (See Appendix B: Interview Consent Form) clearly stated that research participants' interview responses will be used as data sources only and will remain confidential. Participants were asked to choose a pseudonym to be used for data transcription and analysis. If participants did not choose a pseudonym, one was assigned to them. I was sure to inform participants that no names or identifying information would be included in the interview transcripts and that all data was to be transcribed and coded using the pseudonym as means of protecting participants' identities. The consent form also stated that interviews were to be audio-taped, and that consent forms and audio-tapes are to be stored separately from all identifying information in a locked cabinet only accessible by me, my dissertation chair, and a graduate assistant. I also explained that no names or identifying details will be used in any publications or other documents related to this research. All data will be reported as group data so that no one will be able to be personally identified.

In addition, the limits of confidentiality are explicitly outlined in the consent form. The consent form also outlines the possible risks and benefits of participating in the research. For example, it is possible that by reflecting on one's work as a psychologist, participants will gain new insights that could be of benefit to them. On the other hand, they could become upset in recalling a particularly difficult case, or may struggle with difficult emotions as they consider the dilemmas they have faced. If any participant were to become upset, I planned to offer to work with the participant to find an appropriate person to talk to about their distress. However, this did not occur and was therefore unnecessary.

**Procedure.** I used semi-structured interviewing to gather descriptive data about psychologists' experiences working with clients in poverty. Each interview took 60-120 minutes (see Appendix A: Interview Protocol). Interviews took place at a location that was easiest for participants, such as in their workplace or their home. I also offered to use an office at Boston College if preferred but this option was not chosen by any participants. First, I presented information about informed consent and confidentiality and introduced participants to the purpose of my study. I then informed participants of the \$30 reimbursement for their time. Next, I obtained written consent to audiotape interviews and use transcriptions of those interviews as data sources. Interviews were audiotaped using an electronic audio recorder and one backup recorder was also used in case of technical problems.

The semi-structured interview was based on the interview guide presented in Appendix A, which provides a list of demographic questions followed by general, open-ended questions and some probes. Demographic information helped me to place the



participants' responses in context. I guided the interview using these questions and probes in order to help the participants reflect on their experiences with clients in poverty. I asked questions that cover the following areas, corresponding to the aims of the study: 1) psychologists' own perspectives of how their class background, theoretical orientation, and skills, knowledge, and attitudes about poverty shape their goals and strategies for working with clients living in poverty (individual level); 2) psychologists' own perspectives on their interpersonal interactions with clients living in poverty - compared to their interactions with higher-income clients. This includes how they understand and respond to clients' poverty related stressors, as well as their use of power and boundary setting (micro-level); and 3) psychologists' perspectives of how community and institutional level factors that hinder or facilitate their work with low-income clients and the strategies they use to navigate obstacles (exo-level). As originally recommended by Lincoln & Guba (1985), I was also sure to ask clarifying questions throughout the interview in order to ensure that I understand participants' experiences accurately.

During each interview, I took field notes on particular emotional reactions of participants, long silences, and other experiential observations that could not easily be reflected in the transcript. I noted which questions seemed to evoke strong responses and which do not. Additionally, following the interview I wrote field notes to document more of these observations and also to document my general impressions.

Following each interview, a graduate assistant from the Boston College transcribed the interview. Having completed three interviews and transcriptions, I began coding. Coding while collecting data allowed me to make revisions to the interview

protocol for the next set of interviews in order to obtain the richest dataset possible. Also, in order to ensure that I was obtaining accurate data, I engaged in member-checking; that is, I provided participants with results of coding and asked for feedback, which was reviewed and incorporated into the data analysis.

### **Data Analysis**

Analysis is “a process of generating, developing, and verifying concepts” which evolves with the collection of more data (Corbin & Strauss, 2008). For qualitative description, analysis consists mainly of coding, which is taking raw data, organizing it and bringing it to a conceptual level (Corbin & Strauss, 2008). For the present study, I used a technique called content analysis to code the data (interview transcripts) collected in my study (Hsieh & Shannon, 2005). Qualitative content analysis is used to classify large amounts of data into a manageable number of categories while retaining the meaning of the data (Weber, 1990). According to Hsieh and Shannon (2005), qualitative content analysis is defined as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (p. 1278). In the current study, I used qualitative content analysis to explore the problems and processes involved in conducting therapy with clients in poverty. In the end, I hoped to be able to provide a “comprehensive summary” of this process in “everyday terms” (Sandelowski, 2000, p. 336).

Content analysis aims to analyze the data by topic, and then these topics are organized into categories (Corbin & Strauss, 2008). The first step involves reading the entire interview and identifying important topics, which become broad category labels (Corbin & Strauss, 2008). These categories should be few in number and broad in scope

so that a great deal of data can be organized. Corbin & Strauss (2008) recommend 10-15 categories because too many categories can make saturation difficult to reach. Initially there may be more, but over time categories will overlap and can be collapsed. Then, subcategories can be created for each of the larger categories (Corbin & Strauss, 2008).

Hsieh & Shannon (2005) outline three types of qualitative content analysis: conventional, directed, and summative. When a study design aims to describe a phenomenon and when existing theory or research on that topic is limited, conventional content analysis is most appropriate (Hsieh & Shannon, 2005). When a topic is more widely researched but needs more investigation, directed content analysis is the best option for validating or extending existing knowledge (Hsieh & Shannon, 2005). The summative approach focuses more on language, and involves counting words and comparing language usage (Hsieh & Shannon, 2005). For the present study, little is known about the topic, so the directed approach is not appropriate. And, the topic of study is too broad to focus in on language, so the summative approach is also inappropriate. Therefore, the conventional approach will be used. In conventional content analysis, a relatively unexplored phenomenon is described by staying close to the data (Hsieh & Shannon, 2005).

The first step of conventional content analysis is to read all of the data repeatedly, immersing oneself in the data to obtain a holistic sense of it (Hsieh & Shannon, 2005; Tesch, 1990). I did so after each interview was transcribed. The next step involves word by word coding (Hsieh & Shannon, 2005; Miles & Huberman, 1994; Morse & Field, 2005). The coding is first done at the in vivo level, where exact words of participants are highlighted when they seem to express an important concept or an often-repeated idea

and are organized into “chunks” of data (Hsieh & Shannon, 2005). I looked across the interviews and create a full list of in-vivo codes. I then looked for patterns and commonalities across the interviews and collapsed the in-vivo codes where possible, creating a list of second level codes, called “clusters” (Patton, 2002). I identified nine clusters, which is close to the range recommended by both Morse & Field (1995) and Corbin & Strauss (2008) - they each suggest that 10-15 clusters be identified. Finally, for my third level of coding I looked for relationships between the clusters to create three overarching categories.

While some qualitative methods require multiple coders, qualitative description allows for flexibility in this area. Because this is my dissertation study, I was the sole coder. However, in order to check my work, I worked on all levels of the coding process in collaboration with my chair, who then reviewed the codes to ascertain that they had face validity, were parsimonious and non-redundant. Please see Appendix C for sample of coding.

### **Rigor and Validity**

Qualitative research must demonstrate both rigor and validity in order to make a contribution to the field. Rigor is the extent to which I demonstrate that the findings of my study are the result of a thorough, precise, and well-documented process of both data collection and analysis. Validity is the extent to which the findings of the research can be considered authentic, trustworthy, and reliable (Guba & Lincoln, 2005). Rigor and validity are inter-related in that conducting a study with rigor helps to ensure that results are valid. In the following pages, I will describe some of the methods that I used to help

confirm the rigor of the data collection and analysis process and therefore, the validity of the findings: memo-writing, reflexivity, peer review, and member checking.

**Memo-writing.** In addition to the direct coding methods described above, I also engaged in memo-writing throughout the data collection and analysis process. This allowed me to track my ideas and thoughts about the data collection and analysis process. As Charmaz (2006) recommends, the memos were informal and in my natural voice. During data-collection, I made notes of what stood out while conducting interviews, how interviews were similar or different across participants, and my own reactions to the process. During data analysis, early memos helped to track emerging themes as in-vivo codes were developed. Advanced memos helped to develop those themes, as I had the opportunity to reflect on the process of developing categories and clusters. They also helped me to describe the qualities and conditions of the various categories/subcategories that were identified through the coding process (Charmaz, 2006).

**Reflexivity.** Reflexivity is the process of recognizing the researcher as an integral part of the research (Munhall, 2007). Locating the researcher in the research process is a key aspect of ethical qualitative research (Davies & Dodd, 2002). In order to achieve reflexivity, it is important that throughout the process I engage in a great deal of self-reflection. This involves observing and taking note of my own assumptions and being careful not to impose my own meanings and lenses onto the participants' words. As part of this process, I kept memos recording my reactions to participants, my assumptions about the topic, and my emerging impressions of the data. I periodically shared these field notes with my dissertation chair throughout the process (Rossman & Rallis, 2003).

As part of the process of reflexivity, in the following pages I will reflect on how my own identity and multiple social positions could influence my views of the research topic as well as how I came to this topic as an area of interest. I will explore four areas that I believe are relevant to the study 1) my firsthand experiences with poverty 2) my firsthand experiences providing therapy 3) working with the poor in other capacities and 4) my identity as a social justice activist.

First, I am a 31-year-old white woman and a doctoral candidate in the Counseling Psychology program at Boston College. Given the focus of my research on poverty and therapy, it is important to disclose that while my current position as a doctoral student affords me class privilege, I am from a mixed class background and my life history has included firsthand experiences with poverty. This, combined with my experiences as a psychologist-in-training, has certainly primed me for interest in this topic. It was important for me to reflect on my own class background and its influences on my thinking about the research topic throughout the process.

Second, I also have had experiences that impact my view of psychologists providing therapy and the therapy process in general. I have trained at a number of practicum sites providing therapy to various populations, including undergraduate college students, U.S. veterans, children with severe behavioral and mental health disorders, and most recently a variety of clients – many with serious mental health problems and many in poverty - at a public hospital. Many of the clients I have worked with as a therapist-in-training have struggled with poverty, so although I have had much less experience with it than participants in my study, I have had some experience providing psychotherapy with clients in poverty. In this way, I have been “in their shoes” in a sense myself. While this

helped me to understand their points of view and experiences, I had to be careful not to assume that our experiences are similar, and to hear their stories with freshness and openness.

Third, I have experience working with people in poverty outside the counseling role. I was a domestic violence victim advocate, and many of the victims and survivors I worked with were dealing with poverty-related stressors in addition to or because of the violence they experienced. Therefore, I saw firsthand the devastation wrought by poverty, and the inaccessibility and inadequacy of therapy for the low-income survivors. I also worked as a program evaluator for and served on the board of a grassroots community organizing program for low-income women in Cambridge MA called ROAD: Reaching Out About Depression in Cambridge MA, a program which was created in part because of the shortcomings of psychotherapy for meeting the needs of women living in poverty. These experiences, combined with the strong emphasis on social justice in the Counseling Psychology Doctoral Program at Boston College, have each contributed to my interest in the question of psychologist's experiences of working with clients in poverty. I therefore needed to closely examine how my own beliefs, attitudes, and assumptions based on my own experiences affect how I conducted interviews with participants and analyzed the data I collected from them.

Finally, because of my background as an activist on behalf of women, survivors of violence, and the poor, I have become committed to acting as a social justice agent in my work as a psychologist-in-training. I majored in Women's Studies as an undergraduate and was an advocate for women and other oppressed and marginalized groups long before I became a therapist or began training as a psychologist. My current

training program in counseling psychology has an explicit social justice mission, and I have worked to further that mission by co-founding and co-leading a diversity committee in our program. This is relevant because as a social justice agent, it is important to me that psychology as a field becomes more responsive and better equipped to deal with some of the most marginalized individuals in society – the poor. I also have strong feelings of anger and sadness about how unfairly the poor are treated in society and often in the mental health field. So, I needed to monitor these feelings carefully as I talked with psychologists working with the poor in order to hear their own stories accurately.

Overall, it was important that I continually reflected on my own thoughts, feelings, and reactions throughout the research process so that I could be aware of when and how my own ideas and experiences were influencing the process of data collection and analysis. As part of the self-reflection process, I considered my personal reactions to participants, to the data, and to the coding process itself, and bracketed these thoughts and reactions through the use of memos as described above.

**Peer review.** Including outside readers in judging the validity of the researcher's work can contribute to reflexivity (Munhall, 2007). Having an outsider perspective can be helpful for recognizing how the researcher is influencing the research process. Also, peer reviewing allows the researcher to check the results of analysis against that of others. Similar findings across different coders are an indication of the soundness of categories. For the purposes of this study, I included my dissertation chair as a peer reviewer throughout the process.

**Member checking.** Member checking provides an important way to ensure both rigor and validity. Regarding rigor, checking the initial findings with participants will



help to challenge the coding process and ensure accuracy. For example, participants may provide verification of codes or categories, and in the process, they are also likely to critique and/or refine them. In terms of validity, in order to ensure that the participants' experiences have been described and captured in a way that feels true to them, the researcher can share the final results and ask for feedback. In the present study, I gave participants the option to give feedback on codes and categories and on final results.

## Chapter 4: Results

This section describes the results of this qualitative descriptive study of twelve psychologists' experiences providing individual psychotherapy to clients living in poverty. Each participant chose a pseudonym, which I will refer to when providing a direct quote. Also, I will use the following terms to denote the numeric range of participants who described any given experience: "few" describes 1-3 participants, "some" describes 4-6 participants, and "most" describes more than half (7-12) participants. (For more on this approach to counting in qualitative research, see Sandelowski, 2001).

Demographic characteristics of all participants can be found in Table 1. The sample consisted of a diverse group of twelve relatively experienced doctoral level psychologists, 8 women and 4 men. Five identified as White, three identified as Latino/a, two identified as Asian/Indian, one identified as African American, and one identified as mixed race/Latina. The average age of participants was 52, with the youngest participant being 34 and the oldest being 65 years old. One identified as having grown up poor, three identified as coming from a mixed class background (moving between classes as a child), three identified as lower middle or working class, one identified as middle class, and four identified as upper middle class. Seven had a Ph.D. in Clinical Psychology, one had a Ph.D. in Counseling Psychology, one had a Ph.D. in Clinical-Counseling Psychology, and three had a Psy.D. in Clinical Psychology. All participants reported that their primary place of practice was either a community-based outpatient clinic or a hospital-based outpatient clinic, though two paired this with work in their private practice as well. The average number of years of experience since finishing their highest degree was 19.8, with

a range of 7 to 32 years. The average number of years experience working with clients in poverty was 22.8, with a range of 10 year to 32 years (Note: Some participants worked with clients in poverty before achieving their highest degree, which is why this number is higher). Ten participants described their primary theoretical orientation as integrative (see Table 1 for more details on the theories they integrated), while two described it as psychodynamic or psychoanalytic.

In many ways, working with low-income clients is similar to working with other populations, but in certain ways it is unique. The data that emerged from the qualitative interviews can be distilled into three categories of findings representing aspects of the therapeutic process that are unique to work with clients in poverty: A) Practices unique to working with low-income clients, B) Therapist attributes key to working with low-income clients, and C) Contextual obstacles to working with low-income clients. Within these three categories, nine clusters emerged, as follows: Practices unique to working with low-income clients (Category A) included: 1) unique practices for addressing power dynamics with clients in poverty; 2) unique practices for managing boundaries with clients in poverty, and 3) unique practices for working with the relationship between intrapsychic and contextual poverty-related stressors. Therapist attributes key to working with low income clients (Category B) included: 4) possessing a values-based commitment to working with marginalized groups; 5) possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty; 6) possessing a high degree of self-awareness related to poverty; and 7) possessing a willingness to be deeply affected by the work and cope with negative feelings. Contextual obstacles to working with low-income clients (Category C) included: 8) unique agency-

level challenges to the work, and 9) unique social service system-level challenges to the work. These three categories of findings and their associated clusters are described next.

### **Category A: Practices Unique to Working with Low-Income Clients**

Participants described a number of therapy practices that were either unique to working with low-income clients or which required adaptation for work with this population. These practices fell into three clusters: practices dealing with power, practices dealing with boundaries in the therapeutic relationship, and practices dealing with the relationship between intrapsychic and poverty related stressors.

#### **Unique practices for addressing power dynamics with clients in poverty.**

Almost every single participant (11 of 12) highlighted the importance of recognizing and addressing issues of power in the therapy relationship with low-income clients, with a focus on the unique issues that arise when working with this population. Specifically, participants spoke about: 1) the importance of the therapist's maintaining awareness of power dynamics unique to class difference and 2) how the therapist adapts his or her practices to address these dynamics directly as part of the therapy.

***Maintaining awareness of power.*** Most (9) participants expressed awareness of the unique power dynamics involved when working with clients in poverty. Some (4) observed that the power differential may be especially salient with this population because therapists are seldom if ever in poverty as clients may be and are often gatekeepers to poverty-related resources (e.g. SSDI benefits), which complicates the role. As Chris explained, "It's sort of intrinsic if you're not in poverty yourself, you're in a different situation. But I think you also, you hold the access to resources concretely." Some (4) participants noted that as a result of class differences, clients in poverty could

be more deferential toward the therapist. One participant, Mama, put it this way, “Poor people do feel less entitled and even if things go wrong they’re not likely to complain about it”. Another participant, Javier, explained,

You’re wearing a tie; that’s part of the role, but it also reveals that you, you’re in a different class than they are...initially, they see me with more respect, deference, and you’ve got to, you know, help them see that’s happening. It’s one of those contextual influences affecting the relationship, so it’s also a unique opportunity to talk about power differentials that are not only here, but also outside.

A few (3) participants discussed the intersection of class-based differences between therapist and client with other aspects of identity such as race, skin color, and language ability. Mama explained, “I think that inevitably immediately there is an awareness that I’m I am a privileged person. I have a PhD. I’m fair skinned. Um, I’m fluent in English and Spanish. And so that’s already dramatic elephant in the room.” Having identified unique power differences arising in therapy with clients in poverty, participants went on to discuss the importance of addressing this power difference directly with clients as part of the work.

***Addressing power directly.*** Most (9) participants highlighted how important it was for them to address power dynamics related to class directly when working with clients in poverty. One participant, Mama, gave the following example: “I might explicitly say, Yeah, I’ve always had the resources to go to school...and that’s a big difference between us (she and her client).” In this instance, she takes the opportunity of

her client's discussion of difficulty paying for school as a chance to bring up class difference directly.

In other instances, participants described moments when the class disparity between their client in poverty and themselves was starkly obvious and how that prompted them to initiate discussions with their clients about it. For example, another participant, Aparna, told a story about a client who had strong feelings about the fact that her therapist had a car and the client, who had few resources, had to take the bus to and from the office. Aparna described the importance of discussing this moment with her client:

So my client sees me get into a car and drive off, and she's waiting for a bus, you know. To know that...she may have feelings about that, you know. Uh, I might have feelings about that. And so what happens in the work? Do we talk about it? Does it come up in some way, or do I hear, or do I listen for it, you know? So, this client, in fact, one session she came in looking very annoyed with me, you know, and so I asked her—well no, I commented to her - I was like “You know, something about me is bothering you maybe”, and um, and it came out in the session because...the previous week we had left together and literally I got in my car and drove away and she was waiting for the bus. And so she, um, said to me, “That really bugged me”, you know. And so, you know, we had to talk about that. So I think, you know, to leave yourself out of the relationship is a big mistake.

Aparna's awareness of the disparity between her and her client, combined with her willingness to look for an opening to initiate a discussion and acknowledge it, made it

possible for the client's feelings about it to become a named and validated part of the therapy relationship. However, Aparna acknowledged that bringing up this difference was a process:

I thought it was really critical. Um, she continued to be annoyed with me in that session. You could tell sort of she was just irritable, she wasn't taking in anything I said, and so I, um, but we continued on with it, you know. The next couple times we met I brought it up to her again, you know. And...(when) she was sort of, you know, felt ready to tell me that it really bugged her and it wasn't just me; it was anybody who has those kinds of opportunities that she doesn't... and I had to sort of, I just listened and...I told her that, um, I couldn't completely understand it but that I, but I heard her, you know. That I got it, to some extent, but I'm not in her shoes, and to acknowledge that. I think acknowledging that was just important. She didn't want someone to feel sorry for her, you know; she just wanted to be heard...and I think that's so critical. It's not, whatever it is - if it's a negative feeling, if it's a positive feeling, it's, whatever it might be, an angry feeling, that um, that it be allowed to be there...and not sort of, you know, brushed aside.

In this instance, Aparna described the importance of her having listened, patiently waited for her client's readiness to discuss the issue, and attempted to bring it up more than once. When she found the right time, she took the opportunity to acknowledge her client's feelings about having to take the bus as a low-income person while her therapist owns a car and validated her experience of that feeling. She also acknowledged and even emphasized the disparity between them by admitting that she could not completely

understand what her client was experiencing, but was willing to listen and acknowledge it.

Another participant, Martha, also described the importance of the “how” and the timing of bringing up difference with low-income clients. She explained, “But the trick is to know who to do it with and when to do it. Because I could severely put someone down by doing that and make them feel quite ashamed...and I think that in some ways it’s just experiencing it across time, and just always being conscious.” While Martha was concerned about the possibility of shaming a client by bringing up difference, she emphasized the importance of maintaining awareness and finding ways of knowing when and when not to approach the subject – sometimes learning by doing or as she put it “just experiencing it across time”.

Other times, participants reported not needing to worry about the timing of bringing up class difference because the client him or herself would initiate the conversation. In these instances, the therapist was called upon to be willing to address class difference by listening with openness and humility to clients’ experiences of class difference, validating the reality of that difference, and being willing to learn from the client about his or her experience of it. According to participants’ responses, it also may involve the therapist rethinking his or her interventions from a poverty-informed perspective. George explained,

“At one point there was a whole complicated thing with her housing, and she managed to get a lawyer to help her with something, like a free legal service thing. And then she...didn’t like the lawyer and (it) had gotten interpersonally difficult with her. The woman was really trying to help her – it was difficult. Um,



and when I would suggest things like “Well, maybe you could talk to her about what, what you feel” (laughs), she’d look at me like, disbelieving and she’d, ‘cause she has a good sense of humor, she’d say “You could talk to her ‘cause she’d take you seriously, you don’t come from my background, she’d listen to you”. She was right. She was absolutely right. So a lot of, we spent a lot of time talking about that, like what-how do you work from a position of powerlessness? How do you, what could she do uh, uh, to get her way? And she’s taught me a lot about that.”

Here, George’s client confronted him about his lack of recognition of poverty-related stressors, such as dealing with the stigma of being in poverty and how others, such as the lawyer in this case, may have been seeing her differently. She made him aware that in a particular moment of the therapy this blind spot was getting in the way of the work being helpful to her. He described working with this client for many years following this interaction, and how important it was in that moment to understand and listen with humility, as well as to be willing to see and acknowledge his own blind spots about the unique challenges faced by those in poverty.

In sum, most (9) participants acknowledged and gave examples of the importance of both maintaining awareness of the unique challenges faced by clients in poverty in the therapy relationship and directly addressing those challenges. They did this through bringing the issues up directly with thoughtfulness about when and how, being open to learning from and validating clients who are courageous enough to bring them up themselves, and being willing to reconsider therapy interventions that are not sensitive to poverty-related stress and stigma. While issues of power are always at play in therapy,

participants described how class difference between clients in poverty and themselves added unique challenges and required special awareness and skills. I will now turn to another aspect of therapy that is ever-present and poses unique challenges for therapists working with clients in poverty: boundaries in the therapeutic relationship.

**Unique practices for managing boundaries with clients in poverty (cluster 2).**

All therapists must consider boundaries when working with any client. However, therapists working with clients in poverty described developing specific practices with regard to boundaries when working with clients in poverty. These practices have to do with self-disclosure through appearance, verbal self-disclosure, boundaries related to time, boundaries around giving clients food, boundaries around giving clients money, and boundaries around rule-breaking.

*Self-disclosure through appearance.* A therapist's appearance is in many ways a form of self-disclosure within a therapeutic relationship and this can have particular implications for therapists working with clients in poverty. Half of participants (6) commented on issues associated with boundaries around appearance and how this issue must be considered differently with clients in poverty. Some (4) participants noted that what the therapist chooses to wear does reveal something about his or her class and may have strong implications for how the client in poverty sees him or her. For example, Javier shared:

I'm often wearing a tie, I think that often, that immediately gives people the notion that there are power differentials... You're wearing a tie; that's part of the role, but it also reveals that you, you're in a different class than they are.

Another participant, Rachel, remembers an example from nearly 30 years ago of a client in poverty who taught her this lesson. She explains:

One woman in particular brought her child in to see someone and walked into the office, and this woman was wearing this white wool suit with this gold jewelry in this immaculate office and said to herself, “This person couldn’t possibly understand what my life is like...That was a long time ago (laughs). It was close to thirty years ago, I’m sure...I remember it very clearly because I thought, “I don’t want to be that person, I really don’t want to be that person”.

Some (4) participants described developing practices around changing their appearance in order not to reveal their own class status. For example, Aparna discussed her decision not wear a diamond engagement ring to her sessions with poor clients:

And so my husband—my now husband—gave me an engagement ring, and um, I never really wore it (laughs), and um, I wore it when I was out with him. But I never wore it in my professional place (a setting that worked primarily with clients in poverty) because I felt like, it was just this really weird thing to wear this diamond ring and be in session...and I don’t think I ever have since.

In a similar example, Martha decided to bring her relatively expensive phone or purse to work, but would hide it from her low-income clients:

Um, the handbag or these little things like the iPhone or whatever...in those first couple years of it coming out, having one, um, was sort of a status model. So, or even the Coach bags are still a status model, I think...I’ll hide my stuff sometimes...because I’m a little bit more conscious about my patients and, um,

what they're asking me about in terms of my life or what I have. So...I'll just cover it under my jacket or something.

While all therapists must make decisions about self-disclosure when it comes to their appearance, these participants had developed unique practices regarding their appearance and revealing vs. not revealing class related status symbols to clients in poverty.

Regardless of whether participants changed their appearance or not, those that mentioned appearance as an issue described considering their appearance with special attention to how they would be perceived through the lens of class by clients in poverty. In addition to considering self-disclosure through appearance, participants also developed specific practices for working with clients in poverty related to verbal self-disclosure.

***Verbal self-disclosure.*** Most (7) participants reported that although they considered whether to self-disclose differently or more when working with clients in poverty as compared to other populations, they ultimately decided to maintain the same level of verbal self-disclosure as they did with clients of other class statuses. Participants reported considering clinical factors rather than considering poverty primarily when making this decision. Gemini shared,

It doesn't make any difference. They know where I'm, for the most part they can tell. I'm not from here. It has nothing to do whether they're in poverty, or in a shelter, or I see them at the clinic. It doesn't make any difference... For me it depends on the relevance. And why disclose, and disclose what to who and when.

Similarly, Rachel said:

Um, I don't disclose, that's not something I do at all on any kind of regular basis. If someone asks me a pointed question, I may eventually answer it. I mostly want to find out what they think, because it's never what I think they're going to think...If someone says to me "Do you have kids?" and I say "Well, you know, what do you think, and how would- would that make a difference?", I expect people to say "Oh, if you have kids, you'll understand me better.". I don't know. They end up saying, "If you have kids, they're probably perfect, you won't know where I'm coming from"...So you don't know what people are going to say, so I always like to find out what people are going to say. But I don't think that it really matters whether someone's in poverty or not.

In each of these examples, participants report considering more traditional clinical questions such as where the question is coming from for the client and what it means to him or her when considering whether to self-disclose – and they report this is the case no matter the class background of the client. Even when asked directly or indirectly to self-disclose by clients in poverty, Rachel explains that she chooses not to:

Well, um, for people who are struggling, um, they, you know, there have been people who have said, "Well, I'm sure, you know, you get to buy this and you get to buy that, and I don't get to buy that, and I'm really frustrated". And I'll say, "It is frustrating not to be able to have what you want". And there's some transference issues going on there. But if someone says, "Well, did you do this, or did you do that?" I will first always, always say, "What do you think? Or How would it help you to know?" kind of thing. And I won't say "Here's my income"...I'll say "You know, it's difficult not always having what you want or

what you feel you need and not knowing how to go about getting it.”. And part of my role is to help you figure out how you can get what you want and how you can feel powerful even if the money is not always there, and how you can make choices to, to utilize what you do have in a way that provides you with more satisfaction.

Here, Rachel relies on a more traditional conceptualization of the therapist role – one in which the therapist helps the client make sense of his or her questions from the perspective of what the question itself means to the client rather than answering personal questions directly.

A few (2) participants came to a different conclusion regarding self-disclosure with clients in poverty: They found there were times when it was clinically appropriate to increase their level of self-disclosure with clients in poverty. In the first case, Javier explains that he felt it was clinically important to self-disclose feelings about injustice he witnesses occurring in the client’s life:

I am definitely sure that in some situations of injustice, you need to disclose and express your feelings about how unfair a situation is...and I think I have learned that to be important.

In another instance, Cody described his reasons for sometimes revealing his own working class background when working with clients in poverty.

Sometimes I will tell patients that I grew up as a working class kid just so, you know, to me-to me that’s a, not such a terrible piece of self disclosure. And that has often greased the wheel ... ‘cause people who don’t know that about me often wouldn’t make that assumption about me. Uh, so I know that I’ve lived

long enough with people's impressions of me to know that. So, so, if I said it, if people ask me how I know something, I'll say, "Well, I'll tell you how I know something". I'll tell them something about the way I grew up.

These few participants considered the client's poverty and determined that in some instances, revealing his or her personal feelings about injustice or his or her own class background was clinically indicated. Interestingly, their perspective diverged from the majority of participants described earlier who came to the opposite conclusion – that verbal self-disclosure should generally not be altered based on the client's poverty. I will now turn to another boundary consideration for therapists working with clients in poverty – boundaries around time.

***Time.*** Perhaps one of the most basic boundaries in the therapeutic relationship is the boundary of time. This includes factors such as how frequently and for how long the therapist and client meet, what the consequences are when either of them is late, and how missed and rescheduled appointments are dealt with. While settings in which therapists work vary with regard to how much discretion the therapist has over these decisions, some of the decision making about time boundaries does fall to the therapist in most circumstances. Half (6) of participants reported that when they worked with clients in poverty, they found it necessary and clinically indicated to modify the traditional time boundaries of the therapy hour (e.g. 50 minute therapy hour once per week, 24 hour cancellation policies, etc.). This was the case even for therapists who generally felt that traditional time boundaries were helpful for the most part. For example, Terry put it this way:

“Um, the structure, fifty minute hour sort of having that kind of a frame um is important for a lot of the work that we do as a therapist but it’s not the only thing that’s important. So, um it’s often times not adequate. That’s all, so possibly it’s not effective, um, it’s not enough.

Another participant described her decision making process around this and also offered one reason why the traditional time boundaries may not be adequate with this population.

Martha explains:

But the need for structure, Um, I think is implemented by this, the model of, you know, keeping appointments, uh, being on time. I’m a little bit more flexible with time stuff, but then again I know who with and what for...if they always just come in whenever they want to be seen on a walk-in basis, the structure is very very helpful. For other cases in terms of being accommodating if they need to take two busses, I know that that second bus is always late, um, that’s a different story. So it’s really understanding that context, but not excusing it for everybody.

In this case, Martha describes how she tries to maintain the traditional time boundaries to some extent and uses her clinical judgment about why the client may be late or missing appointments, as she would with any client. However, she does so with the added consideration of the context of poverty and how it may be influencing a client who, for example, may need to take two buses to the appointment. Such poverty-related stressors as having to take two buses to get to an appointment could be overlooked if Martha had considered only non-poverty related clinical factors in her decision-making.

Similarly, another participant, Mama, shared how the context of poverty can require additional tasks of the therapist, such as providing instrumental support (e.g.



calling other agencies or services for or with the client) and how this has bearing on decisions about time. She said, “I’m aware of giving them more time if we need more time to call this attorney or call the landlord or call the social security office or something.” Mama indicates here that allowing more time for clients in poverty may be necessary given that their poverty-related stressors and related needed services are part of the treatment.

Another participant felt that the time boundaries should be modified extensively, particularly when considering both poverty-related and cultural factors together. Gemini shared that she uses what she describes as an Afrocentric model that calls for a more flexible approach:

There is more of an Afrocentric model ... even at the clinic I don’t do fifty-minute hours. Sometimes I’ll do forty-five, sometimes it’ll be a half hour. Like, I don’t see people weekly. Most of the people I see are bi-weekly. At the clinic, like there was a guy I see...monthly.

In this case, Gemini felt comfortable meeting with clients for various periods of time and different frequencies based on their poverty-related needs and culturally based customs and preferences.

While half of the participants agreed with this perspective, few (3) described considering time boundaries with clients in poverty and coming to a different conclusion – that it is best to keep with the traditional time boundaries despite the issues raised by the participants described above. For example, Martha shared, “The hour is fifty minutes, and that’s it. It’s pretty straight-forward”. Esperanza shared that she keeps to that except

for a clinical emergency, just as she would with clients who are not in poverty. She stated:

Between fifty minutes and an hour. And usually it's very strict around that unless there's a crisis and I need to hospitalize someone. So I need the pink paper and it might take a little longer and then.

So, while half of participants did modify time boundaries, a few did not do so with clients in poverty. I will now turn to another boundary that some participants reported modifying while others did not: sharing food.

***Sharing food.*** Therapists working with low-income clients are faced with the harsh reality that some of their clients may not have enough food to eat or to feed their families. As a result, therapists must engage in a decision-making process around giving food to clients as part of the therapy, considering both whether or not to do so and how either choice could affect the therapeutic process.

Some (4) participants described some practice of offering clients food. One participant, Gemini, noted that although she was saddened by her clients' hunger, her decision about sharing food was made easier by the fact that her agency provided meals for clients if they asked. She explained:

It's sad. You know, every once in awhile it hits me even more so...I have a client that I see um who comes to the clinic and so we have a session every Monday, it's at eleven o'clock and she'll say, "Can I have lunch?" And I say, "Yeah, tell the front desk you can have a lunch." We have lunches we provide for some people who ask. We have a refrigerator and you know they're bag lunches um just for some people who don't even have food. And you, so we'll give them lunch.

For others, the decision is made more difficult by the fact that their agency does not provide food for clients. Rachel noted this but added that if the client was a child she would go to the staff kitchen to find something for him or her:

Well, I would...if it's a kid, I'd fix a snack in the kitchen. But again, um, we're, we are an agency that doesn't provide those kinds of things.

Another participant, Aparna took that another step further. She shared that she would sometimes take a client out for lunch as part of the session. She explained:

Um, as I said I bought a client, some clients', meals when I knew they wouldn't eat for days, you know, or they didn't anticipate eating for a couple of days, yes. We had a place nearby, so we'd walk down together (laughs) and say "Oh, you haven't eaten; why don't you eat, and we'll talk while we, while you eat". So we'd actually have therapy and eat.

She went on to explain how she perceived this act of giving food affected her client:

Um, I think in those moments...I think, I felt that the client understood...that I understood something about their experience...It feels-felt like the right thing to do... And it felt like, not from sort of like a self-righteous place right thing to do, but it felt like the right thing because...you need to eat.

In addition to giving clients food, a few (2) participants shared their decision-making processes about receiving food from clients. One participant, Esperanza discussed the importance of accepting food as gifts from some clients in poverty for cultural reasons.

She explained,

“When she (the client) brought me tamales as a gift...(it’s) about the meaning of those things. And it’s a cultural piece. It’s about how they feel they feel close to you.”

Similarly, another participant, Martha explained that while she tries not to accept gifts of food from clients, it can be difficult with some clients because of their cultural norms and beliefs. In one case, she knew the client could not afford much food because she was in poverty but still the client insisted. In fact, the client left the food at the front desk because she knew from previous experience that Martha would try not to accept the gift. She shared:

And last week she brought me food for lunch, she said, and I was like “Oh my goodness!” And I think it was enough to feed me for like a week...just rice and beans. And um, and she just leaves it at the front desk and leaves...and so, and um, her ideology is, you know, “If I give, it will be returned”, you know? “God will help me”. But I’m like, “But you can’t really be giving when you don’t have; you need to be taking care of what you have”...But I’ve known her long enough that I can say “No, don’t do this”. That’s why she’ll leave it at the front desk and leave.

In each of these cases, participants considered the intersection of the client’s poverty with cultural factors in their decision-making about accepting food. In addition to considering boundaries around giving to and accepting food from clients in poverty, therapists must also consider boundaries around giving and receiving with regard to money, which I will turn to next.

*Giving money.* Similar to when clients come to sessions hungry as described above, therapists working with clients in poverty are faced with the painful reality that some of their clients may not have enough money to cover their basic needs other than food - such as housing, heat, utilities, and medical costs. Even with the availability of some help from social programs such as TANF and housing assistance, some clients are left homeless or unstably housed. Although the therapist role does not typically include giving clients money, participants described considering this possibility and sometimes acting on it, while considering how their choice could affect the therapeutic relationship.

Most (8) participants described being willing to give clients in poverty money directly in some form or another, while seven of those eight described actually doing so. One participant, Martha, explained her decision-making regarding giving a client money for rent and also disguising the source of the income. She shared:

Certainly there are times when I've paid people's rent and they, they don't know that...I've had people on the edge of eviction um and have looked for resources and have not been able to find it and if you pay someone's rent for a month, or two months, or whatever it is um it doesn't really help if they can't pay it after that. So it's sort of depending on the circumstance but um - so how do you put money into the system so it can be taken out by a client anonymously and they don't know where the resource comes from? I've done that, of course. I think probably most people have.

Here Martha explained that not only does she pay her client's rent without her client's knowledge, but she believes most therapists have done the same. I asked her what the logistical process of giving the money looked like. She said:

You could have a money order. I could have a resource specialist get a money order and then made payable to the landlord. Um, and the client doesn't know where that money has come from...we have like pockets of resources, so um, I'm not usually paying people's rents but occasionally it happens. (Interviewer: So she doesn't know it's from you?) Correct. I don't want that to happen. There cannot be that connection at all, clinically there cannot be that connection... 'cause it would really complicate things. (Interviewer: What would it mean to her if she knew you were giving her the money?) Obligation? Obligation to keep appointments, obligation to be a good patient, um, and I can't have that happening in therapy...so, in that roundabout way I can do things.

Similarly, Martha explained that if a client has given her a gift, she finds a way to give the client an equivalent amount of money back, but hides it by giving the money to a case manager:

Um, and what I'll do, confidentially, is find ways to balance it out. So, and not all my patients- and this is a very unique experience 'cause I haven't done it with many patients—um, I will buy a gift card for, let's say, ten dollars or fifteen dollars to sort of equalize the, the price of food. And because I know the economic circumstances, um, I'll ask one of the social work, um, providers, uh, case managers, to give it to her whenever she's around. And I try to wait—I'm very conscious of how I do it—because I don't want them to figure it out behaviorally, and stuff, so I'll ask, like a case worker when she comes in “I have one of these extra cards, can you give it to her? and just say that you had an extra card”.

She went on to describe more about how case managers are involved. She shared:

They're (case managers) not as analytical as we are, or as I am... They're more practical about it. But they also understand, you know, the need to keep things confidential and, um, 'cause it can get complicated. And behaviorally then people will expect, and it gets, it can confuse your relationship.

Martha also described giving clothing to her clients indirectly through the case manager.

She reported:

Or if I knew her children's size in clothing and if my kids were growing out of clothes, instead of shipping them off to Good Will, um, I'll take out some of the nicer things and give them again to the case manager. And, you know, I wait a length of time so that there's no connection...and the case managers do a wonderful job of giving many resources out to lots of patients, so it's not out of the ordinary. And, and it works out fine that way.

Another participant, Mama, also hid the source of the income she was giving her clients, though not through a case manager. She explains that she tells clients there is a "fund" which is really actually simply a collection of her and her colleagues' personal money:

(Interviewer: So how do you disguise that? Do you get like a gift card or?) Yeah, like uh, like an envelope, an envelope from the main staff...I'll see if I have any money. Um, I'll say, "Yeah, let me go see" and I'll get an envelope and I'll see if I have any money...Or see if there's anybody who has any money. And you know these are extreme case. (Interviewer: When would be a case when you would do something like that?) This is extreme cases, like people don't have anything to eat and haven't had anything to eat all day and it's four o'clock in the afternoon. It's

never something that's sustained....So we kind of you know have this structure but it's not - and it's again to kind of avoid the transference kinds of things because it's my money...And it is kind of a fund because we - I will ask whoever is available for the money..."Does anyone have five dollars?...Ten dollars is the most I would give but we're talking about a meal. You know, like, um I mean and certainly they, you know, they can certainly, I try to give them shelter resource but culturally or for whatever reason time-wise it doesn't work for them to go to a shelter to get a meal. Um, yeah I just might give them 5 dollars.

Despite disguising the source of the funds, some participants did describe exploring the meaning of the giving with the client. Mama reported;

"What does it mean to you that I gave you this 5 dollars from the fund?"...Um, it's such a rare thing that if it is in such an urgent situation like life or death it's not always sort of a processable (sic) thing...but definitely will ask, you know, um, if there's any hint of hesitation referring to it, certainly we'll explore it.

Another participant, Aparna, described both her feelings about giving clients money and how she perceived their experience of it:

I also gave bus money a couple of times. (Interviewer: Just from your own money?) Yeah... I think, I felt that the client understood...that I understood something about their experience, you know. So I felt like it helped, um, and yeah. And I have no regrets about it (laughs), so. It feels-felt like the right thing to do.

Aparna expresses no ambivalence about her decision and explains that she feels sure about giving a client bus money from her own pocket. As opposed to Aparna,



Mama, and Martha who gave out their own money, other participants truly did have a “fund” or a number of vouchers for food or other necessary items they could share with clients if they decided to. Usha explains:

And so we have cards that we use our discretion in giving them, which I’m glad to do but it’s very complicated to have that entered into the therapeutic relationship, and to be frank I really don’t like it. On the other hand...this is the reality of their lives and my own discomfort is not the thing that needs to get in the way of that. However, it really transforms the relationship and it is really problematic.

Here, Usha expresses ambivalence about the process of giving out the vouchers directly to clients, stating that it is problematic. Similarly, a few (3) participants described being unwilling or not in favor of giving clients money as part of the therapeutic relationship – whether or not there was truly a “fund” to give from. For example, Cody explained that he was unwilling to do so:

What I’ve done is to um, give them referrals to um, food bank-food pantries, um, there are a lot of them...and if people want to go and do that, they can get a bag of groceries, um, literally like that. So, but I haven’t given them a twenty out of my wallet to go get a sandwich.

He goes on to explain why:

I really hold a line with that because I see that as a really slippery slope. There are problems associated with-I have often been inclined to do that because I have felt badly. But I don’t ... do any of that just because I think it’s, there’s too-too much room for things to go wrong... and I, despite the fact that I, I think that it

would be, you know, often it'd be a useful thing, I d-I just don't think a good thing clinically.

Similarly, Esperanza shared:

I try not to fall in the trap of pulling my wallet and, "Here have something." I don't think that's helpful. I've done it but it's not helpful. (It's not) respecting their ability to be resilient...How can you help them be able to acquire what they need without having this paternalistic thing - "Let me help you out" and "let me just hand out things" - and also be aware of when they're really drowning and offer something that can make a difference?

Cody and Esperanza described being against giving clients money, although the impulse to do so occurred to them both. And, in the case of Esperanza, she admits that she has indeed done so in the past. Usha shared the reason that she too, resists the temptation to give money - she felt it corrupted the therapeutic alliance:

Yeah, well you know, introduce money into any relationship and it corrupts it you know, to be frank...So I think this is no different...You know, so um. It's just that this is not what I would prefer. But ultimately I think it's a very tricky sort of moralizing decision and that's why it's complicated. So I really avoid it.

She goes on to say specifically how she feels it corrupts the relationship – by forcing a transactional element into the therapeutic dynamic. She describes how she felt with a client after giving him money:

I felt kind of...I would not say "used", but something in that realm. You know, I sort of felt like, you know, I don't know, it just felt like it really kind of damaged

the relationship from my end too. Because I didn't feel um, as close to him, I suppose. Because I felt like it was a transactional relationship.

In sum, most (8) participants were willing to give clients in poverty money directly while few (3) were unwilling to do so. However, those few who were not willing did describe considering the decision carefully. Whether or not participants were willing or unwilling to give clients in poverty money, it was a question that each participant described wrestling with. They described considering their own feelings about it, how their clients would feel, whether or not to disclose it to clients if they did give money, and how would it affect the therapeutic relationship either way.

***Breaking rules.*** In addition to considering carefully the ethics and clinical implications of giving clients in poverty money and food, psychologists must make similar considerations with regard to breaking rules in order to help clients in poverty. It is sometimes the case that rules put in place to protect the resources of systems can create barriers to much needed help for clients in poverty. The therapists who work with them must then make difficult decisions about when and how to break those rules to assist their clients.

Most (7) participants described being willing to break agency or insurance rules in order to help clients in poverty gain access to resources. For example, Terry explained that there are rules about giving clients food vouchers in her agency, but she sometimes feels the need to break that rule in order to help a client in poverty. She explained how she considers the risk of such a decision – that others may not have access to the vouchers in the future – but decides in serious situations to do so anyway:

We have food vouchers, you know, um and the rule is one per family member, per year. And you got a client who's engaged in therapy with you and they come in and they're in acute crisis. I'm gonna do everything I can to get them another food voucher....Um, and I'm gonna do that knowing that every time we give one out to one person we can't give it to somebody else. So it's not, it's not a simple problem. Um, it's not without consequence. So, it's not something to be done lightly...but if I really feel that there's no other avenue um then I'm gonna advocate on the clients we have.

While Terry was breaking an agency rule to help a client gain access to food, other participants described breaking rules to help clients gain access to therapy sessions. For example, George discussed his decision to exaggerate the seriousness of a client's illness in order to convince her insurance company to pay for more sessions during a time when he and his client agreed that the therapy sessions were crucial for her. He explained:

I applied for sessions...I've been through lots of different insurance companies with her over the years. It did change, but it was like, when I had to apply for sessions and I'd, certainly say things—not that they were untrue—but I would, you know, you make the GAF a little lower than, maybe it is. You know, you say, ...if you don't give her eight sessions, she's really going to, ...sink back into her depression in a serious way... 'Cause I felt that on balance, it was important, she needed to come in. She needed to get her services. So, yeah. (Interviewer: And that's something you would need to do more so for somebody with fewer resources?) Absolutely...She was not the "worried well", you know.... We were not frivolously using the services - this is necessary. I think it's necessary. But,

my definition of necessary and the insurance company's...don't entirely overlap.

So yeah, I bent the rules. I felt like yeah I had to.

Similar to George, Esperanza explained that she sometimes felt pulled to break rules to help her clients gain access to therapy sessions:

There was someone -these days we're not allowed to see people twice a week unless we have permission from the higher ups - uh, and I did it with somebody for a few weeks who was really struggling. And by the time I was going to get all the permissions it was going to take too long. So I just did it. The person is now back at one a week. Before (the rule was made) it was easier to do, like before when people would lose insurance we could just bring them in and just not have them, not record the visit.

Here, Esperanza explains feeling justified in some ways to break the rule not just because her client needed the sessions but also because she had worked at the agency prior to the rule's implementation. Javier described something similar, but reports that he tells someone in his agency about the rule breaking:

There's a rule of "no shows": if somebody "no shows" twice in a row, we're not supposed to give them more appointments. I often break that rule, but I make it - I explain why. (Interviewer: You explain to the person in charge of enforcing the rule?) Yes. (Interviewer: And what about to the client?) I do too...They don't have enough money to get the bus, "I could not find time to leave my job", the other thing - "I couldn't find anybody to leave my child with".....It's not only even about not having enough money to buy the bus, having the ability to leave your job and so forth.

Another participant, Cody, reported that he felt entirely justified in breaking rules - such as not reporting a client who is selling his prescription medication— because he felt that if he were in poverty he would not behave differently than his clients do. He told the following story to illustrate this:

I have a guy in my practice...who kind of lives in poverty...He's the longest patient I've seen. One of the oddest—I love him dearly, and he's a very odd guy; he's an opiate addict who sells his Suboxone to buy various things, and I've never turned him into his psychiatrist. Now, some people would say, "That's not right". And I would say "Guilty as charged". But one of the things I say to him is-he will say-he will say to me "if you were in my position you would do the same thing". And I said, "I know. I would". But then I talk to him about the downside of it. I say to him, you know, I say to him "You know, if I were in your position I'd do the same thing, and I would want somebody to say to me 'Here's the downside of that', so that's what I'm doing with you".

He goes on to explain that he feels he is in the minority in terms of his decision, and attributes this to his own working class background:

I know there's really no net gain in me turning him in for selling his, you know, eight of his eight milligram Suboxone for eighty bucks so that he can pay his cable bill. It's like "Really? Am I going to...?". Now you may make a different decision, and, you know like I'm sure, you line up ten people, you know, mental health people, you know, there'd be a fairly, you know, I-I would assume I'm in the minority. But I'm in the minority because of where I come from, and I don't

have any problem with that. But I'm, I-I would not, I would not um...I would not fight with people who criticize me.

In yet another example, Cody describes exaggerating a client's symptoms in order to help his client receive payment for a much-needed dental procedure. Again, he attributes his confidence in his decision-making to his own working class background:

Ah, when I was at (name of former hospital), there was a man who came in...Guatemalan guy, schizophrenic, poor poor poor. Um, completely psychotic, came in and, uh, had like a tooth abscess. And so, couldn't get anywhere with the Medicaid people, social security people. So I got on the phone, and uh, this happened over the course of a couple of weeks; came in and was using a lot of pain meds and finally got really bad. So uh, he def-he, he was told that he couldn't... get any dental help. He's suffering like hell. Um, he couldn't get any dental help unless the dental problem was life threatening. So I say to him "Really?"....So I-so I say: "You know something? I'm going to call them"....So I was going through "Is this really true?", and she (woman at the insurance agency) was reading the protocol where it turned out to be true. He couldn't get dental insurance unless he met all these various criteria. So, I say: "You mean this has to be life-threatening for him to get-he's really suffering". So I hung up, so I said—took her name, got her direct number and said: "Give me five minutes". So, I hung up the phone and I say to him: "Uh, so you heard that and this must be"—I'll make a long story short—what I did was to lead him to tell me that he was suicidal by virtue of that. And I called her back and said: "After having gathered the information for you, I have determined that he's suicidal if he

doesn't get this". And so, that's how I got him dental care...and I actually told that story at case conferences, um, a-because it's, to me it displays the absurdity of the situation and what people often have to do in order to do an end run to help clients. Now, technically it was an unethical act, was probably fraudulent if-if someone were evaluating me. I couldn't care less. Partly that comes from the fact that I'm a working class kid who learned how to do that sort of thing to do my whole life. And here's a guy suffering. Not just suffering physically but psychiatrically-was-he was regressed as a function of this. 'Cause he couldn't get anybody to help him, paranoid about the, why people wouldn't help him, and I thought we were both in this kind of immoral situation that I had to do something about. And I had absolutely no compunction about doing what I did. So that's an example of working with a, a poverty-stricken patient in a real clinical situation...Um, where the system wasn't going to help either of us, and then I had to do something creative. And I don't think I would have thought about that had I not grown up in that kind of circumstance, you know.

While most participants reported being willing to break rules in order to help clients in poverty, one participant, Mama, reported the opposite. She explained that she felt clients in poverty trusted her more for not breaking rules. She stated,

Sometimes it's just um but I think part of the reason our patients trust us is because we follow the rules. We're very boundaried. We file 51A's when we have to. It's many times dramatic and it's horrible. But I think we're perceived as being part of the establishment...I think that does inspire trust. I mean people hate it and protest it, you know? 'Cuz they hate that we are obligated



to file and such but I think it's a way that people feel like we're on the up and up too... So yeah I don't think there's any bending the rules. The only way we can survive is if we do things "write and file." I mean we, I um, I write testimonies for immigration court, you know, everything absolutely has to be 100% up and up. There's no way we could, I a patient will never have me do anything that is unethical or that violates the rules or compromises my job. Because then I'm not doing anybody a favor.

In sum, most participants did report breaking rules, from handing out more food vouchers to a particular client than an agency allows, to exaggerating the severity of a client's illness to gain access to resources, to overlooking session limits or no-show policies so that clients can continue to have access to therapy sessions. However, one participant diverged from this trend, reporting that she would not violate policies or break rules and she felt that this inspired the trust of her clients, even when the results were difficult for them (such as in the case of filing a 51A child abuse complaint on a client). The majority of participants' responses seem to indicate that working with clients in poverty poses unique ethical challenges with regard to rule-breaking and that with one exception, most participants responded to this challenge by being willing to break rules due to the seriousness of poor clients' life situations.

Having discussed how participants described the practices unique to working with clients in poverty related to boundaries – those in the realms of self-disclosure through appearance, verbal self-disclosure, boundaries around time, sharing food, giving money, and breaking rules – I will now turn to the third and final type of practice that participants

identified as important for working with clients in poverty: practices for working with the relationship between intrapsychic and poverty-related stressors.

**Unique practices for working with the relationship between intrapsychic and contextual poverty-related stressors (cluster 3).** Participants identified an important set of practices unique to working with clients in poverty – those that take into consideration the complex relationship between intrapsychic problems (e.g. mental health issues such as anxiety, depression, etc.) and poverty-related stressors (e.g. lack of access to resources such as homelessness, food scarcity, lack of access to medical care, etc.). Participants described two sets of practices related to this relationship: those that a) maintain an awareness of the relationship and those that b) require the therapist to act on that awareness. These two sets of practices are described in the following pages.

*Awareness of the relationship between intrapsychic issues and poverty-related stressors.* When asked about whether it was mainly intrapsychic issues or mainly poverty-related stressors that led to their clients' distress, most (8) participants described being aware that intrapsychic problems and poverty-related stressors are constantly intersecting and influencing each other to create the unique challenges their clients face. In other words, participants described that it was difficult to separate poverty-related stressors from intrapsychic stressors.. Instead there seemed to be an ongoing feedback loop between these two interacting factors. Participants accounted for this feedback loop by developing a practice of maintaining an awareness of it in a) their focus in the therapy hour, b) their conceptualization of clients' distress, and c) their perspective on the source of the client's problem.

*Flexibility in the focus of the therapy hour.* Most (8) participants described a practice of maintaining flexibility regarding where to focus the therapy hour – shifting the focus between intrapsychic issues and poverty-related stressors based on the client’s presentation. Two participants, Rachel and Cody actually said this directly. Rachel said, “It goes back and forth on which is primary” and Cody reported, “It’s a back and forth between those two things”. Cody went on to explain:

To the extent that I can help them, uh, adapt better to their cultural, political, economic...um context, is helping them manage their psychological functioning...I see that as optimal...So, that if somebody’s poor, and they’re struggling with poverty and there’s this kind of mutually enhancing experience between their poverty and their psychopathology, I need really to address both of them so that, you know, like, to help them manage in whatever minor way.

To illustrate this, he gave a case example of a client in poverty he worked with and how he managed to shift the focus of the therapy time based on what the client was bringing in:

Well to the extent that these poverty issues came up I dealt with them. This was a good example of it...I was always sort of trying to help him negotiate the system in one way or the other. So, the system was, you know, SSDI, welfare, food stamps...I was always doing something like that to help him....But, when those things were calm and sort of percolating on their own, mostly it was about doing supportive treatment to help him manage, you know kind of activities of daily life and his family life. So, I would say some mix of both.

Similarly, another participant, Terry, described this shifting focus over the course of treatment with a client in poverty.

Um, uh well I guess it feels like the balance is always shifting depending on the circumstances someone is bringing into you. So it's not, there's not sort of a fixed proportion. Um, it's depending on the urgency or the chronicity um of whatever the social uh determinant is. Um, how it's impacting the client really determines, you know. I'm pretty clear that I never lose, I never lose my focus on DBT skills with this woman. Um, but is it forefront or background or some of each depends on the urgency of what else is going on in her life...and her very real uh very precarious uh financial uh social situation.

Yet another participant, Chris, brought up the point that clients in poverty are more likely to experience crises in their daily lives and dealing with those crises in the short term must be balanced with addressing more intrapsychic issues, for example with his client who was in poverty, struggling to pay his heating bill and struggling with depression. He shared,

Sometimes you have to find the [psychological] stabilization before you can address (poverty related stressors). Like the initial patient I spoke with. He was too depressed to function. It was hard to get him help and get the heating until we get him stabilized.

While Chris described needing to attend to his client's depression before being able to mobilize him to get heating assistance, another participant presented a different scenario. Martha made the same points that crises arise frequently with clients in poverty and that the focus of the therapy must shift depending on that. But, she also presented a different

example than Chris – an instance where she felt the client’s poverty-related stressors needed to be addressed before attending to intrapsychic needs. She explained,

I think it depends on the client and what they bring in front of me. A crisis may have arisen. Whether they just lost their job or were denied, you know, disability or, uh, failed a citizenship test. I think it depends on what comes out in those moments...A lot of it, though, depends on what the client is bringing up....There’s one patient I had...her disability had been denied and, um, she was going through a process of appealing, and it took over a year to gather papers, to find representation, and a lot of it was just based on income. But there’s a lot of other (intrapsychic) stuff in there. But until that income stuff got tackled, we couldn’t make much movement in the other stuff. And it could get kind of frustrating...but at the same time, this was the context. Everything got figured out. And many- much of the mood and the diagnostic material didn’t change, but we could talk about it in a different way now. (Interviewer: And by other stuff, you mean the intrapsychic that she’s got control over?) M-hm. But without that income, it felt like she had no control over it. And so now...she has the income, and we can talk about that...So it’s not just, just the disability, just the income, just the paperwork. But there were things taking place intrapsychically, if you want to call it that.

In addition to describing the constant shifting back and forth of attention between intrapsychic and poverty-related stressors - foregrounding one or the other according to the client’s needs at a particular moment in time - most (9) participants also described the need to directly work on both intrapsychic and poverty-related stressors simultaneously.

This is in keeping with the complex relationship between intrapsychic and contextual or poverty-related stressors that has already been described above. One participant, Aparna, described it this way:

You know, I don't see it again as, "Let's deal with, you know, you getting financially more secure or something, or accessing more resources; then we'll deal with the mental health stuff". Often times they're, they come together. I have not seen them so separated in my practice... So there was, you know, was this kind of combination of different factors that you had to attend to at all times...It wasn't just about, you know, "Well let's put all that stuff aside because you're stable enough now and we can talk about this you know, intrapsychic stuff". It was always sort of managing both and thinking about how the interpersonal issues might affect what she might actually be doing... You know, to help herself feel more stable, become more stable in her own life... You know, not, not just intrapsychically but, you know, in the external sense find a more stable situation...They both have to happen together.

Similarly, Terry described how both intrapsychic and poverty-related stressors arose in the course of therapy and how sometimes working on one (in this case, poverty-related stressors) would in some sense be helping the other (in this case, panic). She reported,

Well, I don't take it as an intra-psyhic issue or um an issue that is sort of...outside of what we're doing together. Uh, you know connecting her with our attorney, writing letters on her behalf, and ways of coaching her around and educating her around the way the legal system works, around sort of how to deal with the landlord, all those kinds of things...It becomes something that is you

know, triggering her symptoms of panic and so we're dealing with it on that level too.

In the case of Terry's client, the work of addressing poverty-related stressors was triggering the client's panic, which then gave her an opening to address the intrapsychic issue of panic. Similarly, another participant, Javier, described how the process of looking for resources to address poverty-related stressors could lead to an exploration of one aspect of the client's intrapsychic reality – his or her feelings and reactions to the process of finding resources. He explained that this was especially helpful given that there is often not time to do these different types of work separately. Instead, they are done together as part of an iterative process – one continually informing the other. He shared,

We look for more resources, we kind of explore what worked, what was wrong, what we can do better. So we're looking at it at, uh, what happened instrumentally. At the same time, we are exploring her feelings and emotions... That's the way – that's what I find useful because we don't have much time... I think that, um, you know, we talked about the woman who feels hopeless, um, and nothings going to go right. So, only after you have addressed that issue, um, can we start working on um, helping her with a case manager. But the reality—that's theoretical—but the reality is that you've gotta really move quickly, you can't wait until this happens. You've really gotta get this case managed, you've gotta get involved as soon as possible to kind of help her with her health issues. So now she will say, kind of, "Ah, what's the point?", and then you have to...help instrumentally as you do the emotional piece. Often both go,

uh, very well and interwoven. And you really have to find – you have to do both sometimes at the same time.

In sum, most participants described maintaining flexibility in the focus of the therapy hour, either moving in a fluid way between focus on poverty-related stressors and intrapsychic issues or addressing both simultaneously and allowing each to inform the other. Having described this practice for working with the complex relationship between poverty-related and intrapsychic issues, I now turn to another such practice described by participants: working with this relationship in the context of case conceptualization.

*Conceptualization.* Case conceptualization is a crucial part of the work of therapy, and similar to how participants reported accounting for the relationship between intrapsychic stress and poverty-related stress in the focus of the therapy hour, they also reported developing a practice of accounting for this in their conceptualization of client's presenting concerns and behaviors. Most (7) participants described accounting for the context of poverty-related stressors when conceptualizing clients' mental health issues and/or their behaviors in the therapeutic relationship. For example, Aparna, discussed how although some may more typically conceptualize and interpret missed appointments as a manifestation of intrapsychic resistance to the therapy process, she is sure not to do so with clients in poverty because of the constant interaction between poverty related stressors and mental health issues. She shared,

I think another is not to interpret situations that come up as resistance, you know.

That um, a client is running late because the bus is running late, you know. Or they missed the bus, and, or whatever it was-the train. Um, or it's a snowy day, you know, uh, or they can't make it this week because they're sick. And my



clients would get sick a lot, you know. So, um, but not to interpret that as some kind of, you know, resistance to therapy or to me or whatever, you know. That it's more that, it's recognizing that the external life that we lead is just as important as the internal one. And so um, and that they, and that they might have had a negative experience that morning that, that kind of contributed to the not wanting to come in, you know. Um, but that, so there are these kinds of structural issues that I think we have to really recognize sometimes...it's kind of a balance between the two, I think.

George brought up the same issue and described a very similar practice as Aparna. In his example, he explained how he accounted for the relationship between intrapsychic and poverty-related stress when discussing a client's missed appointment with him or her:

If somebody, you know if somebody says: "Well the (train system) broke down", well they didn't make the (train system) break down; the (train system) breaks down sometimes, you know (laughs) it's like, it happens. Is that resistance? And that's, it's a complicated thing. The way I think about it - one thing Freud says about it is: "A patient can use anything as resistance. People don't like to look. Anything can be used as resistance". So, the way to tell, in some sense, is more, what's the person's attitude to it? So, there are patients who come in and they say: "The (train system) broke down. I'm so annoyed, I had so many things I wanted to talk to you about and now I'm late, and I'm missing half the session 'cause I got here late". And there are other patients who come in and they say: "The (train system) broke down". And they're thinking (whispers) "Great! I don't have to talk about this! Isn't that lucky that the (train system) broke down? I

only have ten minutes left in the session!”...So the same thing...can mean very different things - depends what it means to the person. It’s not that they made the (train system) break down; you know, of course they didn’t make the (train system)-but, it’s a little bit more like, that’s how I try to sort it out. What does it mean to the person?....What’s going on? And then, I think there’s the other thing of, one has to recognize the reality of people’s lives. They might not have a reliable car. Yeah, it’s hard to get places-you don’t have child-care, you don’t have, you know, it’s hard to get to an appointment, all that. Those things are all real, um, and have to be taken into account.

Gemini shared a similar practice in a straightforward way. She reported having clients who cancel appointments in order to make their appointments with other agencies, such as the food stamp office. She shared,

The reality is this woman ran out of food. So she had to apply for her food stamps. And that is the reality. She could be resistant (to therapy) all she wants but bottom line is she had to get there by three o’clock so that she could sign up for the food stamps.

Terry went one-step further to imply that she is amazed clients in poverty make it to therapy at all:

So, someone “no shows” for an appointment. Um, I don’t assume that they didn’t want to come or they were being lazy, which may be true. Um, but that’s not, that’s not most likely been my experience. It’s most likely there’s been a catastrophe or some kind of tumult that’s gone on. Um, you know caused by, caused by their social situation. Um, so I think there’s flexibility that you need

and uh flexibility and I guess and belief when you're working with people who have such disrupted lives, so easily disrupted lives. Uh, we have a 60 % no show rate for first appointments. It's rather huge. Um, sometimes I think it's a miracle that people are able to get in at all.

In addition to conceptualizing resistance, participants also described taking into account poverty-related stressors when conceptualizing psychiatric symptoms. Mama gave the following example:

Even if someone presents psychotically... We've seen a lot of young men who can have little psychotic brakes after migrating. It's like if you go have no clothes, airless... underneath a truck, for 24 hours... you'd go a little psychotic yourself, you know? No air ventilation. So... poverty fits into that ya know? Other people migrate on a plane. Some people migrate in coolers and underneath buses. People actually hold on to the bottom of the bus for hours while driving, the heat and the fumes, you know of the truck... or the trunk of a car, just even the sensory deprivation of that. I would say it's absolutely always part of our conceptualization because the circumstances especially around migration and in the United States are always about poverty.

Here, she reported seeing psychosis as being in some ways the direct result of the client's poverty given the fact that their option for migrating was so traumatic due to lack of resources. Another participant, Esperanza, was emphatic in her assertion that both the intrapsychic and the context of poverty must be integrated into case conceptualization and formulation with clients in poverty. She explained,

Always, always, always, I think uh, the context always has to be. When I'm talking about the context is eh, who they are, where they're from, what's their history, eh, how were they doing before, how are they doing now, in terms of eh, access to food, housing, services, um, that can never be left out - especially if you are working in the public sector. It informs not everything but a lot. And the history of what the person has gone through. It's always included in my formulations, always.

Another participant, Javier, went further to point out that awareness of both poverty-related stressors and intrapsychic stress must be integrated into therapeutic work at every level even beyond conceptualization, given that poverty-related stressors can contribute to intrapsychic pain.

I think that you need to understand that the context is different...and that, uh, they don't have, not only is there not all these resources available, but also how that affects people. How this lack of resources is creating pain...it's important – you know, that's important because then uh, when you're developing your formulations, you may find that they're depressed, hopeless, for over six months, uh, and then you think about the symptoms of the depression. But if you look at the stressor, it's a lot of – a lot of it is um, lack of resources, lack of home... And um, I think that being aware of that is going to affect assessment, your formulation, your treatment, interventions—everything you do. So, it has to be included in every single aspect.

In sum, most participants reported that the relationship between poverty-related stressors and intrapsychic stress must be accounted for in all aspects of conceptualization. The

final quote from Javier in this section leads to the third and final practice identified by participants for working with this relationship – the practice of integrating both factors when attempting to understand the source of the client’s problem.

*Understanding the source of the client’s problem.* Most (8) participants described a practice of holding both intrapsychic and poverty-related contextual factors in mind when trying to understand and conceptualize the source of the client’s problem. While at times they described foregrounding one or the other, participants ultimately held in mind the relationship between the two in making sense of clients’ pain and suffering. For example, Gemini discussed how she saw both intrapsychic and poverty-related contributors to her client’s depression, but in this case, foregrounded the poverty. She explained,

Yeah, yeah because depending on the issue, like for example, someone who is depressed...yeah there’s a cognitive piece certainly. Um, you know and ah, thought patterns and all that, but see, um a lot of it is because of the poverty. Anybody would be depressed.

Another participant, Martha, discussed the two factors as working together in causing distress but also in the process of helping her client to recover from her distress. As her client began to have more economic resources, her mental health improved. Yet, there were additional mental health issues to work on even as her economic circumstances had begun to change. Here she described the process:

The stress of poverty exacerbates certain....problems in thought process, mood, (and) affect....They’re very much combined. They are combined and they influence one another. Um, for example, the same person, years later, had rented

out a room in her apartment, um, had figured out a way to sell food, and was hopeful about having the first INS (U.S. Immigration and Naturalization Service) meeting. So, she was at a whole different place... And in that way, economics was alleviated. Her income stress was alleviated. But she still had a lot of the sense of guilt and worthlessness, um, but it had helped with hopefulness... So, in the sense of worthlessness, she wasn't sure if she was a worthy mother, and she still had to figure that stuff out. She would still get hit with bouts of sadness where she just wouldn't want to get out of bed, even though the context had improved. Um, but I do feel that they're both sort of blended together sometimes, and they influence each other.

In another case, a participant saw the two factors influencing each other over time as part of development. Aparna described here how childhood poverty could lead to a mental health issue such as anxiety, which could stay with a client into adulthood regardless of current economic circumstances. She explained it this way:

I see like the social context stressors as contributing to stress in general, whether you feel it in the body or the mind... So they do affect each other... and then the internal stress causes more external stress sometimes and, you know. So, and I explain that to my clients that I work with, so it's, um, that, that both are true, you know. It's not sort of one causing the other... it's actually bi-directional in that way.... I think it also produces a great deal of anxiety because if you've been anxious about money once in your life, that chances are that anxiety stays with you on some level. That it may be less intense, of course, but, you know, um, I think it, it changes your psychology.

A different participant, Mama, described a similar process she had observed, where childhood poverty could lead to mental health issues in adulthood. She emphasizes how important it is to incorporate even *past* poverty-related stressors (such as lack of access to food in this example) into conceptualizations of the source of clients' current problems.

She explained,

I can say I have three patients I can think right off of the bat who have or grew up poor and have instances of compulsive eating, or I mean three who are bulimic, not even compulsive eating. Where they can sit long term stretches where they have experienced deprivation um, food deprivation as a child. It cannot, it cannot for me not be part of the conceptualization. I'm just saying that those that just have happened to present as bulimic recently. All of them have experienced severe poverty. I just can't rule that out...as part of the conceptualization.

At other times, participants described poverty-related stressors and intrapsychic problems as both interacting with and enhancing the effects of each other, leading to a phenomenon where, in a sense, the whole equals more than the sum of its parts. In other words, participants described how poverty and mental health problems, when combined, could have a unique effect on clients' distress that is more powerful because of the interaction between the two. Cody explained,

I would say there's a kind of, uh, constant cross-fertilizing between, you know, views of poverty and views of psychological functioning...so that if somebody's poor, and they're struggling with poverty and there's this kind of mutually enhancing experience between their poverty and their psychopathology, I need really to address both of them.

In sum, most participants described accounting for the relationship between poverty-related and intrapsychic factors when conceptualizing the source of clients' distress. Participants thought about the relationship in complex ways, accounting for the influence of poverty on mental health and vice versa, the interaction between the two, and how this interaction could increase the impact of each on the client. Maintaining awareness of this has implications for other practices described by participants, which require them to act on the awareness and adapt their therapeutic techniques to account for both factors.

In the previous pages, I have described the first set of practices participants use to work with the relationship between poverty-related and intrapsychic stress: maintaining awareness of that relationship in a) the process of maintaining flexibility in the focus of the therapy hour, b) case conceptualization, and c) understanding the source of the client's distress. I will now turn to describing how participants reported acting on that awareness.

*Acting on awareness of the relationship between intrapsychic and poverty-related stressors.* Cody's last comment in section c above indicates that maintaining awareness of the constant interaction between poverty-related and intrapsychic stressors led him to feel that he must address both poverty-related and mental health factors as part of treatment. This leads to the second set of practices related to psychologists' work with this relationship: practices that require the therapist to act on the awareness that both poverty-related and intrapsychic factors are at play. Participants described two sets of practices in which they acted on this awareness by changing their therapeutic techniques to account not only for intrapsychic but also for poverty-related stress: a) maintaining a



willingness to provide instrumental support themselves as part of the therapy and b) being willing to work closely with case managers when they are an available resource.

These two sets of practices are described in the following pages.

*Willingness to provide instrumental support.* Most (11) participants reported being willing to provide instrumental support during the therapy hour and/or seeing the provision of instrumental support by therapists as a necessary part of the work. One participant, Aparna, put it this way:

I think one really important skill is to know how to... leave the time and space in your work to, um, be an advocate sometimes. Not necessarily all the time, but to be an advocate to other um, places like housing offices, the court system, legal aid, you know, immigration services; lots of different places...to know that that's a part of the job sometimes.

Another participant, Esperanza, gave many examples of the types of instrumental support she helps with and went on to explain that in addition to the obvious practical benefit to clients, she sees the provision of this instrumental support as an opening or a gateway to important therapeutic work.

Sometimes I need to write a letter...I have lists of the food pantries so I just hand 'em out. Sometimes I need to make little maps. It depends. Sometimes it's a way of connecting and discussing...the difference in food and what that means to ask for food. And that becomes a whole topic of the session. Sometimes I've written letters to support, (for) a woman who is living in domestic violence and if she given priority in housing. Sometimes I have written letters for a mother whose son was murdered and she needs to move out of that housing project because it

has too many memories. Um, so it depends....I always do it in the session because there's always something that can be used as a therapeutic moment. And we write letters together sometimes and, how much do you want to disclose or not disclose?...So, I do it in the session. Take a few minutes and see if I can use it in a different way.

Another participant, Mama, gave different examples of instrumental support she provided for her client, and went on to say that she feels that psychologists as healthcare providers are required to be brokers of such advocacy and services. She explained,

I do tons to try help around the practical things, getting her a free T-pass, a discounted reduced fair T-pass, um, referring her to social workers um around getting job placements, helping her transfer from one place she's been living where she's being mistreated by neighbor to another. So, a lot of work around helping her with the circumstantial things as an in-route to trying to establish some trust. I think that...we're brokers. I mean we as psychologists and physicians of privilege, healthcare providers, we're brokers for services. People can't get to them without our endorsement, our advocacy.

Other participants also described the importance of considering advocacy for instrumental support as part of the work of therapy with clients in poverty. For example, Chris gave an example of a letter he wrote for his client to maintain heat in the winter and went on to say that he feels therapists need to get their "hands dirty" so to speak and not to consider the provision of instrumental support separate from the role of the therapist. He stated,

There were, at times, there were certain resources that were helping him access those resources around him, like the heating program, some of the housing type of issues, um...you know, connect him to one of the local agencies (name of agency) something that administrates (sic) the um, the fuel assistance program. Um, there were times where there were, um, utility bills that would come in where you would have to write a letter, you know saying his health would be jeopardized if you disconnect the phone or the heat, or you know whatever the bill happened to be outstanding...The context is important here. So that means you need to get your hands dirty...So, it's not like, "Oh, this is beneath me to make these phone calls".

In sum, almost every single participant (11) described the importance of including Instrumental support in the work of therapy. Some pointed out that this work in the realm of instrumental support can be a gateway to intrapsychic work while others went further to say that in fact it is, in and of itself, a crucial part of the role of the therapist. However, the process of empowering clients to gain access to the instrumental support they so desperately need can be a complicated one for a psychologist in the role of therapist to navigate. In some of the settings in which participants worked, case managers were an additional resource made available to clients in therapy. In these cases, participants described the importance of working closely with these case managers as part of the work of doing therapy with clients in poverty.

*Working with case managers.* Most (8) participants described the need to work closely with case managers to help clients gain access to instrumental support, in part because they often have specialized knowledge of resources that therapists may not have

as readily, depending on their training, background, and familiarity with local community. Terry put it this way:

I see a case manager or resource specialist um as being hugely helpful. Um, they may know exactly where the English as a second class for this particular client um, where the doors open, or they might know which housing list has just opened, and you know, so they have invaluable input.

Another participant, Martha, described feeling fortunate to have access to case managers at her agency:

Well, fortunately I work here, where as an institution we have case managers. We used to have a housing advocate in the old days. Um, we have a good idea, based on our own social workers here, um, we have lists of agencies, and we have contacts with people. So, um, that has helped... That has helped a great deal in having someone work with me, um, to either take on that portion of the work or for us to balance that portion of the work.

Here, Martha brought up an important point – case managers may help to take some of the tasks of providing instrumental support away from therapists working with clients in poverty. Given how most participants in the previous section described the importance of providing instrumental support themselves, this could take something away from the process for the therapist. However, another participant, Cody, addressed this issue by working very closely with the client and the case manager together in an integrated way:

I would want it integrated with the therapeutic process. Like I would like, I worked with case managers in the past and have had very good relationships with

them...Um, what I would like is their time, resources, and expertise integrated into mine... I wouldn't want it dissociated from it.

Similarly, Javier described integrating the work with case managers into the therapeutic work by having joint sessions with the case manager when possible. He explained,

When it's possible...the case manager can come into the session...If not, I'll email them – I'll make sure that happens as soon as possible.

In sum, participants described working closely with case managers and integrating this work with their therapy work as much as possible.

The previous pages provided a description of practices that take into consideration the relationship between intrapsychic and poverty-related stressors (cluster 3), including maintaining awareness of the relationship and acting on that awareness. Prior to that, the other two types of practices identified by participants as unique to working with clients in poverty were also described, including those that deal with power (cluster 1) and boundaries (cluster 2). These three clusters of findings make up the first category (Category A) of findings from this study: practices unique to working with clients in poverty. I will now turn to the second category of findings (Category B): Therapist attributes key to working with low-income clients.

### **Category B: Therapist Attributes Key to Working with Low-Income Clients.**

In addition to developing unique practices for working with low-income clients, participants also described having personal and professional attributes that were key to work with this population. These attributes constitute the second category (category B) of results of this study and they consist of four distinct clusters: possessing a values-based commitment to working with marginalized groups (cluster 4); possessing experience

with, knowledge of, and empathy for the devastating realities of living in poverty (cluster 5); possessing a high degree of self-awareness related to poverty (cluster 6); and possessing a willingness to be deeply affected by the work and to cope with negative feelings (cluster 7).

**Possessing a values-based commitment to working with marginalized groups (cluster 4).** Most (8) participants described possessing a values-based commitment to working with marginalized groups generally or with people in poverty specifically and explained that this was a powerful motivation for their work. For example, George shared that he chose his workplace with this in mind, and went on to explain that issues affecting marginalized people have been a concern for him since early in his life:

I'm kind of concerned about things like social justice, and equality, and unfairness. I think, especially, uh, in terms of psychodynamic work I don't think...it should just be for the rich. I feel very strongly it shouldn't just be for the rich and, that's partly why at (name of agency) we try to—it's under threat now—but we try to do psychodynamic work with anybody, you know?...Uh, regardless of how much money they have. So, that's why that's important to me...Um, I mean it's something that I think about a lot because my political belief...I mean I would say that, uh, I'm constantly, you know, reading about and thinking about the problem of inequality, um, especially in terms of, you know, of wealth and opportunity and all of that. So it's of big concern to me. I mean I grew up knowing about that and being concerned at a very early age.

Similar to George, another participant, Esperanza, reported that she believes access to good mental health care is a basic human right, which is a motivating factor for

working with the poor. In addition, she also has a long-standing connection to those in poverty - she migrated to the U.S. from another country with a great deal of poverty, and she felt that working with the poor here was a way to stay connected to her home country.

She explained,

I have a very deeply felt belief that mental health is a human right and that everybody should have access. And um, and it shouldn't be about what you can buy in mental health. I had a private practice in (names country) and worked in communities. Did a lot of community work and there shouldn't be a difference of who can pay and get services and who struggle with nothing. And that sort of shaped me. Shaped what I do and shaped what I like to do...I feel that part...makes me feel at peace with what I believe in...in terms of social justice and open access and mental health as a human right. That, as a belief, and then my personal part...about not feeling like I deserted my country and my people. Here, I'm here with my people, so.

Another participant, Mama, also connected her valued-based commitment to working with the poor to her sense of being connected to her own background. In this case, being Latina and concerned with issues in her ethnic and racial community led her to become passionate about work with the poor. She explained,

Um, gosh, you know I think my main interest has been to work with Latinos and then I discovered they're issues with poverty. Um, so yeah, I think my first kind of clinical placement was with (names agency doing work with Latino/a community), the same team that I'm working. So about twenty years ago. Um, and I really um you know I felt very compelled by the work. I think you know,

perhaps I had some notion that there was some public service there. And you know, Latinos certainly have been underserved. They're just not, there are not enough Latinos in colleges and so I think things that have to do with poverty and, but I think ultimately I was interested in serving my own people.

This personal connection seems to be a key factor underlying participants' deeply held dedication and commitment to working with this population. George, who was quoted earlier, also went on to connect his values of working with the poor to his own cultural background, which shaped his current political beliefs. He shared,

Well, uh, I don't think you can sort of walk around the earth and not look at the inequality (laughs), um, and other people, and not worry about that, frankly.

Also, uh, I grew up in (name of country) where inequality was absolutely, you know, huge and, and intersected with race in a very complicated way—it's not that there weren't poor white people, there certainly were and are—but there was such inequality with black people, uh, and such poverty that it was impossible to grow up and not be acutely aware of that and not feel very bad about that... So, it's of great- of great concern to me. And my, you know, political, uh, my political background, I'm a leftist, I'm-I'm an anti-capitalist... I think there's something wrong with the system which leaves, you know, ninety percent of people without money and a few super wealthy. There's something wrong with that. So it concerns me, greatly... It's political; it's a political sentiment as well.

Similarly, another participant, Martha, shared how her own racial and ethnic identity impacted her commitment to working with the poor. She explained,



There was a huge piece of my identity in terms of community work serving the underserved. Coming to (names city), which, way back when, the disparity between poverty was really high, and um, based on race and based on ethnicity...and, so, that was the area that I wanted to focus on....and the disparities in terms of infant mortality, um, income, education. And even back then I was in graduate school I was like the three percent, because there weren't many of us. There weren't many of us getting degrees, Ph.D's. So, it was almost like a mission. (Interviewer: Many of us meaning?) People of color. Many Spanish speakers, many bilinguals, many Latinas....And, um, so it was a mission to change things. And that's, I think, what really got me started.

Martha's sentiments echo many other participants' in that most participants articulated a deeply held commitment to working with marginalized groups that came in part from her own personal experience and connection to those who experience oppression in society. This commitment was a common attribute of participants in this study, who seemed to indicate that it was an integral part of their work with clients in poverty. I will now turn to another attribute described by participants that also has to do with what they bring from their own personal experience to the work: possessing first hand experience and knowledge of the devastating realities of living in poverty.

**Possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty (cluster 5).** In addition to the values-based commitment evident in participants' responses, most (8) participants also described the importance of having deep knowledge of the experience of living in poverty and as a result, developing a high degree of empathy for that experience. One participant, Cody, explained that a

therapist working with clients in poverty must be able to understand deeply the experience of poverty both from the client's first-hand perspective and from a distance that allows one to see how the poverty-related stress is affecting each part of his or her life and psyche. He explained it this way:

You have to have a lot of experiential and clinical range to treat poverty-stricken people. Because you have to understand, in a very sophisticated way, kind of what their world is, kind of from thirty thousand feet... but you have to have your feet on the ground and sit and stand next to them...while you're doing the work.

He also discussed how during his training his supervisor taught him to ask good questions to begin to understand the first-hand experience of poverty that his clients were living with. He shared,

He (supervisor) would ask questions like: "What do you have in your refrigerator?" or, "How do you spend your money?", or "Who's the person you love the most, and what do you do with that person?". He would ask those kinds of questions. And from a poverty standpoint, to articulate the landscape in that way is a kind of knowledge, right? So I think you have to do that. I think you have to understand what the social, political, and economic realities of people's lives are. I feel like I've got a bit of a leg up on that, coming from where I came from. Um, and I think you have to integrate that into some kind of theoretical frame that informs your clinical point of view so that you can be effective...Psychodynamic, CBT, all of it funnels through those filters.

Here he also made the point that because he came from a working-class background, he feels he has an advantage when it comes to understanding the context of poverty. He also

explained that whichever theoretical orientation a therapist is informed by, he believes that deep knowledge of poverty should “funnel through all those filters”. He went on to explain that understanding the point of view of the client requires some humility. He shared,

And the skills are mostly about making contact with people in a very straightforward, uh, humble, modest way where, uh, to-you have-you have to be able to learn how to understand things from their point of view.

Another participant, Javier, shared his knowledge of the uniquely painful experiences associated with poverty, such as not knowing where one will sleep at night. He stated,

Uh, you know, sometimes if you have that knowledge that – how painful it is to not know where you’re going to be sleeping, I’m thinking about how is that different from somebody else? Well, (sighs) because it’s a significant stressor that just doesn’t – you can’t get rid of right away.

Here he recognizes that in the case of poverty-related stressors such as homelessness, as a therapist he feels he cannot “get rid of” it right away. In addition, he uses his experience with clients who don’t have a place to sleep to deepen his understanding and empathy for the pain created by that situation. This empathy leads him to consider the injustice that some people are born with more resources than others, and those who have less are at a disadvantage throughout their lives. He went on to share his own personal understanding of this injustice using a metaphor. He said,

Some people are poor in third base. You are just so much closer to home. And a lot of people I see don’t even have a bat. If you come back to the metaphor of baseball...you know, you just have to help them find a bat.... Uh, I’m trying to

use a metaphor to the maximum, but I'm just saying that you have to find a way to include their context into the whole therapy process or else it's not going to work.

Yet another participant, Mama, conveyed her empathy for and knowledge of the terrible realities of poverty— in particular the possibility of not having enough food to eat - this way:

Um, the other thing I would say is poverty is hard - it's mad hard. It's harder than anybody can possibly imagine if you don't know it. I think that it's painful, it's physically painful. I mean not only if you're hungry but including when you are hungry. I don't know - I don't know what it is to be hungry. Um, I think it is important to have that empathy that perspective of compassion

Other participants described an active empathy building on their part – an active and ongoing attempt to put themselves in the shoes, so to speak, of their clients. Aparna described actively visiting the places her clients go shopping and attempting to understand their food choices. She explained that this helped her to distance herself less from their realities:

Well, you know, if a person's talking about where they went shopping, then I'd have a better point of reference to know what they're talking about, you know...how much did that cost, you know. And so we'd talk about specific food bills and things like that...And um, so that's how it would come up...But it's for me to have more of a first-hand account of what it might be like...Rather than just theoretically talking about something...So, um, and I also think choosing to do things, like I've done uh some community work that is, um, you know that is

placed in lower-income background places, lower-income neighborhoods. So going over there to see sort of like well, what are the food options, you know? Just being, I think just sort of trying to immerse yourself in the world a little bit more than you normally would, perhaps. So things like that...You know, um...going towards it. So that it's ah, you know, I feel like that just keeps me grounded in the work better because it sort of, otherwise you could really function in a very different way...And sort of like "Okay, the session's done, I'm gone" (laughs) "And I'll go back to my life, whatever that is". We do that anyway, but you know...it's less distancing in certain ways.

Similarly, Esperanza described trying to "hold in place" in her mind a glimpse of what her clients in poverty are dealing with:

For me, (it) is to have a glimpse, because I think it's only a glimpse, of what their life is like and try to understand what it is like. Um, to hold in place every day that I sit with someone that, all the struggles they're dealing with.

It seems that for some participants, actively thinking through and trying to feel some small part of what their clients are going through in poverty helps them to maintain empathy for and knowledge of the experience.

In addition to describing the importance of knowledge and empathy for the experience of poverty, some (5) participants explained that they gained this knowledge and empathy through years of direct experience working with clients in poverty. One participant, Terry, put it simply – she said, "I feel pretty well prepared. Um, prepared by experience, taught by the population". Similarly, another participant, Mama, said it this way:

I've been doing the same, I've been doing this work for I guess twenty years right now. If you had asked me (whether I was prepared to do this work) twenty years ago what would I have said? Um, I guess I had no idea what I didn't know.

Here, she made the point that without many years of experience she would not know what she didn't know, and from her perspective this was a key part of her knowledge of poverty – understanding that as someone who was not in poverty herself, she could not fully know the experience.

In sum, knowledge of and empathy for the painful realities of living in poverty was identified by most (8) participants as an important attribute. Participants described, often in rich detail, their own knowledge of the context of poverty and their efforts to maintain empathy for the challenges their clients face. In addition, some (5) described the importance of their direct experience working with clients in poverty in helping them gain the knowledge and empathy they had. I will not turn to another attribute participants identified as important for work with low-income clients: possessing a high degree of self-awareness related to poverty.

**Possessing a high degree of self-awareness related to poverty (cluster 6).**

While self-awareness is a key attribute for therapists working with any population, participants described two aspects of self-awareness that they felt were particularly important for work with clients in poverty: 1) maintaining awareness of one's feelings toward, reactions to, and assumptions about clients in poverty; and 2) awareness of the impact of one's own class background on work with clients in poverty. In the following pages, I will describe what participants shared regarding both of these aspects.

*Maintaining awareness of one's feelings, reactions, and assumptions.* Most (9) participants described the importance of maintaining awareness of one's feelings toward, reactions to, and assumptions about clients in poverty. For example, one participant, Esperanza, discussed the particular draw to want to “rescue” clients in poverty from their circumstances. She shared how she challenges herself to recognize that pull and examine what unspoken dynamics may be at play in the therapy relationship specific to the clients' poverty and its effect on the therapist. She explained,

Rescuing somebody - it's very dangerous. Um, when I find myself trying to do too much for someone I always try to catch myself. What else is going on with me, with the person? What's unspoken?

Another participant, Aparna, described a different reaction that challenged her when working with clients in poverty – the sense she sometimes had that because of the client's poverty it would not be fair or appropriate for her to experience negative emotions toward a client. She shared,

Um, and to respect the fact that you have your own feelings about it...I think sometimes we fall into this feeling like you can never be angry with your client who's poor, you know...Or that you can't have negative feelings about somebody in a moment when they're frustrating you, you know...And, but again it's about I think just an authentic kind of relationship where you can feel anything you would regardless of that, with any person you might meet, you know.

While Aparna pointed out that self-reflection involves allowing oneself to feel even negative feelings toward clients in poverty, another participant, Chris, identified that he

needed to be aware of his assumptions about and possible hidden biases toward people in poverty. He explained,

Um, I think very early on I made assumptions...that it was some kind of short coming...Then I realized it - very often that there were tragic events, or illnesses...like if you look at that you see that an enormous number of those people have that happen, you know, because a catastrophic event, um, and all the assumptions about even who those people are. You know, they're kids and they're women, or they're people who just got burnt out of their house, or you know that stuff, so. I think that there was a fairly rapid learning curve but you know I realized I kind of had a middle class perspective of you know well, "If you just tried harder." And you know that, that's maybe the flip side of my family narratives...there were people who were able to be very transcendent. And in some of the like, some of these patients that have done very well, that are very resilient. But not all of them can. And not all of them will be able to and that you know you try to suspend too much judgment about that...So that means you have to look into yourself a little bit about what your limitations are.

Here, Chris explained that his own middle-class background and stories in his family about family members from previous generations overcoming poverty brought him to have assumptions about his clients – that perhaps they should just try harder. However, through the process of self-reflection, he was able to recognize this assumption and question it. Chris' example brings to the surface the second area of self-awareness and reflection described by participants: maintaining awareness of the influence of one's own class background on the therapists perspectives and approach to the work.



*Maintaining awareness of own class background.* Most (7) participants described maintaining an awareness of his or her own class background and how it is affecting the work with clients in poverty. Because participants came from varied class backgrounds (see demographics in Table 1), the effect of each participants' class background on the work was unique to them. However, what was common to each participant who commented on this was that each seemed to be maintaining awareness of the effect of his or her life experiences with poverty or lack thereof, and how it was affecting perceptions of the client and the work. For example, one participant, Aparna, described having had a varied class background, living part of her life in relative affluence and part of her life in relative poverty as her family had migrated to the U.S. from another part of the world. Her parents' commitment to sending income back to her home country made a big impression on her and influenced her values about spending and giving money. She explained,

So for example, my father and my mother earned a certain income when we first moved here, but part of that income was always sent to relatives to (country of origin) who were living in a far more difficult situation financially...and so for me I always knew that that income did not mean that that's what you lived on...but rather you set aside something for helping other people in your family because you have an extended family idea...So I think it's, it's, the migration issue too that made it, you know...It kind of contributed to what I thought about class.

She went on to describe how that impacted her decisions as an adult in terms of her spending, and caused her to reflect on how class status can be fluid over the lifespan, but

for clients in poverty it may be that they are stuck in poverty for their entire life. She explained how it impacted her clinical work:

I think it-it helps me have more of an empathic, kind of, attunement around these issues...and, also the impermanence of class in certain ways...It reminds me of sort of the, both the stability of class and the impermanence of it.

Another participant, Cody, identified as having been raised in a working-class household and neighborhood. Given that he did have to worry about money growing up, he explained how this could help him understand to some extent barriers that clients in poverty might be facing. However, on the other hand, given that he was not in poverty himself, he also saw limitations to how much he could understand from a first-hand perspective. He shared,

They (clients in poverty) have a lot of trouble getting to appointments because, you know, they're working ninety hours a week or they're working in places where their bosses aren't going to, you know, let them out. Um, you know, even though I'm not from that immigrant community and I didn't grow up poor, I grew up around a lot of people who worked that way.

He went on to explain how despite his working class background, when one of his clients described his life circumstances in severe poverty, it was unfamiliar to him:

You know...if you listen to him (the client) describe what the world is like in that group of people, these people live in a world, it's a little bit of a Darwinian theater, you know. They live in a world that is, kind of, kind of foreign even to me because I, you know, I'm a working class kid.

Another participant, Javier, explained how when he was a graduate student, he had so little access to income he struggled to eat and pay for his books. However, similar to other participants, he made the distinction that his situation was quite different from his clients in poverty, who may be dealing with such circumstances permanently throughout their lives. He shared,

You know, when I was a student, I didn't have enough to eat. I was in the hope it was a temporary thing... You know, a lot of the people I deal with (clients), it'll be permanent.

He went on to explain how even though his situation as temporary it did increase his empathy for clients in poverty.

I think that understanding, unfortunately, knowing that you, you really don't know if you're gonna eat well the next day, uh, does have an influence and allows you to be more empathic... You know, when I was, you know, at school I, I didn't realize at times, how am I going to pay for this book? How am I going to pay for this? You know, I was very fortunate that I that I was able to make it. But I worried about it for quite a while.

On a different note, another participant, Rachel, shared how she felt that her own middle class background did not prepare her for her work with clients in poverty, even in seemingly small ways such as how she was taught to dress for work. She described it this way:

I mean I certainly had all these - I still to some extent have - all these little business suits as someone who was starting out in the field. And um, I would go to daycare centers and I'd think "I can't wear this stuff", and I wouldn't want

someone to come in when I'm looking all professional or whatever that means. I'm not saying I should be dressed in rags. But I certainly had thought about how my own background doesn't really or certainly didn't, especially in the past, prepare me for the kinds of life experiences that people I was working with experienced every day - and that I had no knowledge of.

Rachel, Javier, Cody, and Aparna's rich descriptions of how their varied class backgrounds affected their level of empathy and understanding of their clients reveals the importance of maintaining awareness of how one's class background affects work with clients in poverty.

In sum, most participants described the importance of maintaining self-awareness, both of their own feelings toward, reactions to, and assumptions about clients in poverty and in terms of recognizing the impact of their own class background on the work. While participants noted that self-awareness and recognizing the impact of past experiences on the work is important, they also described the importance of recognizing how the work is affecting oneself. I will now turn to another attribute necessary to work with clients in poverty described by participants: possessing a willingness to be deeply affected by the work.

**Possessing a willingness to be deeply affected by the work and cope with negative feelings (cluster 7).** Participants described two main ways in which they were uniquely affected by work with clients in poverty: a) they were affected emotionally, describing both positive and negative emotions arising uniquely from work with clients in poverty and b) they were required to develop ways of coping with these strong emotions – particularly the negative ones.

*Therapist feelings about the work.* Participants shared that they were deeply affected by work with clients in poverty on an emotional level, and that this was an important aspect of the work. Participants described experiencing both positive and negative emotional reactions.

*Positive emotional reactions.* Most (7) participants described being positively affected by the work on an emotional level, experiencing optimism or hopefulness; a sense of privilege that clients in poverty allowed them into their lives; feeling gratitude and respect; and feeling amazed, inspired by, and a sense of admiration for clients' resilience. For example, one participant, Usha, shared that the relationships she has built with clients and her sense of being privileged inspires her to continue doing the work. She shared,

I mean I, I do appreciate the relationships I've built. And I do think it's a real privilege for people, you know, that people let you in their lives in such a way and I think that is why I do it.

Another participant, Terry, shared that she found hope in her clients' ability to survive the devastation of poverty. She explained:

On a more personal level, I think there's something um, there's something quite wonderful about working with a population of survivors, um, with people who are resilient. Um, so I find that um, quite incredibly hopeful. ...So um, so when you see what people can get through it sort of reminds you about the strength that people have. Um, and probably the biggest, the biggest impact on me that this work has on me is as I said, it leaves me hopeful about what human beings can do.

A different participant, Esperanza, shared that her clients in poverty often surprise her with their strength and resourcefulness:

I think the ability to use their resources in moving on - they never cease to surprise me. People never cease to surprise me. What they're able, the skills they've developed to get out of situations, to master situations that feel hopeless to me.

Esperanza went on to say that her awe and surprise at clients' resilience keeps her happy in her job. She stated,

It's still my dream job ten years later...I'm excited every morning that I come here. Even though I'm tired when I leave...still very excited to be here every day.

Finally, another participant, Mama, expressed a similar sentiment in similarly strong terms, sharing the following:

I kind of feel a little more...happiness. I thank God I have the most beautiful patients in the world....Um, I feel enormous joy and I feel it is an enormous privilege I have. My patients have just taught me so much and um, about life, and so I just feel more so privileged, very happy. I couldn't ask for a more rich work.

In sum, participants described many positive emotions evoked by the work, but this was only part of the story they told - participants also described being strongly affected by negative emotions.

*Negative emotional reactions.* All (12) participants reported experiencing negative emotional reactions as a result of working with clients in poverty. These emotions included sadness and despair, hopelessness, anger and frustration, helplessness, overwhelm, fatigue, guilt, and worry. For example, Rachel reported,

I certainly sometimes, despite my optimistic bent, feel mired....you know, I feel (pauses) depressed, not clinically, I don't think, but sort of hopeless. You know, what can be done? What can be done? Um, what else? Um, sadness, um, frustration, sometimes.

She went on to explain that witnessing the oppression of poverty made her feel tired, and helpless that she could not do more for her clients:

Well, it's more that...how you feel sometimes after you've sat with someone who's kind of, sat with a series of people, who are really oppressed and really bad, reality-based situations. And it's like, "Uhh, I just want to take a nap!"....You know?...So it's, it, I mean, that's what I mean, that you have to, kind of put it in perspective and say to yourself, at least I say to myself, you know, "I'm doing what I can, I can't take on all of this, I'm not going to adopt these children and take them home with me."

Usha expressed a similar sense of helplessness, recalling her bearing witness to a particularly painful moment in one of her clients' lives:

Um so, there was this one period, which was really the worst, when she (her client) was in, when she was homeless and she was attending this day program and you know and then she moved in with her daughter, who was horribly controlling and wouldn't let her eat anything in the house unless she bought it and she had no money. So she would literally come into my sessions and say like, "I'm so hungry, I'm so hungry." Um, and it's I'm mean the kind of helplessness that you feel you know witnessing something like this.

Another participant, Javier, also described feeling deeply affected by the work, experiencing feelings of pain and sadness. He shared,

It affects me emotionally, it affects me cognitively, it affects me, um, socially.

I think if I weren't aware of how much it hurts—that's a strong word, but it does hurt me—it makes me sad to see so many people go through so much pain.

Others shared how the oppression of poverty made them feel angry about the social injustice. For example, Gemini stated:

This is the richest country in the world, supposedly. And yet, we have these massive amounts of poor people... There's always gonna be poor people but when you have people out in the street and people ignore them... people live under the bridges, you know, um, people live on the banks of the (name of river) until the cops chase them away. You know, they have their tents. Like this time of year there's a bunch out there. They don't want to be in shelters, on the (name of river)... They (the public) see the poor as being invisible, bottom line. Just the fact that people pay these superstars, these athletes and all these millions of dollars and you have people who are asking for lunch, you know, a little brown bag lunch, people living in hotel rooms, people living in shelters. You know, it's disgusting... It's absolutely, absolutely, absolutely disgusting.

Another participant, Mama, shared a similar perspective, and added that her anger is connected to her empathy for those she works with, and with a perspective of how sociopolitical colonization is connected to poverty.

Uh, I'm so angry at how the world has been constructed. There's no reason that people should be living in poverty. You know richest country in the world



and...certainly not with all the accesses (sic) there are in the world. But it's a reality of how you know colonization and you know European colonization and just the division of resources in the world. So I feel angry um, I feel empathy, enormous empathy.

Rachel, whose feelings of fatigue, sadness, and frustration were described above, went on to express her anger and disgust at seeing social injustice in her work. In particular, she shared an example about a client she worked with that has stayed with her:

I actually know someone who is seriously thinking about giving up custody of her child because the child's medical issues could only be addressed by, you know, some major, whatever, that she didn't have insurance to cover, but if she gave up custody, then the state would pay for... Without going into details (sighs), are you kidding me?! So, anger and frustrations that there's situations where people find themselves in through no fault of their own...I know you can't record this expression on my face...But it's like, you know, really?! You know, uh, so, frustration and anger at system sometimes.

Finally, one participant, George, described being affected in that he sometimes felt guilty, which caused him to self-reflect on his reasons for doing the work. He shared, There's probably a little bit of like, um, a little bit of guilt at like I'm trying to do good, I'm going to help this person who's disadvantaged... which although that's a good thing to do, it's a little bit like, um, like there's a certain amount of guilt that I feel for having to be in that position... You know, like it's, who's this for? Is this for me or is this for them?... In a way it's for me 'cause my way of doing, giving back something, or doing something.

In sum, all twelve participants described how the work evoked strong negative emotions in them, including such feelings as sadness, helplessness, tiredness, anger, and guilt. Given that all participants had also been doing this work for five or more years (as this was part of the inclusion criteria for the study), they described needing to find ways of coping with these negative emotions in order to sustain them in the work.

*Coping with feelings about the work.* Participants described four main ways of coping with the negative feelings that arose in the context of their work with clients in poverty: a) seeking social support; b) setting limits and/or maintaining psychological distance from the work; c) taking perspective or using cognitive strategies; and d) engaging in nourishing activities and hobbies outside of work.

*Seeking social support.* Most (7) participants described seeking social support as a strategy for coping with negative feelings. The most common type of social support described by participants was consultation with colleagues, as half (6) of participants shared that they use this type of support. For example, Chris answered this way when asked how he copes, “not working in isolation with it and building to really have a cohesive staff because, you know, you can’t do this work alone.” Another participant, Martha, shared some of the ways consulting with colleagues can be helpful:

I consult with my colleagues. There, there are certain colleagues I can sit down with and talk about this...So um, that’s a good place for me to go....consultation is a very important gift we have here (at her agency)...They make sure you’re doing the work appropriately. They offer advice. Um, they might normalize, they might minimize, and they might question, um, and there’s a good sense of

trust here in this department where you can, you know, pick someone's brain, and we'll share stories.

While Martha highlighted the importance of her colleagues' advice and questioning, another participant, Terry, emphasized the importance of being able to experience and share negative emotions with colleagues and being able to cry with them if necessary:

Make sure you work in a system where you feel valued, with colleagues you can talk to, um it's um, the work is too heavy if you don't have a system that you can share it with. If I can't walk down the hallway and collapse in someone's chair, um, and cry if I need to cry, or do whatever I need to do, um or rant and rave, um then the work would be, if I was lonely and doing the work that would really be a problem.

Other participants discussed seeking social support from sources other than colleagues. Javier shared that he talks with his family and friends as well as colleagues about his negative feelings, "I think it's – I'm aware of it, uh, I do get sad, I do sometimes, uh, feel very sad. I—firstly—I talk about it, that helps me. I talk with my family, I talk with people close to me, peers, etc." Another participant, Mama, mentioned discussing her negative reactions to the work in her own therapy. She said, "I was in psychotherapy for ten years so we'd talk about it in psychotherapy." Finally, another participant, Martha, said that just being with her kids away from work was a support to her. She shared simply, "I go home to my kids".

In sum, most participants described seeking social support as a coping strategy. The most common source of social support was colleagues, but participants also mentioned talking with friends and family and their therapist, as well as spending time

with their children as a way to deal with negative feelings arising from their work with clients in poverty.

*Setting limits and maintaining distance.* In addition to seeking social support, some (5) participants also described coping strategies that involved setting limits (for example, on how much time outside of work they spent discussing work), or maintaining some psychological distance from the work, (for example, by attempting not to let the work affect them personally in their lives or investing in having safety and security in their own lives). Cody shared that keeping his own personal life stable and supportive helped him to face the instability of his clients' lives day in and day out. He said,

I'd say that at bottom I have a good life, you know...that sort of provides a sort of buoyancy....when you do this work you have to have a decent life that is supportive.

Another participant, Chris, shared something similar. Although he wondered if he should instead be giving money to people in poverty, he shared that he spent money on his home (where I conducted the interview) in an attempt to make it a sanctuary from the painful realities of his clients' lives:

It's not a mansion but it's a pretty cool house. It, so, does that feel hypocritical because you know, shouldn't I be giving all my money to the poverty patients?

And um, you know, but I think it's a balance. This is a refuge, this is a sanctuary.

Chris also described setting limits by working part time with clients who were not in poverty as a way to cope with the painful feelings evoked by work with poor clients. He shared,

It's very hard working full time at the clinic where I am. Some people have tried and done it and they don't tend to last long. It's usually, you need to have a balance. And for me I like having a private practice group. Which, again, it's three of us that own the practice but we're supportive of each other and there's a cohesion with that. And I do work with a higher-level population there, um.

(Interviewer: Higher income you mean?) Yeah. ... Um, it's one of the survival strategies. I've always had at least one other job... The vicarious traumatization is a real phenomenon and you really need to acknowledge that and you really need to find ways to balance it and I think working different jobs or having different roles, doing supervision (is a way to do that).

Similarly, Javier shared that he also maintains a private practice alongside his work in a hospital with clients in poverty:

But also helpful – I have a private practice, and I don't have many poor people there... and, um, it is helpful for me to see the contrast of, that, how it is in my practice and here. It emotionally is also helpful... Because, uh, it's less frustrating. It's more difficult to work here... I don't think I could do this job full-time here.

While these participants described setting limits on how many hours per week they spend doing work with clients in poverty, others described setting limits in other ways. For example, Rachel shared that she attempts to set some psychological limits on how much she identifies with her poor clients' struggles, trying not to take on their experience in a personal way. She explained,

And I- and I set those limits. Cause I need to do that. And I try very hard to help my students, the people who I supervise, to set those limits too, because there's a

limit to what you can do...I mean, if someone, I mean, any s-sad story I hear, it's like (sighs), it is gut-wrenching. But I try and remember that my job is to not be mired in the muck with them. Because then we're both trapped. My job is to figure out how I can help them with their situation, and I need to be a bit distant to do that. To stand next to them, not mush with them.

She also explained that she tries to set limits on how much she takes the work home with her:

Most of the time, I leave the office at the office...because I, I know I'm no good to anybody if I, if I'm bringing that home. Do I wake up every middle of the night?...Oh, maybe occasionally. But not very frequently.

Similarly, Gemini shared that she attempts not to bring the work home:

And also the level of trauma is just so high. I keep balanced. I try not to bring stuff home. So I don't talk about clients because I don't need to. But I know some people who need to, for example, "Let me tell you about this client I saw today." I don't get into that. So I just leave it there and um. I have other things, that like I am saying I have other things I need to do.

In sum, some (5) participants reported coping with the stress of work with clients in poverty by creating some distance from and/or setting limits on the work in some way. These strategies included investing in and creating stability in their own lives to the extent possible, setting limits on how much time they spent working with clients in poverty by doing other types of work for part of their time, trying not to overly identify with clients' pain and suffering, and trying not to take work home with them.

*Maintaining perspective.* In addition to seeking social support and setting limits, half (6) of participants described using perspective taking as a way of coping. These included such things as keeping in mind the whole person in addition to his or her poverty, focusing on smaller manageable goals, and accepting limitations of working with clients in poverty. For example, Aparna discussed her attempt to hold the whole person in mind as a way of coping with the painful realities of the poverty faced by clients. She said,

For me it helps to kind of separate that rather than trying to, you know, see this as sort of defining everything a person is which is a big problem...I think of course it's a big part of one's life, but it's not the entire human being. And that's something that I really feel helps me kind of think about who I'm working with, you know. That I don't, that for me it doesn't sort of define a person. It sort of, it defines a situation. And so I think I, and then I sort of step back and I think "Well what can, what can we be doing to deal with the situation?", you know.

It seems that reframing the client's poverty as a situation that can be dealt with rather than a defining aspect of him or her helped Aparna to feel that the work was manageable. Others also mentioned taking a different perspective as a way of coping, for example focusing one's attention on small pieces of work that seem possible or manageable to work with. For example, Usha shared, "It's hard. I think...you have to find pieces of it that you can try to work with". Similarly, Rachel shared that she focuses on parts of the client's situation that seem workable, even if they may seem small in the face of the enormous stress of poverty. She shared,

But, yeah, all you can do is what you can do, and it's not, it's not making people feel better about a bad situation, it's not that at all. It's helping them to look at that situation and find a small, little avenue of wiggle room that they can do something about and make themselves feel better about that... And I think once you can start to make those kinds of changes that way, you can feel more energetic, and you can feel less depressed, and you can feel like, you know, it's not that it'll all go away, but I can do some stuff... that there are small but significant steps that they can take to, to move out, or to move away from bad situations.

In addition to viewing the work as a series of small manageable steps, participants also described the importance of accepting the limitations of what can be done as part of the therapy with poor clients. For example, Rachel said that she steps back and accepts that there are limits to what she can do. She shared that one of her strategies is:

...just stepping back and saying 'I need to take care of myself now.'... And I'm doing what I can do, and all I can do is what I can do... trying to be, despite being somewhat optimistic, being realistic about what I can accomplish. I mean, if someone has spent so many years in a certain situation, and all these factors have impeded their lives, and, and caused their lives to be what they are, I can't come in, you know... with my magic wand or anything and change it.

In sum, half (6) of participants used perspective-taking strategies to help manage the sense of overwhelm, despair, or other negative feelings that can arise in working with clients in poverty. Keeping in mind the whole person in addition to his or her poverty, focusing on smaller manageable goals, and accepting limitations of working with clients



in poverty were described as helpful ways of managing the psychologists' own negative feelings and reactions.

*Engaging in nourishing activities and hobbies outside of work.* Finally, in addition to the coping strategies described above, some (4) participants reported that engaging in nourishing activities and hobbies outside of work helped them to cope with the stress of work with low-income clients. These included writing poetry, shooting pool, reading, and listening to and playing music. For example, Chris shared,

You know music is another way of um dealing with the things...we're both (he and his wife) musicians so you know um. My wife is in education actually special education and...um, we both have found that music is an important way of balancing some of the difficulties and intensity.

While only some participants mentioned these hobbies as important, it seems noteworthy that they included these activities that are seemingly unrelated to the work as an important aspect of self-care and coping with negative emotions arising as part of the work.

In sum, working with clients in poverty requires a great deal from therapists, and participants in this study articulated some key personal and professional attributes required for the work: possessing a values-based commitment to working with marginalized groups (cluster 4); possessing experience and knowledge of and empathy for the devastating realities of living in poverty (cluster 5); possessing a high degree of self-awareness related to poverty (cluster 6); and possessing a willingness to be deeply affected by the work and cope with negative feelings (cluster 7). While possessing these attributes was important for helping participants thrive, they also described many

contextual factors that were not helpful and in fact posed challenges and obstacles to the work.

### **Category C: Contextual Obstacles to Working with Low-Income Clients**

In addition to describing unique practices for and attributes key to work with low-income clients, participants also described contextual challenges and obstacles to work specifically with clients in poverty. Their description of these challenges constitutes the third and final category (Category C) of results from this study. Participants described two types of challenges, which are the two final clusters of results: unique agency-level challenges (cluster 8) and unique social service system-level challenges to the work (cluster 9). These challenges are described in the following pages.

**Unique agency-level challenges to the work (cluster 8).** Most (11) participants described agency-level challenges they encountered when working in agencies and organizations that specialize in providing care to low-income clients. These included a) insufficient resources and lack of access to case managers and b) unhelpful rules, policies and procedures within the agency.

*Insufficient resources and lack of access to case managers.* Most (7) participants discussed the challenges of working in an agency or organization that is not sufficiently resourced – a phenomenon that parallels and often accompanies work with low-income clients. The agencies and organizations that typically do this work are often without the basic resources they need – much like the clients they serve. One of the most commonly mentioned observances of this was in the instance of case management – participants explained that they were not compensated for doing case management work and yet there

are often few to no case managers available to help clients to help clients gain access to poverty-related resources. One participant, Usha, explained:

It helps if there's somebody else involved like a team, or DMH (Department of Mental Health - an organization which provides case management to clients with serious mental health problems)...that really really really helps. And so that's like a blessing. Uh, you know but that's not that common anymore... We used to have them but as our patients have suffered financially, so has the hospital. And we've lost all those buffers. (Interviewer: You're doing case management and therapy with every client?) Everything. With everyone.

Another participant, Chris, shared that his agency does have case managers (referred to as resource specialists), but he wishes there were more of them. He said, "I do think it helps to have, you know, we have really good, um, resource specialists but I think we need a little bit more of that." Another participant, Esperanza, also mentioned that there was one person in her agency who did help with case management, but that person was expected to serve all the clients being seen at the agency and was understandably overworked. She shared,

Uh, I wish we had more staff. I wish...that we had like uh, somebody here... We have clinical social workers on a team, but I wish I had like a community outreach worker that had all these resources... There's somebody downstairs but she's so overworked.

Yet another participant, Cody, shared something similar:

We don't have them (case managers). Um, it's a budgetary thing, I don't think it's a political thing, but I think if we had better case management we could service

them (clients) a lot better because, I'm not a good case manager. I'm not...I wasn't trained to do it, don't really know what the resources are. You know, you pick things up here and there, but I don't do it in any systematic way.

Participants also noted that when they did do case management as part of therapy (and many reported that they do, as evidenced by responses outlined under the section above regarding providing instrumental support), they are typically not compensated and their work does not "count" in productivity requirements at their organizations. Chris explained,

The paperwork and the documentation and, you know, the letters that you have to write, it's a phenomenal amount of time...and then more and more of these unfunded mandates, as well...We do so much crisis work...and not all of it is face-to-face. We section, pink paper, (this is an informal term commonly used to describe the process of filling out the documents required to hospitalize a client against his or her will because his or her life is believed to be at risk) as many of seventy patients a year off of our unit - not the emergency room - off of the third floor, which is unprecedented. Most clinics (have) maybe a couple of times a year. But there's a huge number and you know that involves security and ambulance services. So it's a huge amount of time that gets spent...(Interviewer: That's not reimbursed?) Well it hasn't been but the new one will be. But that's one of the frustrations - is that you know I'm on an intake, we share this two hour block or four hour block of intake. You know I get one of these patients, you know that takes three hours of my time. I don't get credit beyond the one hour maybe...You know, so the hospital is looking at my productivity and saying, you

know you're accountable for this but you're also accountable for writing up all these notes within eight days. You know, this is where it's getting difficult. The sense Chris describes of things "getting difficult" and being asked to do too much with too little was echoed by other participants, such as Usha, who said she felt the crunch of insufficient resources even in her own paycheck. She shared, "Um, I think it would be better, I think it would be easier if we were paid more." Another participant, Gemini, shared that because of insufficient staffing, she was expected to take work home on the weekends, unpaid. She explained,

So, I wind up doing work, um, on weekends. So I try to limit that and I hope that the clients don't show...that way it gives me an hour to catch up. So um, yeah so it depends. Things have a way of working out, you know, and so Fridays I don't see patients and all and go to know shelters or anything 'cuz that's like paperwork day. To try and catch up so I can decrease the amount that I have to do on the weekends.

In sum, participants identified insufficient resources and the resultant lack of case managers as one factor having a negative impact on their work with clients in poverty, and to some extent on their personal wellbeing, given that it could mean decreased pay and being expected to work on weekends in some circumstances.

*Unhelpful rules, policies and procedures within the agency.* In addition to lack of resources, some (5) participants also identified challenges associated with unhelpful rules, policies, and procedures within their agency. For example, Martha shared that in her organization, administrators monitor her case notes to find out whether evidenced-

based models are being used in therapy. She explained that when working with clients in poverty, this seemed to her to be an unhelpful practice:

Nowadays that our notes are being read, and I think they, um, they're being reviewed more often to make sure that we're using evidence-based models or techniques, and insurance, are reading our work more often. Um, so that it's, they're determining how fast we should be closing cases...The old days I could hold onto a case like (name of client described earlier in interview) off and on for, you know, forever, or as long as I'm working here. In the old days, analytically, you never closed a case, it just went away, they would come back when need be. In the newer days, nowadays, that's not it, and short-term work is all that we're supposed to- that's what's being promoted. So, it's becoming more of a challenge, I think.

Another participant, Mama, described how her agency has in place policies that pressure clinicians to see more clients in less time, which she finds impossible. She explains,

I think that right now I don't feel very supported because when there's financial crisis and so um the bottom line is how many patients we see and this does not take into account how much collateral work each patient takes...I think that right now the institution just doesn't want to hear about that stuff. They just want us to see as many new patients as possible. And there's no way we can do it. There's no way we can, I think that, I think a lot of our patients (in poverty) are complexly traumatized and I think that we don't have enough time for them. You know, I think PTSD requires a lot more resources than we can give them. So I think in that respect I don't feel particularly supported.

In addition, participants identified as a challenge practices and policies in their agencies requiring them to complete a great deal of paperwork. Chris mentioned paperwork in a quote included above, and another participant, Gemini, had this to say:

I think what I find though is the difficulty getting all the paperwork done. Um, we have electronic medical records and uh, so everything's on the computer. And so if I'm seeing clients at the clinic, have meetings, and then I'm going to uh one of the family shelters, I'm not doing any notes. You know, um, when am I supposed to do the notes? So when I get home? So that's, and so I have a hard time with that. You know, and I know this is a reality. Everybody complains about paperwork.

While completing a great deal of paperwork would be difficult in working with any population, Gemini notes that working with clients in poverty requires her to move locations, and this is an additional barrier. In addition, work with clients in poverty who are requiring additional poverty-related resources means more time for paperwork for the clinician.

In sum, most (11) participants described agency-level challenges they faced in work with clients in poverty, including a) insufficient resources and lack of access to case managers and b) unhelpful rules, policies and procedures within the agency. In addition to these, participants also described system-level challenges that are unique to work with clients in poverty.

**Unique social system-level challenges to the work (cluster 9).** Most (8) participants reported that problems within the larger social service system (state and federal programs for housing and food assistance, etc.) made their work with clients in

poverty more difficult. While it is obvious that problems with the larger social service system makes clients' lives more difficult, it makes sense that this also makes the work of therapy more difficult for the clinician. Clinicians cannot work in a vacuum with clients in poverty – they rely on larger social systems to help address poor clients' multitude of needs. When these systems are failing clients, they are also failing those who are trying to help them, oftentimes leaving them with a feeling that echoes the hopelessness many poor clients feel.

For example, Mama reported:

I mean when a client can get those resources it's awesome and makes work doable and when they can't it makes the work very hard. Yeah, I mean simply put, like this patient who lost her welfare it's much harder. It makes a stressful situation even that much more stressful.

Mama's reference to her client losing her welfare benefits echoes the sentiments of another participant, Gemini, who notes that clients in poverty often have many hurdle to jump through in order to get their basic needs met. She shared her perspective:

This is disgusting and, you know, the institutions try to help, you know, and people try to help but sometimes it's the system that makes people jump higher, and higher, and higher over these hurdles. It doesn't, it doesn't need to be that way.

Usha shared that in addition to seeing clients "jumping through hurdles," she also sees them humiliated in the process, and then restricted in how they can use the resources they worked so hard to get. She shared how she sees this process unfold in her role as therapist:



I think what's hard about being poor is that you know, you may get finally some uh, through much humiliation, you know sort of like access to some resources, housing, etc. And then there are these really restrictive rules around how to use them. Like you can't have people live with you. You can't have this. You can't do that. And so and then inevitably the pressures on their family are going to be high etc. and then you lose them (the benefits)...And this is a cycle I have been through with many many of my patients.

Usha's wording here seems significant – she reports she has been through this *with* many of her clients. As a therapist dedicated to helping this population, she feels she is in some small ways alongside them in experiencing the problems with the larger social services system. She went on to explain how difficult it is for her clients to become independent from the system, given the many hurdles:

So, disability being completely ridiculous because...in a way, you can't work for more than a certain amount because then they say you don't need the check...Or the healthcare system. It's better here than anywhere else but you know, the kinds of things, hoops they have to jump through to get the most basic things. And if they make a little bit more money, like literally five minutes later it feels like, they're...Their food stamps get cut. Their rent check - this happened to a patient of mine who's really, really, really trying to get a job. And he got a job and like literally like the next day housing was like, well now you have to pay more rent. You know, they don't give them a chance to accumulate anything...and then they end up in the system and crawling out of the system is unfortunately impossible....you know they design it to be impossible.

In sum, most (8) participants described many problems in the social services system that presented unique challenges to their work with clients in poverty, including keeping clients “jumping through hoops” to gain access to needed resources, often humiliating them and holding them to unreasonable rules in the process, and keeping them dependent on the system. These system-level challenges were identified by participants as a key contributor to the difficulties and obstacles they face in their work with clients in poverty.

This final category of results described agency and system-level obstacles and challenges faced by participants. Given that psychologists working with clients in poverty are working within a broader social context themselves, these obstacles and challenges are interwoven with their everyday interactions with their clients, and are an important part of work with low-income clients.

## Chapter 5: Discussion

As reviewed above, while growing numbers of researchers and thinkers in the field are paying attention to class dynamics in therapy (e.g. Carr et al., 2014; Ming Liu, 2013; Pugach & Goodman, under review; Smith et al., 2013, etc.), the literature on therapy with those in poverty is still sparse. The purpose of the present qualitative descriptive study was to uncover the nuances of therapy practice with the poor. Specifically, I interviewed 12 psychologists about their experiences providing individual psychotherapy to clients living in poverty. In the following pages, the unique practices, attributes, and obstacles they described will be reviewed in the context of Bronfenbrenner's (1979, 1986) ecological model and findings from existing research.

### **Results of the Present Study in Context of Theory and Existing Literature**

The results of the present study are best understood using an ecological framework. In applying Bronfenbrenner's (1979, 1986) ecological model to the phenomenon of psychologists' work with low-income clients, one could envision the psychologist being influenced by the environmental context at multiple levels: a) the *individual-system* representing the psychologists' own personal and professional attributes needed to do the work; b) the *micro-system*, meaning the psychologist's interactions with her or his clients, and in the context of therapy, how the psychologist navigates the interpersonal challenges associated with that relationship by adapting existing or creating new practices and c) the *exo-system*, representing the impact on the individual of larger social settings and structures; in this case, agency and social service level factors that hinder or facilitate psychologists' work with low-income clients and the strategies psychologists use to navigate obstacles. These three levels correspond to the

three categories of findings in the present study: *Practices* unique to working with low-income clients correspond to the *micro-system level*; *Attributes* key to working with low-income clients correspond to the *individual-system level*; and *Obstacles* to working with low-income clients corresponds to the *exo-system level*.

**Practices.** The present study's results indicate that work with clients in poverty required participants to both adapt their existing practices and create new ones. Participants identified practices related to acknowledging and addressing issues related to power, boundaries, and the relationship between intrapsychic and poverty-related stressors.

**Power.** While power is always a part of a therapeutic relationship, according to the results of the present study, power dynamics can become even more salient when working with clients in poverty, at times requiring the therapist to adapt existing practices to address these dynamics. This may be in part because poor clients often come to therapy with prior experiences of powerlessness (Abrams, Dornig, & Curran, 2009; Goodman et al., 2007; Hagglund & Ahlstrom, 2007), and the role of the therapist traditionally prescribes a great deal of power (e.g. the power to define health and disorder, to apply labels to the client, and to make assessments and treatment decisions) (Heller, 1985). Feminist therapy theorists (e.g., Balmforth, 2009; Heller, 1985; Miller & Stiver, 1997) have voiced criticism of traditional approaches to therapy that do not acknowledge this power and/or do not call into question the role of the therapist as "expert" (e.g. Brown, 2009).

Participants in the present study reported being aware of the unique power dynamics involved in work with this population and adapting their practices accordingly.

For example, they thought a great deal about how the class differences between themselves and their clients intersected with other power dynamics to shape the therapeutic alliance. Most participants directly addressed those class differences by initiating conversations about it with clients. For example, one participant reported that after her client saw her getting into her car while the client waited for the bus, she deliberately brought that up in the next session to see how it was impacting her client. She took the opportunity to acknowledge her client's feelings about having to take the bus as a low-income person while her therapist owns a car, and validated her client's experience of that feeling. She also acknowledged and even emphasized the disparity between them by admitting that she could not completely understand what her client was experiencing, but was willing to listen and acknowledge it.

Participants also reported that they were careful about when and how to bring up these power dynamics and supported clients who were courageous enough to bring up these issues themselves. For example, one participant described an instance where he gave his client advice to share with an attorney. He said that his client responded by saying, "You could talk to her (the attorney) 'cause she'd take you seriously, you don't come from my background, she'd listen to you". He went on to say, "She was right. She was absolutely right. So a lot of, we spent a lot of time talking about that, like what-how do you work from a position of powerlessness? And she's taught me a lot about that." In this instance, the participant's client confronted him about how his position of power as a middle-class person led him to fail to recognize the stigma of being in poverty. He went on to describe working with this client for many years following this interaction, and how important it was in that moment to understand and listen with humility, as well as to be

willing to see and acknowledge his own blind spots about the unique challenges faced by those in poverty – blind spots stemming from his position of power as a middle class person and as her therapist. In sum, participants articulated that although issues of power are always at play in therapy, class difference between clients in poverty and themselves as therapists added unique challenges and required special awareness and skills.

These findings are consistent with the few but important previous findings on the subject of power in therapeutic relationships with clients in poverty. For example, two studies examining low-income clients' experiences in therapy have found similar results with regard to attention to power (Balmforth, 2009; Pugach & Goodman, under review). Pugach and Goodman (under review) conducted a qualitative study of low-income mothers' experience of therapy and found that participants in their study emphasized the importance of therapists' willingness to share power with them (rather than wielding power over them) when handling issues of expertise, decision-making, and the use of psychological or medical jargon (Pugach & Goodman, under review). In addition, Balmforth (2009), who explored qualitatively the psychotherapy process from the perspective of six clients who identified as working class and who were working with middle class counselors found that participants felt uncomfortable and powerless because of perceived class differences between themselves and the therapist; and that the unequal balance of power between therapist and client caused great psychological disconnection between them. From the client's perspective, it seems clear that attention to power is an extremely important practice for therapists working with clients in poverty.

In sum, findings from the present and previous studies highlight the importance of maintaining awareness of class-related power differences in the

therapeutic relationship and addressing them directly. This may not be easy or natural for therapists or client's to do. In fact, it may feel awkward or risky; but the findings of this study in the context of other research shows that both clients in poverty and experienced therapists working with them want to have these conversations, and see them as a necessary part of the work.

***Boundaries.*** Many traditional therapy approaches adhere to relatively strict boundaries based on the idea that a therapist should be non-self disclosive and emotionally neutral or, in traditional psychoanalytic thought, a “blank screen” upon which the client may project emotional responses (Brown, 2009; Wachtel, 1993). Though this metaphor may be somewhat outdated even within psychoanalytic theory and less applicable to the many forms of mental health intervention that have emerged over time, most standard therapy approaches require the therapist to set specific limits around the kinds of practices deemed appropriate within the therapeutic framework. These include constraints on self-disclosure, the timing of meetings, sharing resources with clients, and adhering to rules within the agency or mental health care system. As participants in this study described, these boundaries may be drawn in substantially different ways in practice with the poor.

***Self-disclosure through appearance.*** A therapist's appearance is in many ways a form of self-disclosure within a therapeutic relationship. For example, a therapist wearing a wedding ring in session could be considered a form of self-disclosure that one is married. The same is true of wearing clothing or accessories that are known to be expensive and are symbols of wealth – whether or not it is meant that way, it discloses something about the therapist to the client. This can have particular implications for

therapists working with clients in poverty. Although every therapist needs to consider his or her appearance and what it conveys to clients, therapists working with clients in poverty must be particularly aware of the class-based information conveyed by his or her appearance, clothing, and personal items. For example, the therapist may need to consider how what they chose to wear affects the client, who is unlikely to be able to afford to make the same clothing choices the therapist can. Half of participants in the present study commented on issues associated with boundaries around appearance and how this issue must be considered differently with clients in poverty. Some participants noted that what the therapist chooses to wear does reveal something about his or her class and may have strong implications for how the client in poverty sees him or her. In addition, some participants reported changing their appearance when working with clients in poverty by hiding status symbols that indicated their class (e.g., not wearing diamond rings, hiding expensive designer bags and purses, etc.). Regardless of what they chose to do, those that mentioned appearance as an issue described considering their appearance with special attention to how they would be perceived through the lens of class by clients in poverty. While half the participants commented on these issues and the adaptations they considered, to my knowledge self-disclosure through appearance when working with the poor specifically has not been discussed previously in the literature.

*Verbal self-disclosure.* Regarding verbal self-disclosure, most participants in the present study reported that although they considered whether to self-disclose differently or more when working with clients in poverty as compared to other populations, they ultimately decided to maintain the same level of verbal self-disclosure as they did with clients of other class statuses. Participants reported considering primarily clinical factors



(such as where a client's personal question to a therapist is coming from and what it means to him or her) rather than considering the client's poverty when making this decision - and they reported that this is the case no matter the class background of the client.

Interestingly, these findings generally diverge from existing theory and literature. For example, in addition to similar calls from feminist theorists advocating flexibility in boundaries around self-disclosure (Brown, 2009; Jordan, 2000; J. Smith, 2000), theorists such as Thwandiwe (2010) have also called for therapists to "locate the self" in their interactions with marginalized populations. The practice of "locating the self" requires therapists to self-disclose his or her many social locations and invites a conversation about the intersection of those locations and identities with the client's. Thwandiwe (2010) argues that this signifies to the client that the therapist is interested in how these issues influence the client both inside and outside the therapy room.

Additionally, empirical studies on work with the poor echo theoretical calls like Thwandiwe's (2010) for more self-disclosure with marginalized groups, such as those in poverty. For example, Azocar, Miranda and Dwyer (1996) modified group cognitive behavioral therapy (CBT) to meet the special needs of poor clients. As part of that adaptation, therapists engaged in self-disclosure about themselves and their background in initial sessions, and encouraged the clients to do the same, which they argued allowed for a more personal orientation in group members' relationships. Also, participants in Pugach and Goodman's (under review) qualitative study of low-income women's experience of therapy indicated that therapists' use of some degree of self-disclosure was meaningful and helped to "level the playing field" with regard to power, as well as

reducing clients' sense of stigma and isolation.

In addition to diverging from existing theory and literature, the finding that most participants did not self-disclose differently when working with clients in poverty can also be thought of as diverging from the other findings of the current study: Participants in this study reported a great deal of flexibility in boundary setting in arenas apart from verbal self-disclosure. It is unclear what accounts for this divergence, but it is possible that instead of disclosing about themselves, participants communicated their care and concern about the client's poverty by bringing it up and addressing it directly through other practices discussed here rather than by disclosing about themselves. While some argue that lack of self-disclosure could increase the power differential between client and therapist, participants in the current study reported being attentive to issues of power, and bringing those issues up directly with clients as well. It is possible that self-disclosure did not seem to be a poverty-related issue from the perspective of participants in this study, but this is an area in need of further study. And, it is noteworthy that two participants did diverge from the majority of the sample in reporting self-disclosing their class background or their feelings about the injustice their clients were facing.

*Time.* Perhaps one of the most basic boundaries in the therapeutic relationship is that around time – including such elements as how frequently and for how long the therapist and client meet, what the consequences are when either of them is late, and how missed and rescheduled appointments are dealt with. While in many cases agencies or organizations that hire therapists have policies related to such things, the therapist often has some discretion in clinical decision-making around time boundaries. Half of participants in the present study reported that when they worked with clients in poverty,

they found it necessary and clinically indicated to modify the traditional time boundaries of the therapy hour (e.g. starting and ending a session on time as scheduled, keeping 50 minute therapy appointments once per week, 24-hour cancellation policies, etc.). For example, a participant described excusing a client's repeated lateness for appointments in consideration of the fact that the client has to take two city buses to get to the appointment because he or she does not have access to a reliable working car. This was the case even for therapists who generally felt that traditional time boundaries were helpful for the most part. These findings are in keeping with previous literature on the importance of flexibility in this type of boundary setting when working with clients in poverty (Brown, 2009; Jordan, 2000; J. Smith, 2000). In fact, Pugach & Goodman (under review) reported that among low-income women, therapists' willingness to accommodate participants' needs in regards to practical issues (e.g. time, place, bringing children to appointments, etc.) was critical to most participants. While most participants in the present study reported flexibility with regard to time, a few participants reported not showing such flexibility (e.g. keeping to the 50 minute once weekly frame, confronting clients about lateness, keeping 24-hour cancellation policies, etc.).

*Sharing food.* Therapists working with low-income clients are faced with the harsh reality that some of their clients may not have enough food to eat or to feed themselves and their families. As a result, they may be tempted to step outside of the traditional boundaries of the client-therapist relationship to provide something more than psychological help – something more basic, such as food. While this may seem unusual or even shocking to therapists who are not confronted with immediate material deprivation in their clients, therapists in this study described needing to engage in a

decision-making process around giving food to clients as part of the therapy, considering both whether or not to do so and how either choice could affect the therapeutic process.

As a result, some participants decided to adopt a practice of offering clients food - either food provided by the agency they worked for or food they purchased themselves for clients. In most cases, this was described as being important because the client literally did not have enough food to eat and/or was hungry during the session. Participants described being saddened and angered by the fact that clients could not find access to food even when, in general, we live in a society full of resources. No participants described feeling regret about giving clients food - in fact, one participant thought the intervention was helpful in conveying her empathy for her client. She stated simply, "It feels-felt like the right thing to do... because...you need to eat". In addition to giving clients food, a couple of participants shared their decision-making processes about receiving food from clients. In these cases, participants described considering the intersection of the client's poverty with cultural factors in their decision-making about accepting food. For example, if the therapist felt it was important culturally for the client to be able to give food as a gift to the therapist, he or she would accept it, but would then find a way to discreetly give the client back the amount of money the therapist believed the food cost, for example in the form of an "extra" gift card for a grocery store that the therapist would say the agency was giving out to clients who needed it.

A review of the literature reveals little on this somewhat surprising and possibly controversial finding. While some have considered the use of food to augment the therapeutic effects psychotherapy (Warren, 2010), food was not shared in that study as a result of the client's poverty. And, while multicultural counseling theorists have

discussed the possibility of sharing food as a culturally sensitive practice (Erickson & Schreier, 2010), this is arguably quite different from sharing food with clients because they are literally starving in session. A client who comes to therapy without having had enough food to eat poses a unique ethical challenge to therapists. On the one hand, the therapist has likely been trained not to step outside of traditional boundaries by handing his or her client food (or money for food) in session. The therapist has likely not been trained to think through the ethical dilemmas and effects on the therapeutic relationship this unique situation presents and may feel trepidation about seeking consultation given the taboos in the field about giving clients anything other than psychotherapeutic help. On the other hand, the therapist is a human being who cares for the client, and likely recognizes that it is unjust for his or her client not to have access to food. It would seem quite a bit to ask of a therapist and a client to sit through a 50-minute therapy session discussing the client's psychodynamic or cognitive-behavioral challenges while both people are aware that the client has not eaten in the last day, or longer. One could argue that in this case, the therapist should help the client access food through formal social service systems. In fact, many participants reported doing this (see section on providing instrumental support below). But calling an agency to try to get enrolled in a food stamps program or even calling food pantries are challenging tasks when one is hungry. And, the therapist may feel helpless given the relative brokenness of many social service systems designed to help people in poverty gain reliable access to food. In fact, participants discussed this as a challenge (see section below on obstacles). Furthermore, one could argue that based on some of the oldest and most well known psychological theories of human health and development, such as Maslow's hierarchy of needs (Maslow, 1943), a

therapist cannot reasonably expect psychological change as a result of therapy when the client does not have the resources to meet a more basic need, such as the need for food. One can imagine arguments for and against giving clients food, but only those therapists actually faced with this dilemma must make a real choice – one that could have profound consequences for their therapeutic relationship with a client, whichever choice they make.

*Giving money.* Similar to when clients come to sessions hungry, therapists working with clients in poverty are faced with the painful reality that some of their clients may not have enough money to cover their basic needs other than food - such as housing, heat, utilities, and medical costs. Even with the availability of some help from social programs such as TANF and housing assistance, some clients are left homeless or unstably housed and without their basic needs met. Although the therapist role most certainly does not typically include giving clients money, participants described considering this possibility and sometimes acting on it, while considering how their choice could affect the therapeutic relationship.

Perhaps surprisingly, eight out of twelve participants described being willing to give clients in poverty money directly in some form or another, while seven of those eight described actually doing so. This included paying clients' rent without their knowing, collecting money from colleagues to give to a client, giving clients money through a case manager so that the client would not know where it came from, and giving clients vouchers from the agency that function as money for them to buy goods. One participant reported believing that most therapists working with clients in poverty have given clients money. She reported, "Certainly there are times when I've paid people's

rent and they, they don't know that...I've done that, of course. I think probably most people have." Another participant, who described giving clients bus money stated, "I have no regrets about it...it feels-felt like the right thing to do". This echoes participants' feelings about sharing food – to them it feels like a good and even at times therapeutically helpful thing to do.

However, not all participants felt this way. Another participant reported giving clients money but went on to express her ambivalence about it. She shared, "It's very complicated to have that entered into the therapeutic relationship, and to be frank I really don't like it. On the other hand...this is the reality of their lives and my own discomfort is not the thing that needs to get in the way of that". Few participants described being unwilling to give clients money in one form or another, but even those participants reported considering the decision carefully. Therefore, whether or not participants were willing or unwilling to give clients in poverty money, it was a question that each participant described wrestling with – a question one could argue that this is certainly a practice unique to working with clients in poverty. Participants described considering their own feelings about it, how their clients would feel, whether or not to disclose it to clients if they did give money, and how it would affect the therapeutic relationship either way.

This is perhaps the most striking finding of the current study – that therapists working with clients in poverty are reporting actually giving clients money through various methods, and sometimes without the client's knowledge. This is clearly outside the bounds of what most therapists would agree is typical psychotherapeutic practice. However, it echoes strongly the writing of first-hand accounts of therapists working with

clients in poverty. Jackson (2011) quotes a therapist working with clients in poverty (quoted earlier in this Chapter 1 of this paper) who says,

I woke up at three a.m. praying for a miracle for my client. I did not wish for self-esteem, release from the terrors of a lifetime of trauma or a flash of insight. I prayed for cash-filthy lucre, dead presidents and gold bars. She has heart, vision and a tenacious spirit. What she lacks is cash to finance her dreams and her basic survival needs.” (Quote from a therapist, Jackson, 2011, p. 1).

Although therapists in this study did not provide cash to “finance the dreams” of their clients, they did at times provide temporary income in times of crisis to support their basic survival needs.

While this is a qualitative study and cannot be generalized to the larger population of therapists doing this work, it raises important questions that are in need of further investigation. How common are these practices? How do therapists decide which clients to do this for and when? Is it understandable or even therapeutic for therapists to do this? What is the effect on clients? Could it be harmful? Are therapists working with clients in poverty talking with each other about these types of practices? Or is it a secret practice they are hesitant to share with others? These questions are deserving of further study, as the answers to them could have powerful implications for the practice of psychotherapy with clients in poverty.

Furthermore, although as mentioned above feminist therapists have called for more flexible boundaries in the therapeutic relationship (Brown, 2009; Jordan, 2000; J. Smith, 2000), to my knowledge there is nothing in the way of literature specifically on the subject of therapists giving financial resources to their clients. As a result, much like



the present study's findings on sharing food, there is little to guide therapists' thinking on this issue. The fact that so many of the participants in this study separately shared that they gave clients money in one form or another reveals that this is a practice that at least some therapists working with clients in poverty have adopted. Even those who did not adopt the practice had considered it, which is a sign that although this is a rarely if ever discussed in the literature, it is a potentially common practice among those psychologists working with the poor.

*Breaking rules.* In addition to considering carefully the ethics and clinical implications of giving clients in poverty money and food, psychologists must make similar considerations with regard to "breaking rules" in order to help clients in poverty. It is sometimes the case that rules put in place to protect the resources of systems can create barriers to much needed help for clients in poverty. The therapists who work with them must then make difficult decisions about when and how to break those rules to assist their clients.

Most participants in the present study described being willing to break agency or insurance rules in order to help clients in poverty gain access to resources such as giving out more than the allotted number of food vouchers from the agency to a client, exaggerating the seriousness of a client's illness in order to convince his or her insurance company to pay for more sessions, and overlooking agency session limits or no-show policies so that clients can continue to have access to therapy sessions. However, one participant diverged from this trend, reporting that she would not violate policies or break rules and she felt that this inspired the trust of her clients. The majority of participants' responses seem to indicate that working with clients in poverty poses

unique ethical challenges with regard to rule-breaking and that most participants responded to this challenge by being willing to break rules due to the seriousness of poor clients' life situations.

Similar to findings on sharing food and giving money, this is a rather controversial finding as it is a practice that is arguably outside the bounds of traditional therapeutic boundaries. It is therefore likely to be considered taboo, and is probably seldom discussed among therapists. It is unclear how common this practice is, how it affects the therapeutic work, and how and when therapists decide to do so.

While I was not able to find writing specifically on the topic of this type of rule breaking in therapy with clients in poverty, one scholar in the field provides a valuable reflection on a situation where traditional boundaries were stretched, which may have applicability to this issue (as well as to the issues of sharing food and giving money). Her story was described above in the review of literature for this study, but is worth repeating here as her reflections may have some bearing on the predicament therapists find themselves in when faced with a dilemma about whether or not to break rules (and also, to share food, or give a client money, as described above). J. Smith (2000) shared a story about a client who calls her on a cold winter night when her apartment has been sprayed for cockroaches. They typically meet in the client's home for sessions, but in this case the client asks her to meet for a session in a parking lot in her car. While traditional frameworks for therapy would find this request far outside the usual boundaries, Smith (2000) decides to agree and the session turns out to be an important one. She describes the decision-making process this way:

It reminds me of a poster I once saw of a frog whose legs become awkwardly

tangled as he tried to inch along the bottom of a leaf without falling off. I'm the frog: the more alienated the person I am working with, the more I find myself bending in ways which – at the least – trouble my sense of form, and typically make me look foolish. While most therapy with poor women goes on in my office and uses conventional methods, the work pushes for accommodations (J. Smith, 2000, p. 73).

Though some of these types of accommodations are not often discussed in the literature on treatment for the poor, they may be necessary. The results of the present study indicate that some therapists do in fact make extraordinary accommodations – accommodations that may be difficult to make sense of from a traditional therapy perspective and that may even be shocking to other practitioners or clinicians, such as breaking rules or even laws at times to help clients gain access to resources. Since there is little to no writing about how therapists actually manage the process of setting and negotiating these specific types of boundaries when working with low-income clients, these therapists are on their own in making these difficult clinical and ethical decisions.

*Relationship between intrapsychic and contextual poverty-related stressors.* The third and final set of practices unique to working with clients in poverty identified by participants includes those that take into consideration the complex relationship between intrapsychic problems (e.g. mental health issues such as anxiety, depression, etc.) and poverty-related stressors (e.g. lack of access to resources such as homelessness, food scarcity, lack of access to medical care, etc.). Participants described two sets of practices related to this relationship: those that a) maintain an awareness of the relationship and those that b) require the therapist to act on that awareness.

*Awareness of the relationship between intrapsychic issues and poverty-related stressors.* When asked about whether it was mainly intrapsychic issues or mainly poverty-related stressors that led to their clients' distress, most participants described being aware that intrapsychic problems and poverty-related stressors are constantly intersecting and influencing each other to create the unique challenges their clients face. In other words, participants described that it was difficult to separate poverty-related stressors from intrapsychic stressors. Instead there seemed to be an ongoing feedback loop between these two interacting factors.

Participants accounted for this feedback loop by developing a practice of maintaining an awareness of it in a) their focus in the therapy hour, b) their conceptualization of clients' distress, and c) their perspective on the source of the client's problem. Most participants described a practice of maintaining flexibility regarding where to focus the therapy hour – shifting the focus between intrapsychic issues and poverty-related stressors based on the client's presentation and/or addressing both simultaneously and allowing each to inform the other. In addition, most participants described accounting for the context of poverty-related stressors when conceptualizing clients' mental health issues and/or their behaviors in the therapeutic relationship. This included conceptualizing diagnosis, behaviors typically interpreted as resistance (e.g. missing appointment, arriving late, etc.), and conceptualization at every stage of the therapeutic process (assessment, formulation, intervention, etc.). Finally, most participants described a practice of holding both intrapsychic and poverty-related contextual factors in mind when trying to understand and conceptualize the source of the client's problem. While at times they described foregrounding one or the other,

participants ultimately held in mind the relationship between the two in making sense of clients' pain and suffering. This included recognizing the contribution of poverty-related stressors to intrapsychic distress, as well as recognizing the possibility of the two factors intersecting and compounding each other over the course of the client's development. Maintaining awareness of this has implications for other practices described by participants, which require them to act on the awareness and adapt their therapeutic techniques to account for both factors.

With regard to flexibility in the focus of the therapy hour, these findings are consistent with previous literature indicating that addressing poverty-related stress as part of the therapy hour improves the effectiveness of therapy for low-income clients (Falconnier & Elkin, 2008; Pugach & Goodman, under review; Smith, et al., 2013; Smith, Shellman, & Smith, 2013). For example, Falconnier and Elkin (2008) conducted a study exploring the extent to which having therapists directly acknowledge economic stressors in the context of traditional therapy affected therapy outcomes. They conducted the study with a sample of mostly white and female clients with depression, some of whom were middle income, and some who were low-income. Their findings were that therapists' direct exploration of clients' economic stressors was significantly related to decreased depressive symptoms and increase Global Assessments of Functioning (GAF) regardless of treatment condition (CBT or interpersonal therapy) and regardless of income level. In other words, all clients, regardless of income level or treatment condition, benefited from exploring the effect of economic stressors on their mental health.

Findings from the current study on accounting for the context of poverty-related stressors when conceptualizing clients' mental health issues and/or their behaviors in the therapeutic relationship are consistent with writing by other scholars on the subject. For example, feminist therapy encourages therapists to look outside the individual for sources of distress (Goodman et al., 2004) and to expand their lens to examine oppressive social, political, and historical factors as well (e.g. Brown, 2009; Evans, Kincase, Marbely & Seem, 2005). In fact, according to some feminist scholars, failure to do so can exacerbate the excessive self-blame and low self-worth poor clients may already be experiencing (Smyth, Goodman, & Glenn, 2006). In addition, advocates of multicultural and class competence have stressed the importance of clarifying the internal and external aspects of clients' presenting problems, and where the two overlap (Hays, 2009). Jackson (2000) describes this as, "the dilemma of tackling the oppression versus the depression" (p. 243) and J. Smith (2000), who writes from her firsthand experience as a therapist doing work with clients in poverty, discusses how therapists working with the poor may have difficulty distinguishing intrapsychic issues from contextual ones. Participants in the current study addressed this dilemma by developing a practice of maintaining awareness of both intrapsychic and contextual factors, simultaneously, and also continually bringing awareness to the ways in which they influence each other.

In addition to previous writing on the subject by these theorists and scholars, a relatively recent study of therapists' work with clients in poverty also reported similar findings in this area. Smith, Li, Dykema, Hamlet, and Shellman (2013) conducted a qualitative investigation analyzing narrative data from 10 therapists regarding their work with poor clients. Their study differed from the present one in two important ways: 1)

they interviewed Masters level therapists from both social work and psychology fields whereas the present study focused on doctoral level psychologists; and 2) participants in their study worked with clients in poverty for many fewer years on average than those in the present study. Despite these differences, one of their findings was remarkably similar to the present study's findings on attending to intrapsychic vs. poverty related stressors. They report that participants in their study described the importance of "discerning the effects of poverty in clients' lives from symptoms of psychological disorder, suggesting that the two needed to be integrated meaningfully within clinical diagnoses" (p. 144). The consistency of findings between this and the present study, in addition to writing by other scholars in the field described above, gives credence to the importance of this particular practice when working with clients in poverty.

*Acting on awareness of the relationship between intrapsychic and poverty-related stressors.* Some have suggested that helping clients interact more effectively with social systems and addressing the environment when problems stem from environmental stressors is a key aspect of cultural (or class) competence in therapy (Hays, 2009; Smith, 2009). Consistent with this, most participants in the present study described the importance not only of maintaining awareness of the relationship between intrapsychic and poverty-related stress, but also acting on that awareness by providing instrumental support during the therapy hour. This included tasks such as providing lists of food pantries, making calls and writing letters to social service agencies, advocating for the client with other service providers, etc. Some pointed out that this work in the realm of instrumental support can be a gateway to intrapsychic work while others went further to say that in fact it is a form of psychological work in and of itself, and can be a crucial part

of the role of the therapist. However, the process of empowering clients to gain access to the instrumental support they so desperately need can be a complicated one for a psychologist in the role of therapist to navigate. In some of the settings in which participants worked, case managers were an additional resource made available to clients in therapy. In these cases, most participants described the importance of working closely with these case managers as part of the work of doing therapy with clients in poverty, in part because case managers often have specialized knowledge of resources that therapists may not have as readily, depending on their training, background, and familiarity with local community.

These findings are consistent with previous quantitative literature on the importance of advocating on behalf of clients and attending to instrumental support needs in therapy with low-income populations (e.g. Grote et al., 2007; Liu & Estrada-Hernandez, 2010; Miranda et al., 2003). For example, Grote et al. (2007) achieved better treatment compliance and outcomes for low-income women with depression when they adapted the treatment by addressing barriers to effective treatment - in part by engaging clients in a process of identifying and problem solving practical issues such as transportation and childcare as part of the therapy. In addition, Miranda, Azocar and colleagues (2003) modified group cognitive behavioral therapy (CBT) so that therapists would engage with clients in multiple ways with clients, acting as psychotherapist, case manager, translator, and advocate. They found that for 200 ethnically diverse low-income individuals, those attending the modified treatment attended more sessions and were less likely to end treatment prematurely. Also, six months after treatment, those in the



modified group reported less depressive symptomology and higher levels of social adjustment than those in the typical CBT group.

Qualitative studies on the topic have resulted in similar findings. Pugach and Goodman (under review) reported that for their sample of low-income women, “Nothing was more salient to participants than therapists’ willingness to “go above and beyond” talking about feelings to help survivors change their external circumstances” (p. 17). In fact, they reported that for their participants, when therapists did not offer instrumental support, therapy seemed irrelevant for them. Similarly, Smith et al. (2013) reported that therapists working with low-income clients in their study engaged in interventions in addition to psychotherapy and felt that poverty needed to be addressed within all of their interventions. Appio, Chambers, & Mao (2013) presented findings from other qualitative studies that illustrate lived experiences and insights from poor and working-class people and one of their conclusions was that “Clinicians must directly attend to poor clients’ material needs in the context of psychotherapy. This is vital to our efforts to promote clients’ emotional and psychological well being (p. 159). They suggest that clinicians must inquire about clients’ basic needs as part of ongoing clinical assessment and actively assist clients in obtaining needed resources (Appio, Chambers, & Mao, 2013). Therefore, findings from the present study that participants provided instrumental support are supported by both quantitative and qualitative previous findings and recommendations from scholars in the field.

**Attributes.** The findings of this study indicate that working with clients in poverty requires a great deal from therapists, and participants in the study articulated some key attributes required for the work. These attributes correspond to the *individual-*

*system level* of Bronfenbrenner's (1979, 1986) model, representing the psychologists' own personal and professional attributes. These include: possessing a values-based commitment to working with marginalized groups; possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty; possessing a high degree of self-awareness related to poverty; and possessing a willingness to be deeply affected by the work and to cope with negative feelings.

***Possessing a values-based commitment to working with marginalized groups.***

Most participants in the present study described possessing a values-based commitment to working with marginalized groups generally or with people in poverty specifically and explained that this was a powerful motivation for their work. Participants also commonly described this commitment as coming in part from his or her personal experience and connection to those who are oppressed in society. Interestingly, another scholar investigating this topic found similar results. Smith et al. (2013) found that among therapists working with clients in poverty who participated in their study, the rewards and motivations for doing the work reported by participants included values-based reasons such as wanting to help others and give back; a sense of connection to poverty-related issues via clinicians' own life experiences; and a motivation to change social systems for the better. Given the many challenges of the work, it makes sense that therapists have a strong values-based commitment and motivation to propel them forward. That the present study's results echo those of Smith and colleagues' (2013), which is the only similar qualitative study on therapists' experience of this work in the literature, makes clear that those driven by their own social justice-based values and personal life experience are more likely to choose this type of work.

*Possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty.* Most participants also described the importance of having deep knowledge of the experience of living in poverty and as a result, developing a high degree of empathy for that experience. Other participants developed an active empathy building on their part – an ongoing attempt to put themselves in the shoes, so to speak, of their clients. Participants shared, often in rich detail, their own knowledge of the context of poverty and their efforts to maintain empathy for the challenges their clients face. In addition, some participants discussed the importance of their direct experience working with clients in poverty in helping them gain the knowledge and empathy they had.

Other qualitative researchers studying this subject have found similar results. Smith et al. (2013) for example, found that among master's level therapists working with low-income clients, it was typical for participants to have had previous hands-on working experience in poor communities, and that this experience was instrumental in helping them make sense of and empathize with the realities of poor clients' lives. Another group of qualitative researchers looked at counseling competencies of therapists providing in-home counseling for children in poverty (Tate, Lopez, Fox, Love, and McKinney, 2014). Tate and colleagues (2014) found that one of the most important professional dispositions and behaviors for therapists was holding a non-judgmental attitude, which could be considered a prerequisite for these therapists to empathize with their clients. Pugach and Goodman (under review) reported yet another similar finding in their qualitative study of low-income women's experiences in therapy. They wrote, "Every single participant highlighted how important it was for her therapist to understand deeply what it means to struggle every day with the material hardships of poverty" (p. 14). Pugach and Goodman

(under review) also reported that participants found it meaningful and comforting when therapists truly understood the emotional and practical challenges they faced living in poverty. Participants in their study also noted that when therapists had substantial previous experience working with low-income communities, they noticed an increase in the therapists' empathy and understanding (Pugach & Goodman, under review). In sum, having experience with poverty and being able to empathize with the experience of it was identified as a crucial attribute by participants in the present study as well as participants in many other previous qualitative studies.

*Possessing a high degree of self-awareness related to poverty.* While self-awareness is a key attribute for therapists working with any population, participants described two aspects of self-awareness that they felt were particularly important for work with clients in poverty. First, most participants described the importance of maintaining awareness of one's feelings toward, reactions to, and assumptions about clients in poverty. This included recognizing the pull to "rescue" clients, recognizing that it is ok to have negative feelings come up in the process even toward a client in poverty, and needing to be aware of one's own possible hidden assumptions about and biases toward people in poverty. Second, most participants described maintaining an awareness of his or her own class background and how it affected work with clients in poverty. Because participants came from varied class backgrounds (See Table 1), the effect of each participant's class background on the work was unique to them. However, what was common to each participant who commented on this was that each seemed to be maintaining awareness of the effect of his or her life experiences with poverty or lack thereof, and how it was affecting perceptions of the client and the work.

This attribute identified by the present study's participants is consistent with the writing of therapists working with clients in poverty who have shared their firsthand experience in the literature. For example, Smith (2009) has discussed the importance of gaining awareness of one's own possible hidden assumptions about and biases toward people in poverty. She writes that she experiences these attitudes in the form of her own blind spots, classist stereotyping, and feeling overwhelmed (Smith, 2009). Similar to Smith (2009), J. Smith (2000) points out that therapists are likely to have their own emotional reactions to clients that they need to maintain awareness of. For example, she writes that therapists may feel horrified by the unfair circumstances of their clients' lives and therefore guilty about their own life circumstances, making it more difficult to maintain a safe psychological distance from the realities of poverty.

In addition, this particular attribute has previously been identified as important by theorists of cultural competency, which can be considered analogous to class-based competency for work with clients in poverty. For example, D.W. Sue (2001) writes about the importance of cultural competences such as acknowledging and confronting one's own biases and stereotypes about marginalized groups and understanding one's own worldviews. Similarly, Vera and Speight (2003) call on therapists to increase their awareness of their own values and biases and attempt to understand the worldview of their clients in a manner that aims to withhold judgments about areas of difference between themselves and clients. Yet another group of scholars, Liu, Pickett and Ivey (2007) warn that counselors should be aware of their upward mobility bias, which assumes that "individuals are constantly interested in upward social mobility, achievement, and success" (p. 197). Counselors could then label those who are not

subscribing to that bias as lazy or unmotivated (Liu, Pickett, and Ivey, 2007). Finally, more recently, Appio, Chambers and Mao (2013) write that, “psychologists will not be able to work effectively with poor men and women without first engaging in efforts to bring their own assumptions about poverty and privilege into awareness” (p. 158). In sum, scholars in the field have called for therapists to develop a high degree of self-reflection and awareness related to poverty, which participants in the present study also identified as a key attribute.

*Possessing a willingness to be deeply affected by the work and cope with negative feelings.* Participants in the present study identified two main ways in which they were uniquely affected by work with clients in poverty: a) they were affected emotionally, describing both positive and negative emotions arising uniquely from work with clients in poverty and b) they were required to develop ways of coping with these strong emotions – particularly the negative ones.

*Therapist feelings about the work.* Participants shared that they were deeply affected by work with clients in poverty on an emotional level, and that this was an important aspect of the work. Participants described experiencing both positive and negative emotional reactions. Most participants described positive feelings such as optimism or hopefulness; a sense of privilege that clients in poverty allowed them into their lives; gratitude and respect; and a sense of admiration for clients’ resilience. However, in addition, all twelve participants reported experiencing negative emotional reactions as a result of working with clients in poverty. These emotions included sadness and despair, hopelessness, anger and frustration, helplessness, overwhelm, fatigue, guilt, and worry. In a similar study to the present one, Smith et al. (2013) found similar results

in their study of masters level clinicians doing the same work. Participants in their study described the work as overwhelming and emotionally difficult but also discussed the rewards of the work, which evoked positive feelings, such as witnessing clients' successes (Smith et al., 2013). Participants in both the Smith et al. (2013) and the present study reported experiencing a great deal of both positive and negative emotions as part of the work, suggesting that the work can be very intense, and that therapists must be willing to be deeply affected by the work in order to do it well.

*Coping with feelings about the work.* Participants described four main ways of coping with the negative feelings that arose in the context of their work with clients in poverty: a) seeking social support (e.g. from friends, family, colleagues); b) setting limits and/or maintaining psychological distance from the work (e.g. investing in and creating stability in their own lives to the extent possible, setting limits on how much time they spent working with clients in poverty by doing other types of work for part of their time, trying not to overly identify with clients' pain and suffering, and trying not to take work home with them); c) taking perspective or using cognitive strategies (e.g. keeping in mind the whole person in addition to his or her poverty, focusing on smaller manageable goals, and accepting limitations of working with clients in poverty); and d) engaging in nourishing activities and hobbies outside of work (e.g. writing poetry, shooting pool, reading, listening to and playing music, etc.).

Smith et al. (2013) found similar results. Participants who were masters-level therapists providing therapy to low-income clients reported that because the work was taxing, they sought support from friends and others outside of work and also sought support in their workplace. In addition, participants in their study reported that they

coped by taking self-care and relaxation time, and using cognitive strategies like developing a positive outlook. Unlike participants in the present study, some of their participants reported relying on spirituality and their own personal therapy as ways of coping. In sum, based on the present study and previous work by Smith and colleagues (2013), it seems important for therapists to find ways of coping with the immense challenges of working with client in poverty, such as those described above.

**Obstacles.** In addition to describing unique practices for and attributes key to work with low-income clients, participants also described contextual challenges and obstacles to work specifically with clients in poverty. These obstacles correspond to the *exo-system level* of Bronfenbrenner's (1979, 1986) model, representing the impact on the individual of larger social settings and structures. Given that psychologists working with clients in poverty are working within a broader social context themselves, these obstacles and challenges are interwoven with their everyday interactions with their clients, and are an important part of work with low-income clients. Participants described two types of challenges: a) unique agency-level challenges, and b) unique social service system-level challenges.

***Agency-level challenges.*** Most participants described agency-level challenges they encountered when working in agencies and organizations that specialize in providing care to low-income clients. They discussed the challenges of working in an agency or organization that is not sufficiently resourced – a phenomenon that parallels and often accompanies work with low-income clients. The agencies and organizations that typically do this work are often without the basic resources they need – much like the clients they serve. One of the most commonly mentioned observances of this was in the



instance of case management – participants explained that they were not compensated for doing case management work and yet there are often few to no case managers available to help clients gain access to poverty-related resources. In addition to lack of resources, some participants also identified challenges associated with unhelpful rules, policies, and procedures within their agency; for example policies where clinicians' notes are read by supervisors to check for evidence-based practices (which may not be proven effective for poor clients), policies which encourage clinicians to see as many clients as possible without recognizing the additional collateral and case management work required of therapists working with clients in poverty, and policies which require a great deal of paperwork on top of the additional paperwork often required for helping clients access services. Notably, previous scholarship on therapy with clients in poverty does not address the specific agency-level pressures and obstacles described here. This is ironic given that scholars have focused intensively on the environmental context of clients in poverty, but have focused less on the environmental context of the therapist working with those clients.

***Social service system-level challenges.*** In the current study, most participants reported that problems within the larger social service system (state and federal programs for housing and food assistance, etc.) made their work with clients in poverty more difficult. While it is obvious that problems with the larger social service system makes *clients'* lives more difficult, it makes sense that this also creates difficulties for the clinician. Clinicians cannot work in a vacuum with clients in poverty – they rely on larger social systems to help address poor clients' multitude of needs. When these systems are failing clients, they are also failing those who are trying to help them, oftentimes leaving

them with a feeling that echoes the hopelessness many poor clients feel. Problems with the system cited by participants included systems keeping clients “jumping through hoops” to gain access to needed resources; systems often humiliating clients and holding them to unreasonable rules in the process; and systems being designed to be difficult to escape, leaving client depending on them for support.

While not discussed specifically as a contextual obstacle for the therapist, Smith and colleagues (2013) did find when interviewing therapists that they were aware of these systemic challenges for clients in poverty. Participants in their study reported witnessing that social systems were difficult to navigate for clients and that clients were trapped in poverty because it is systemic and cyclical in nature. However, similar to the findings on agency-level challenges described above, apart from this finding by Smith and colleagues (2013) there is little literature on the systemic *exo-system level* factors affecting therapists doing this work.

It is interesting to note that participants did not identify problems related to clients’ work lives as an obstacle at the *exo-level*, particularly given literature on the importance of work for psychological health for all people - including those in poverty (Ali, 2013; Blustein, 2006, 2013; Perry & Wallace, 2013) and given that meaningful, well-compensated work could represent a way out of poverty for these clients. This may be in part due to the open-ended nature of the questions I asked participants – I did not ask about clients’ work lives specifically because I did not identify content areas of clients’ lives for participants to focus on. It could also be in part because the clients these participants worked with were in such dire poverty that they were unable to work due to homelessness, lack of transportation, etc. or because social services systems kept clients

“jumping through hoops” to keep services – an exo-level obstacle participants did identify. Related to this jumping through hoops, one participant did mention that it seemed impossible for clients to get out of poverty through working because as soon as they began earning money, their still needed social service benefits would be reduced. However, it would be interesting to explore in more detail how psychologists engage with clients in poverty around issues of work in future studies, especially given literature on the psychology of working showing that career counseling interventions can be successfully adapted for low-income clients (Blustein, Kozan, Connors-Kellgren, & Rand, 2015).

### **Summary**

In sum, while some in the field have begun to focus their attention on the needs of low-income therapy clients specifically (e.g. Carr et al., 2014; Ming Liu, 2013; Pugach & Goodman, under review; Smith et al., 2013, etc), there is still relatively little literature on low-income clients as a unique clinical population deserving of specialized attention when compared to other demographic groups. Yet, participants in the present study described their work with clients in poverty as different from work with other groups. They described unique experiences at three levels of Bronfenbrenner’s (1979, 1986) model.

At the *micro-system* level, participants described *Practices* unique to working with low-income clients such as acknowledging and addressing issues related to power, boundaries, and the relationship between intrapsychic and poverty-related stressors. Perhaps most striking was participants’ perspectives on boundaries in the context of poverty. Most reported sharing resources (food and money) with their clients and

breaking rules within their agency or the larger system in order to meet their clients' needs. These practices are by most standards extraordinary modifications of traditional therapeutic boundaries, and, as discussed further in the next section, raise important and interesting questions about the intersection of ethics and clinical decision-making in the face of severe material deprivation of clients. Also striking was how participants talked about the relationship between intrapsychic and poverty-related stressors, which they saw as continually influencing each other to create unique challenges, and the importance of instrumental support provision. Some pointed out that this work in the realm of instrumental support served as a gateway to intrapsychic work while others went further to say that in fact it was itself a form of psychological work. These findings on addressing relationship between intrapsychic and poverty-related stressors are not entirely new (see e.g. Brown, 2009; Evans, et al., 2005; Goodman et al., 2004; Hays, 2009; Jackson, 2000; J. Smith, 2000; Smith et al., 2013; Smyth, Goodman, & Glenn, 2006), but they provide a rich description of the way therapists think about and address this complex issue.

At the *individual-system* level, participants described *Attributes* key to working with low-income clients such as possessing a values-based commitment to working with marginalized groups; possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty; having a high degree of self-awareness related to poverty; and possessing a willingness to be deeply affected by the work and to cope with negative feelings. Regarding possessing a values-based commitment to working with marginalized groups, the present study's results echo those of Smith and colleagues'

(2013), providing further evidence that those driven by their own social justice-based values and personal life experience are more likely to choose this type of work.

Regarding the need for deep knowledge of poverty, participants in this study echoed prior literature (e.g. Pugach and Goodman, under review; Smith et al., 2013; Tate, et al., 2014), reinforcing the importance of therapists' gaining experience working with low-income clients and doing the work to deeply understand poverty in order to cultivate empathy for its unique challenges. Likewise, participants' emphasis on the need to possess a high degree of self-awareness related to poverty is consistent with the writing of therapists working with low-income clients who have shared their firsthand experience (e.g. Smith, 2009; J. Smith, 2000), theorists of cultural competency (e.g. D.W. Sue, 2001), and others who have written on the topic of bias in therapy with poor clients (e.g. Appio, Chambers and Mao, 2013; Liu, Pickett and Ivey, 2007; Vera and Speight, 2003). That the present study's findings are consistent with existing literature provides more evidence that poverty-related self-awareness is an important attribute for therapists doing this work.

As for possessing a willingness to be deeply affected by the work and to cope with negative feelings, these findings are also consistent with other qualitative findings (e.g. Smith et al., 2013), which reinforces the point that therapists experience a great deal of both positive and negative emotions when working with low-income clients and must find ways of coping with the immense challenges they face.

At the *exo-system* participants described *Obstacles* to working with low-income clients, such as unique agency-level challenges and unique social service system-level challenges. Interestingly, although literature on therapy with the poor has paid a great

deal of attention to the effect of contextual stressors on clients' wellbeing, very little has been written about the effect of these contextual stressors on the therapists who work with them. By addressing these obstacles where possible, and helping therapists cope better with their negative effects where not possible, therapists doing this work may be better supported to effectively help their clients.

Overall, while some of the findings here are consistent with existing theory and literature, others represent new and relatively unexplored territories. Implications of these findings, as well as limitation of the current study, will be discussed in the following pages.

### **Limitations**

Findings from the present study should be interpreted in light of several limitations. First, although a qualitative descriptive methodology enables a straightforward description of psychologists' experience in everyday terms, this methodology also limits the generalizability of the findings. The experiences of twelve psychologists cannot represent those of psychologists generally. Second, it is important to note that I interviewed participants who had decided to stick with working with clients in poverty, often for many more years than the lower limit outlined in the inclusion criteria for the study (five years). Therefore, the present study does not shed light on the experience of psychologists who begin working with clients in poverty and decide to switch to a different population. Given the many challenges described by this study's participants, much could be learned from those who decide not to continue doing this work. Third, although the sample was relatively diverse in terms of age, gender, race/ethnicity, and years in the field (See Table 1), participants were all recruited from

one urban area and a small number of agencies and institutions within that geographic area. It is possible that psychologists working in other geographic areas could have different experiences based on local and state policies and available resources, and the different challenges facing clients in poverty in different environments and parts of the country. Despite these limitations, however, I believe that these findings suggest new ways of thinking about how psychologists adapt to the challenges of working with this population and provide evidence that clients in poverty are indeed a special population, which has implications for training, policy, and research.

### **Implications for Practice**

While the field of counseling and clinical practice is moving toward the use of more standardized and manual-based treatments, the practices described by this study's participants would appear to move in the opposite direction. Far from being manualized, pre-determined, or prescribed, the practices described by this study's participants call for increased flexibility among clinicians in almost every area of practice: flexibility to spend time and energy in the therapeutic dyad addressing issues of power, flexibility in considering boundaries of all kinds, and flexibility to interpret and conceptualize clients' problems and behaviors in the context of poverty related stressors. As a longtime therapist working with clients in poverty and theorist in the field J. Smith (200) puts it, the work "pushes for accommodations" (p. 73). This is consistent with work by other researchers who have found that mental health interventions are effective for treating poor clients when they are specifically tailored to address poverty-related stressors (e.g., Ammerman et al., 2005; Grote et al., 2007; Miranda, Azocar, Organista, Dwyer, &

Areane, 2003; Miranda, Chung, et al., 2003). The present study sheds light on just how much tailoring and flexibility may be necessary.

Practitioners who wish to make such adaptations could use the findings from the present study to guide their efforts. Participants in this study were well-seasoned clinicians who stuck with the difficult work of doing therapy with low-income clients for many years, often decades. Their experience and perseverance in the work suggest that other clinicians may have something to learn from them.

Regarding power, for example, clinicians might well benefit from developing the practice of continually reflecting upon class differences between themselves and their clients and directly addressing them in therapy. Practitioners might also use study findings related to boundaries as a foundation for further thinking in this arena, especially on the subject of resource-related sharing. As described throughout, participants stretched traditional boundaries by developing practices of sharing food and money with clients in desperate need. In my experience, these kinds of practices are not discussed widely among clinicians. Although I am not recommending that therapists immediately adopt these practices, I strongly urge practitioners working with low-income clients to begin to discuss the ethical quandaries involved in their attempts to do class-competent and effective clinical work with low-income clients, especially when those clients do not seem to have the most basic survival-related resources. Such conversations could take place at forums within agencies and organizations as well as at conferences in the field

Regarding the relationship between intrapsychic and poverty-related stressors, given the resonance between the current study's findings and other research (e.g. Brown, 2009; Evans, et al., 2005; Goodman et al., 2004; Hays, 2009; Jackson, 2000; J. Smith,



2000; Smith et al., 2013; Smyth, Goodman, & Glenn, 2006), I believe clinicians working with clients in poverty should work to continually acknowledge and maintain awareness of the complexity of the relationship between these two sets of stressors and how they shape client experience.. This would include discussing with clients the effects of poverty on mental health and flexibly adapting the focus of the therapy hour to account for such effects. Therapists should work to include the relationship between intrapsychic and poverty-related stress at every stage of conceptualization (assessment, formulation, interpretation, etc.). They should also develop more systematically their capacity to work in integrated ways with these two compounding sets of difficulties by, for example, showing willingness to provide instrumental support during the therapy hour

In addition to developing new practices, psychologists working with clients in poverty should attempt to develop (or further develop) the personal attributes participants identified as important, including possessing a values-based commitment to the work, empathy for those in poverty, and self-awareness related to poverty, as well as recognizing and coping with one's own emotions that arise in the context of the work. Clinicians wishing to develop these attributes should engage in self-examination through processes such as journaling about these issues, informally discussing these topics with colleagues, and looking for more formal opportunities to engage in self-reflection as part of trainings, conferences, or continuing education. In addition, therapists and therapists-in-training considering working with low-income populations might be encouraged to ask themselves where their motivation comes from and why.

Apart from self-examination, therapists can seek knowledge and information about the realities and effects of poverty that would help them to develop these attributes.

This may include seeking out new work experiences, reading firsthand accounts of life in poverty, or actively building empathy for that experience. For example, one participant in the present study discussed imagining what options would be available to her at the grocery store if she was poor, and this helped her to think through the challenges of poverty even when not at work.

Finally, given findings in the present study on contextual obstacles facing clinicians, practices in agencies, health insurance reimbursement systems, and the social service system should ideally be modified to support therapists doing this work where possible. At the agency level, managers and supervisors could begin by acknowledging all of the uncompensated and challenging work clinicians are doing on behalf of clients in poverty – work that is often not required in providing therapy to other populations. This includes the vast amount of paperwork participants in the present study identified as problematic, as well as the case management they are required to do and are not paid for since it is often done outside the billable therapy hour. Agencies could examine their policies and their budgets to see if any of these obstacles could be eliminated; for example, could some of the non-poverty related paperwork be reduced to make time for the paperwork required to help clients gain access to resources? Or, could more case managers be hired given the demand? If not, those who are managing agencies could at least acknowledge these challenges and validate the level of difficulty of the work, if they are not already doing so.

At the social service system level, change may be more difficult. The obstacles identified by participants are systemic and deeply embedded in bureaucratic structures through local, state and federal government, so change to those systems would require

advocacy at those levels. Therapists themselves may advocate for these types of changes on behalf of clients, but given the enormity of what they are already faced with in helping clients navigate these systems, it may be a challenge to do so. Perhaps more psychologists who are not working “on the front lines” so to speak, should focus on this advocacy work, as many already do. In the meantime, perhaps agencies clinicians are working for could create forums for therapists who are doing this work to discuss these challenges with each other, and provide support.

### **Implications for Training**

Findings of this study are directly applicable to clinical training. Training for new psychologists in the field could be developed based on what these experienced and persevering participants shared about their practices and the attributes they find important, as well as the obstacles they face. In fact, much of what they report is consistent with calls in the field for training new clinicians to strengthen their knowledge and awareness of the complexity of the experience of poverty and its relationship with mental health and to examine their own beliefs, biases, and assumptions about poverty. (e.g. American Psychological Association, 2008; Goodman et al., 2004; Lewis, Arnold, House & Toperek, 2003; Liu, Pickett, & Ivey, 2007; Smith, 2009; Smith, et al., 2013; Smith Shellman, & Smith, R., 2013; Stabb & Reimers, 2013).

A training program based on the results of the current study would have the goals of a) supporting clinicians in reflecting upon class-based power differences between themselves and their clients and directly addressing these differences through conversations with clients; b) helping therapists to develop new, more flexible approaches to boundaries when working with low-income clients and think through

potential ethical dilemmas involved; c) supporting clinicians in examining how intrapsychic problems and poverty-related stressors are inseparable and intersecting, and using that knowledge to inform their practice by maintaining flexibility in the focus of the therapy hour, and incorporating that knowledge in their conceptualization of clients' distress and the source of their clients' problems; and d) engaging in self-reflection around the attributes that participants of the current study identified as important, including possessing a values-based commitment to working with marginalized groups; possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty; possessing a high degree of self-reflection related to poverty; being willing to be deeply affected by the work; and finding ways to cope with negative feelings that arise as part of the work.

A variety of strategies could be used to achieve these goals, including a) providing case examples of successful and unsuccessful therapy moments with clients in poverty; b) journaling and other self-reflection exercises using prompts from case-examples; c) experiential and group activities designed to increase empathy and inspire self-examination related to thoughts, feelings, assumptions and beliefs about clients in poverty; and d) well-facilitated honest conversations about the challenges and ethical dilemmas that arise as part of the work. Both psychologists-in-training and those who are already practicing would likely benefit from such a training, and these same exercises could be used in supervision and consultation meetings as well.

In addition to methods described above, many have recommended providing psychologists-in-training with hands-on experience working with clients in poverty (Pugach & Goodman, under review; Smith et al., 2013; Smith, Shellman, Smith, 2013).

Indeed, participants in the present study indicated that their previous experience was vital to their ability to empathize and respond to poverty-related stress. However, trainees working with clients in poverty will need additional supports, such as supervisory experiences focused on the specific challenges of this work and guidance through some of the ethical dilemmas that may arise around boundaries in the therapeutic relationship. In addition, trainees may not have developed longstanding supportive relationships with experienced colleagues, which participants in the present study identified as an important source of support. Finally, it is important to consider that some of the strategies participants described using to cope with the negative feelings arising as part of this work may not be readily available to trainees, such as engaging in nourishing activities and hobbies outside of work and setting limits and/or maintaining psychological distance from the work. Trainees are often stretched in many directions as they are faced with the multiple demands of doctoral training (coursework, research, comprehensive exams, and clinical work) and are likely to be feeling stretched financially. In fact, some participants in the present study mentioned graduate school as a moment in their class background that was particularly challenging. Therefore, although they are highly unlikely to be facing the poverty their clients are, they may not have much psychological distance from the experience of struggling to meet basic needs and may not have time and money for nourishing activities outside of work. Those who wish to train upcoming psychologists to work well with this population are therefore faced with a paradox of sorts: on the one hand experience working with the poor seems to be the best teacher; on the other hand, immersion in the work can be overwhelming without the right supports. Just as the ecological context of participants in the present study was considered using

Bronfenbrenner's (1979, 1986) ecological model, the context of trainees' work lives should also be considered when developing training experiences for them.

### **Implications for Research**

The current study's findings point to some new directions for future research. First, findings on the unique practices developed by participants in the study warrant further investigation – particularly those practices that have received little to no attention in the literature to date. In particular, findings on the extent to which participants reported stretching and modifying boundaries in the therapeutic relationship by sharing food, giving clients money, and breaking rules, are difficult to make sense of in the absence of other studies on the subject and theoretical models for ethical decision-making in the context of work with clients in poverty. Future research in these areas should focus on the following questions: How frequently do therapists working with clients in poverty give clients food or money? How frequently do they bend or break agency or insurance rules to help clients gain access to resources? How do they decide when and how to do this? What is the impact of these practices on the therapeutic relationship from the client's perspective? How does the therapist reconcile these practices with traditional perspectives on boundaries? Do therapists working with clients in poverty hide these practices from their colleagues? And if so, what is the consequence of that?

Second, findings on the extent to which therapists are affected by the agency and system level environments they work in, while perhaps not surprising, are nonetheless important to understand better. There are often calls in the field for psychologists to do more in the way of advocating for clients and to provide class-competent psychotherapy to the poor (e.g. American Psychological Association, 2008; Liu, Pickett, & Ivey, 2007;

Smith, 2009; Smith, et al., 2013; Smith, Shellman, & Smith, 2013; Stabb & Reimers, 2013). The current study's findings support these suggestions – participants in this study reported doing much of what has been called for in the field. However, findings on the level of difficulty of the work and the many systemic obstacles faced by therapists working with clients in poverty suggest that more research is needed to understand the effect of these system-level factors on the therapist, as well as possible solutions to the problems they face. For example, how can existing models of compensation where clinicians are paid for case management and instrumental support be implemented more broadly? How are decisions made about hiring within agencies with regard to how many case managers are available to support therapists?

Third, future research should address some of the limitations of the current study. First, although qualitative research is a valuable first step in understanding the work of psychologists working with clients in poverty, quantitative studies would be helpful for answering questions about the prevalence of the practices, attributes, and obstacles discovered by the present study. Second, the present study included participants who worked with clients in poverty for many years. Future studies should also focus on those who have “burnt out” and/or decided to work with other populations. It would be important to understand what led these therapists away from the work, given how many clients in poverty are in need of help. Third, although the sample was relatively diverse demographically (See Table 1), participants were all recruited from one urban area and a small number of agencies and institutions within that geographic area. Future research should focus on other geographic areas, where therapists could have difference

experiences based on local and state resources and policies and clients could face different challenges.



## Conclusion

The present study contributes to the literature on poverty and mental health by exploring from the perspective of the therapist, what working with clients in poverty looks and feels like. Given the high rates of mental illness (Adler, et al., 1993; Bruce, Takeuchi, & Leaf, 1991; Fiscella & Williams, 2004; Hudson, 2005; Seeman et al., 2004) and low rates of successful treatment (Armstrong, et al., 1984; Diamond & Factor, 1994; Falconnier, 2004; Garfield, 1994; Greeno, et al., 1999; Maynard, et al., 1997; Miranda et al, 1998; Nadeem, Lange, & Miranda, 2008; Siefert et al., 2000) among the poor, understanding the nature of therapy with the poor from the perspective of highly experienced clinicians is an important step in the direction of providing better treatment for this underserved population. The findings of the study help shed light on the practices psychologists adopt when working with clients in therapy, the attributes that are important for the work, and the obstacles they face. Together, these findings indicate that indeed clients in poverty are a special population, and that work with this population requires unique adaptations. Findings from this study can inform practice and training in myriad ways, but they also raise many new questions in need of further research. My hope is that the present study inspires clinicians and future researchers to consider clients in poverty as a unique population in need of further care and attention, and points the way toward what that care and attention might look like. Ultimately, I hope that the study and others like it will inspire change that improves mental health treatment and quality of life for our most disadvantaged citizens and that alters the perspectives and practices of the therapists who are fortunate to work with them.

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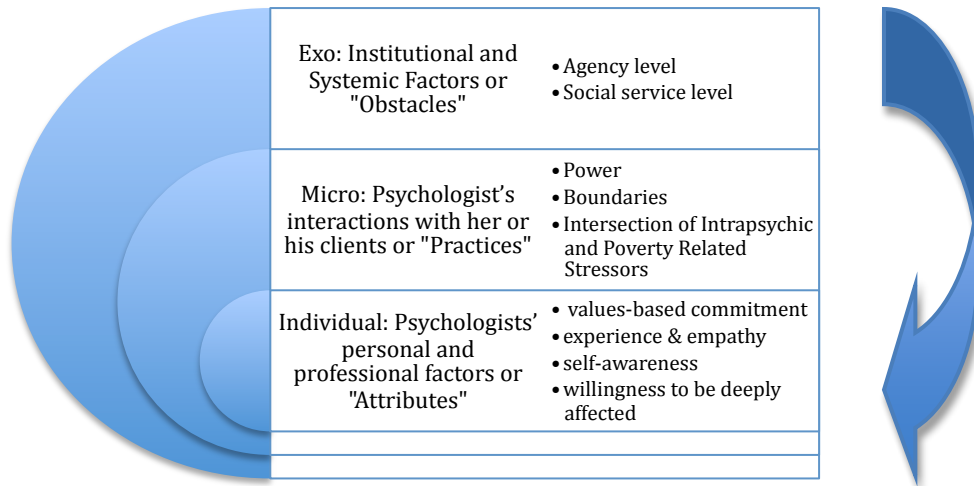
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**Figure 1**

**Results in the Context of Organizing Framework: Ecological Model**



**Table 1: Sample**

<b>Name</b>	<b>Age</b>	<b>Gender</b>	<b>Race/ Ethnicity</b>	<b>Highest Degree</b>	<b>Years experience since highest degree</b>	<b>Years experience with clients in poverty</b>	<b>Primary Theoretical Orientation</b>	<b>Primary Practice Setting</b>	<b>Class Background</b>
Gemini	54	Woman	Black/ African American	Ph.D. Clinical Psychology	22 years	22 years	Integrative: CBT & Psychodyna mic	Communi ty-based outpatient clinic	Lower Middle Class
Javier	49	Man	Latino	Ph.D. Clinical Psychology	16 years	22 years	Integrative: CBT, DBT, Psychodyna mic, Feminist, Ecological, Cultural, Humanistic/ Existential	Hospital- based outpatient clinic	Middle class at times, poor at times
Usha	34	Woman	South Asian /Indian	Ph.D. Clinical- Community Psychology	7 years	10 years	Integrative: Trauma- informed, Psychodyna mic	Hospital- based outpatient clinic	Middle Class
Rachel	65	Woman	White	Psy.D. Clinical Psychology	32 years	32 years	Integrative: Psychodyna mic (object relations), Behavioral, Family systems, Developmen tal	Communi ty-based outpatient clinic	Lower Middle Class



Esperanza	56	Woman	Latina/ Mixed Race	Ph.D. Counseling Psychology	12 years	30 years	Integrative: Psychodyna mic, CBT, biological/m edical, trauma focused, IFS, EMDR	Hospital- based outpatient clinic	Upper Middle Class
Martha	44	Woman	Latina	Ph.D. Clinical Psychology	17 years	20 years	Integrative: Psychodyna mic, CBT, bio-medical, Family Systems, Humanistic/ Existential	Communi ty-based outpatient clinic	Poor
Chris	61	Man	White	Psy.D. Clinical Psychology	29 years	32 years	Integrative: Psychodyna mic, development al, systems, CBT	Communi ty and hospital- based outpatient clinic	Upper Middle Class
George	58	Man	White	Ph.D. Clinical Psychology	19 years	15 years	Psychodyna mic/Psychoa nalytic	Private practice and Hospital- based outpatient clinic	Upper Middle Class
Mama	44	Woman	Latina	Ph.D. Clinical Psychology	12 years	20 years	Psychodyna mic	Hospital- based outpatient clinic	Upper Middle Class and later, Middle Class

Terry	61	Woman	White	Psy.D. Clinical Psychology	30 years	34 years	Integrative: Systems, DBT, CBT	Hospital- based outpatient clinic	Upper Middle Class
Cody	55	Man	White	Ph.D. Clinical Psychology	26 years	27 years	Integrative: Psychodyna mic, Narrative, CBT	Private Practice and Hospital- based outpatient clinic	Lower middle, working class
Aparna	43	Woman	Asian/ Indian	Ph.D. Clinical Psychology	16 years	10 years	Integrative: Psychodyna mic, Multicultura l, Feminist	Hospital- based outpatient clinic	Middle class at times, low- income at times



## **Appendix A: Interview Protocol**

**Boston College  
Lynch School of Education  
Department of Counseling, Developmental, and Educational Psychology  
“Psychologists’ Experiences Working with Clients in Poverty: A Qualitative  
Descriptive Study”**

**Investigators: Angela Borges and Lisa Goodman, Ph.D.**

### **Informed Consent**

- Review Forms
- I also want to let you know:
  - If you are at all uncomfortable with any question, you can decline to answer that question.
  - For any reason, you can end the interview at any time.

### **Introduction**

- Today I’ll be asking you about your experiences as a therapist working with clients who are living in poverty. By this I mean clients who:
  - are living below the U.S. poverty line (under \$10,830 for an individual; \$14,570 for a couple; \$22,000 for a family of four);
  - or are receiving state assistance such as food stamps, WIC, or TANF.
  - or clients who are struggling to meet their basic needs and for whom this is a chronic struggle.

You probably don’t know your clients’ exact incomes, so this is just a guideline.

- I want to begin by asking you a few background questions.

Age

Gender

Man

Woman

Transgender

Ethnic Background and Race

Highest Degree or Diploma and Where

Ph.D. – Clinical Psychology

Ph.D. – Counseling Psychology

Psy.D. – Clinical Psychology

Ed.D. – Counseling or Clinical Psychology

Years of experience in the field of mental health since highest degree:

Have you had course work in doing psychotherapy with low-income clients while in your graduate program?

Yes

No

Did you receive clinical supervision that included discussion of poverty during your training?

Yes

No

Have you attended special workshops and/or training seminars on poverty and mental health?

Yes

No

If you answered “yes” to the previous question, how many workshops or seminars have you attended since receiving your highest degree?

To what extent have you found these workshops and seminars helpful to you in your work with clients in poverty?

- Not at all helpful
- Somewhat helpful
- Helpful
- Very helpful

Describe the main theoretical orientation most represented in your graduate training.

- Psychodynamic
- Cognitive-behavioral
- Family Systems
- Biological/Medical
- Humanistic/Existential
- Integrative
- Other: Describe

Describe your current primary theoretical orientation.

- Psychodynamic
- Cognitive-behavioral
- Family Systems
- Biological/Medical
- Humanistic/Existential
- Integrative
- Other: Describe

What is your primary practice setting?

- Community based outpatient clinic
- Hospital based outpatient clinic
- University or college counseling center
- Private practice
- School
- Residential setting
- Inpatient psychiatric facility
- Partial hospital or Day treatment center
- Other: Describe

Other practice settings?

Community based outpatient clinic  
 Hospital based outpatient clinic  
 University or college counseling center  
 Private practice  
 School  
 Residential setting  
 Inpatient psychiatric facility  
 Partial hospital or Day treatment center  
 Other: Describe

- I am interested in learning about your own experience of working with these clients and what tensions arise in the process. I'll start with some introductory questions.

### **Interview Questions**

#### **I. Introductory Questions – Personal History and Current Work**

1. About what proportion of your clients are struggling with poverty?
2. How long have you been working with clients in poverty?
3. How did you come to this work?
4. What is your own class background? Have you had personal experience with poverty?
5. How does your own class background affect your work? Can you tell me a story that illustrates this?
6. About what proportion of your clients are struggling with poverty?
7. I'd like you to tell me about your work with one client in poverty. Please tell me a little about:
  - a. the client
  - b. their presenting problem(s)
  - c. your approach to the work
  - d. how the treatment went

Probe: How did the clients' poverty shape the work?

## **II. Questions About Factors Influencing the Therapist At All Levels of the Ecological Model**

### **II.A. Individual-Level System**

#### II.A.1. Experience of Class Competence: *General*

8. Overall, how well prepared do you feel to do work with clients in poverty?

Can you tell me a story that illustrates this?

Probe: What feelings come up for you when working with clients in poverty?

What is your subjective experience?

Probe: How do you cope with/handle these feelings?

9. Did you receive any specific training on working with clients in poverty? Can you describe it and how it was or was not helpful?

#### II. A.2. Experience of Class Competence: *Knowledge*

7. What do you think is important to know about working with clients in poverty? Can you tell me a story that illustrates this?

Probe: Do you feel you have enough knowledge of poverty?

Probe: How do you put this knowledge into practice?

Probe: To the extent that you feel you have knowledge of poverty, how did you find out about it?

#### II. A.3. Experience of Class Competence: *Skills*

8. How are the skills needed to work with clients in poverty different from skills you need to work with other clients? Can you give me an example?

Probe: Do you feel you have these skills?

Probe: How did you learn these skills?

#### II. A.4 Experience of Class Competence: *Attitudes*

9. What kinds of opportunities have you had to explore your own attitudes/beliefs about poverty and what did you discover in that exploration?

#### II. A.5 Theoretical Orientation

10. How does your theoretical orientation shape how you work with low-income clients? Can you tell me a story that illustrates this?

Probe: What, if anything, does the theory your orientation is based on say about poverty or material needs?

Probe: Does your own clinical judgment differ from the ideals of your theoretical orientation when working with clients in poverty?

11. Are there specific models, conceptualizations, or theoretical orientations that you have found work better with clients in poverty? Ones that do not work well? Can you tell me a story to illustrate this?

#### **II. B. *Micro System***

##### II. B.1. Questions About Therapist Understanding of and Response to Mental Health Problems as Internal vs. External

12. How do you think about the clients' mental health problems in relation to their poverty and external circumstances? Can you tell me a story to illustrate this?

Probe: How does poverty enter the case conceptualization process with poor clients?

##### II.B.2. Addressing External Stressors

13. Do you work directly with clients' external circumstances related to poverty (i.e. problems with unstable housing and employment, lack of access to resources, etc.)? Can you tell me a story about that? (NOTE: note which external circumstances they focus on – work, housing, etc. and can ask if certain ones don't come up).



Probe: If so, how? If not, why not?

Probe: If so, how do you decide the level of your involvement (e.g. do you call an agency for a client? Accompany them? Refer them to someone else?)?

Probe: If so, how do you decide when to do something for the client (e.g. call an agency) vs. encourage them to do it for themselves?

Probe: If so, do you need to bend or break rules in your agency to do?

Probe: If not, why not?

14. How important is it for therapists to address external circumstances in your opinion? How feasible?

### II.B.3. Questions about Therapist use of Power and Boundary Setting

15. How does the poverty of the client influence the power dynamics between you and your client? Can you tell me a story to illustrate this?

16. How are boundaries different when working with low-income clients than with other populations? Can you tell me a story to illustrate this?

Probe: How are boundaries around self-disclosure different with low income clients than with other populations?

Probe: How are boundaries around time (session length and scheduling) different?

Probe: How are boundaries around location (where to meet) different?

Probe: How are boundaries around role different when/if you are addressing external circumstances or stepping out of traditional counselor role?

## II. C. Exo System

### II. C.1 Structural Constraints

17. To what extent do you feel supported in your workplace to work with low-income clients? Can you tell me a story to illustrate this?

Probe: What do you wish you had?

Probe: What are the obstacles?

Probe: What makes it easier?

18. How do the resources available to your clients (i.e. state and community resources such as childcare, financial assistance, etc.) affect your work? Can you tell me a story about this?

## **II.D. Macro System**

### **II. D. 1 Cultural Views**

19. I'm interested in how you think about the traditional role of the therapist: To what extent do you think the traditional therapy role works with low-income clients? By traditional role I mean, 50 minute hour, office, etc.
20. How do you think the dominant U.S. culture's view of the poor affects your work with low-income clients?

## **III. Recommendations**

21. What would be your recommendations for therapists providing care to clients in poverty? What advice would you give other therapists?
22. What makes it easier to work with clients in poverty? What makes it harder?
23. What would help you to provide more effective care to clients in poverty?

Probe: What kind of training do you wish you could have?

Probe: What kind of changes in work settings do you wish would?

## **IV. Closing**

24. Is there anything else you'd like to share that we didn't cover?

Thank you!



## **Appendix B: Interview Consent Form**

**Boston College Consent Form**  
**Lynch School of Education**  
**Department of Counseling, Developmental, and Educational Psychology**  
**Informed Consent for Participation as a Subject in “Psychologists’ Experiences**  
**Working with Clients in Poverty: A Qualitative Descriptive Study”**  
**Investigators: Angela Borges and Lisa Goodman, Ph.D.**  
**Study Funders:**  
**Boston College Research Expense Grant**  
**Society for the Psychological Study of Social Issues (SPSSI) Grant-in-Aid**

### **Introduction:**

- You are being asked to participate in a research study exploring psychologists’ experiences with providing outpatient psychotherapy to those in poverty.
- You were selected as a possible participant because you have more than 5 years experience working with low-income clients conducting individual therapy on a regular basis.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

### **Purpose of Study:**

- The purpose of this study is to explore psychologists’ experiences providing therapy to low-income clients. We hope to shed light on the factors affecting the psychologist doing the work, how prepared psychologists feel to do the work, and how they manage difficulties that arise. In turn, we hope this information will contribute to improvements in mental health services.
- The total number of participants is expected to be between 12 and 15.

### **Description of the Study Procedures:**

- If you agree to be in this study, I would like to interview you to ask you about your experiences conducting therapy with low-income clients. During the interview, I will ask questions about things such as how prepared you feel to do the work, what contextual factors affect the work, what your work actually looks like, how you think about it, and how you manage challenges that arise. The interview should take about 60 to 120 minutes and will be audiotaped. Interviews will take place at a location that is easiest for you, such as in your workplace, your home or another quiet place near your home or workplace. We may also use an office at Boston College if preferred. I will also ask if you would like to receive a transcript of this interview and a chance to talk to me about changes you’d like to make. We could have that conversation by phone or in-person, as you choose.

**Risks/Discomforts of Being in the Study:**

- There may be unknown risks. However, identifiable risks may include experiencing emotional reactions in response to discussing issues of poverty and mental health treatment. If you became emotionally distraught during your involvement in the interview, with your permission, I will help link you to alternative supports or resources to aid you in your distress.

**Benefits of Being in the Study:**

- The purpose of this study is to learn more about psychologists' experiences doing therapy with low-income clients.
- Potential benefits to participation may include feelings of hope and altruism surrounding participating in research aimed at ultimately improving mental health services for underserved populations. Also, it is possible that by reflecting on one's work as a psychologist, participants will gain new insights that could be of benefit to them in their work.

**Payments:**

- You will be reimbursed \$30 for participating in the interview. You will be paid within one month of this interview. If you choose to withdraw from the study, you will still be paid the full amount (\$30).

**Costs:**

- There is no cost to you to participate in this research study.

**Confidentiality:**

- Your interview audiotapes will be kept strictly confidential. Although names might be used during the interview, when the interview tape is transcribed no names or identifying information will be recorded. I will ask you to choose a pseudonym to use instead. This pseudonym will replace your name in the interview transcripts. This form and the audiotapes will be stored in a locked cabinet that will only be accessible to the researchers of this project (i.e., Dr. Lisa Goodman, Angela Borges, and **one of two graduate research assistants both of whom will be transcribing interviews**). The audiotapes will be destroyed after they are transcribed. No names or identifying details will be used in any publications or other documents resulting from this research. All data collected from this study will be presented as a group, so that no one can identify any one individual within the study. I may also quote you or other participants without identifying where the quotation came from. The information collected will be kept for five years after the results of the study are published. This consent form will be stored separately from the information you provide, **and will also be destroyed by shredding five years after the results of the study are published in order to ensure confidentiality.**
- As is the case in any research project, there are certain limits with regard to confidentiality. For example, if you tell me about a child or elder who is being abused, or about your intent to hurt yourself or others, we may be required to inform the Department of Child and Family Services or other appropriate authorities.

- Mainly just the researchers will have access to information; however, please note that a few other key people may also have access. These might include government agencies. Also, the Institutional Review Board at Boston College and internal Boston College auditors may review the research records.

**Voluntary Participation/Withdrawal:**

- Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University.
- You are free to withdraw at any time, for whatever reason.
- **You may skip a question if you wish.**
- **You may turn off the recorder whenever you wish.**
- There is no penalty or loss of benefits for not taking part or for quitting.
- During the research process, you will be notified of any new findings from the research that may make you decide that you want to stop being in the study.

**Getting Dismissed from the study:**

- **The researcher may dismiss you from the study at any time if it is in your best interest (e.g. distress has resulted).**

**Contacts and Questions:**

- The researchers conducting this study are Lisa Goodman, Ph.D. and Angela Borges. For questions or more information concerning this research you may contact them at 617.552.1725.
- If you have any questions about your rights as a research subject, you may *contact: Director, Office for Research Protections, Boston College at (617) 552-4778, or irb@bc.edu*

**Copy of Consent Form:**

- You will be given a copy of this form to keep for your records and future reference.

**Statement of Consent:**

- I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study.
- \_\_\_\_\_ I have received (or will receive) a copy of this form.

**Signatures/Dates**

Study Participant (Print Name): \_\_\_\_\_

Participant or Legal Representative Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness/Auditor (Signature): \_\_\_\_\_ Date \_\_\_\_\_

### Appendix C: Sample Coding Document

Name	Level 3: Category	Level 2: Cluster	Level 1: In Vivo Code	Quote
Mama	Practices	Awareness of the relationship between intrapsychic issues and poverty-related stressors	Participant describes taking poverty-related stress into account in every aspect of the work, including conceptualization	Even if someone presents psychotically... We've seen a lot of young men who can have little psychotic brakes after migrating. It's like if you go have no clothes, airless... underneath a truck, for 24 hours... you'd go a little psychotic yourself, you know? No air ventilation. So... poverty fits into that ya know? Other people migrate on a plane. Some people migrate in coolers and underneath buses. People actually hold on to the bottom of the bus for hours while driving, the heat and the fumes, you know of the truck... or the trunk of a car, just even the sensory deprivation of that. I would say it's absolutely always part of our conceptualization because the circumstances especially around migration and in the United States are always about poverty.
Cody	Attributes	Possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty	Participant describes the importance of understanding poverty experientially	You have to have a lot of experiential and clinical range to treat poverty-stricken people. Because you have to understand, in a very sophisticated way, kind of what their world is, kind of

				from thirty thousand feet... but you have to have your feet on the ground and sit and stand next to them... while you're doing the work.
Gemini	Obstacles	Unique social system-level challenges to the work	Participant is disgusted with how social service system makes clients "jump over hurdles" to get access to resources.	This is disgusting and, you know, the institutions try to help, you know, and people try to help but sometimes it's the system that makes people jump higher, and higher, and higher over these hurdles. It doesn't, it doesn't need to be that way.