LOW-INCOME WOMEN’S EXPERIENCES IN OUTPATIENT PSYCHOTHERAPY:
A QUALITATIVE DESCRIPTIVE ANALYSIS

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Low-income women’s experiences in outpatient psychotherapy: A qualitative descriptive analysis

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Abstract

As poverty rates in the United States increase, women continue to be disproportionately represented among individuals in poverty. As a result of their poverty, low-income women experience a range of acute stressors and chronic life conditions, within a sociopolitical climate that is highly stigmatizing. Not surprisingly, low-income women experience mental health issues at substantially higher rates than their higher-income counterparts. Despite the clear need for mental health services for this population, rates of access to treatment are low and attrition rates are high. The minimal research examining treatment outcomes for low-income women reveals mixed findings. Further, there is little research on low-income women’s qualitative experiences of therapy; the role of their poverty and what they perceive to be meaningful and effective. The present study attempted to fill the gap in our understanding of low-income women’s psychotherapy needs and experiences, in an effort to offer new insights about directions for research, training, and practice that can improve mental health services for this high-risk population. This study employed a qualitative descriptive methodology to explore low-income women’s (n=10) experiences in traditional outpatient psychotherapy, with a particular focus on how poverty shaped their experiences and what they perceived to be most effective and meaningful. Six clusters emerged from data analysis: Awareness, Instrumental support and flexibility, Building strengths, Respect and dignity, Shared
power, and Authenticity. These clusters, in turn, coalesced into three overarching themes: Awareness, Practices, and Relational Quality. Awareness pertains to participants’ sense that their therapist understood the nature of poverty and was sensitive to the role of poverty-related stressors in their clients’ lives. Practices reflects therapists’ willingness to respond directly and actively to participants’ poverty-related needs, as these are inextricably intertwined with their mental health. Relational quality refers to the participants’ view of how therapists approached relational dynamics; in particular, how they negotiated issues such as power and transparency. Findings are discussed in the context of feminist theory and current research. Limitations are also presented along with recommendations for future research, training, and practice.
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Chapter 1: Introduction

Research on health disparities has demonstrated dramatically that a variety of marginalized populations in this country have relative difficulty securing effective health services in general (e.g., Brown & Jemmott, 2002; Institute of Medicine, 2002; United States Department of Health and Human Services [USDHHS], 2002), and mental health services in particular (e.g., Beeber et al. 2007; Miranda, McGuire, Williams, & Wang, 2008; Nadeem, Lange, & Miranda, 2008; Siefert, Bowman, Heflin, Danziger, & Williams, 2000). Reasons for such disparities range from decreased access to services to begin with (e.g., Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Levy & O’Hara, 2010; Maynard, Ehreth, Cox, Peterson, & McGann, 1997) to the nature of the fit between what mainstream interventions offer and what specific underserved groups need or want (e.g., Falconnier & Elkin, 2008; Goodman, Smyth, & Banyard, 2010). Although the reduction of health disparities has become a major priority within the public health arena (e.g., USDHHS, 2002), its focus remains primarily on ethnic minority groups (e.g., LaVeist, 2005; USDHHS, 2011). Though poverty clearly intersects with race/ethnicity, poverty itself has not received nearly as much attention in the research literature.

In this short chapter, we briefly highlight why health disparities researchers need to pay more attention to impoverished communities, and how the proposed study takes a step in that direction. Chapter 2 then provides a broad overview of literature relevant to the proposed study, including a discussion of the experience of poverty and subsequent mental health difficulties, what we know about psychotherapy with poor clients, and how feminist therapy theory illuminates potential avenues towards a deeper understanding of the experience of impoverished consumers of mental health services. Chapter 3 describes
the objectives and methodology of the study, Chapter 4 explores the results, and Chapter 5 discusses the findings within a feminist framework and considers the implications for research, training, and practice.

**Poverty, Mental Health, and Practice**

The relative paucity of attention to poverty in the literature on health disparities represents an enormous oversight for a number of reasons, elaborated in the next chapter. First, the rates of poverty in this country continue to grow each year at alarming rates (U.S. Census, 2009). Second, poverty is associated with a myriad of mental health difficulties, including depression (Siefert et al., 2000), posttraumatic stress disorder (PTSD) (Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshall, 2001), substance abuse (James et al., 2003; Ziberman, Tavares, Blume, & Nady, 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999). Third, low-income individuals access mental health services at lower rates than their higher income counterparts, often dropping out of treatment prematurely or failing to initiate treatment altogether (e.g., Garfield, 1994; Nadeem, Lange, & Miranda, 2008; Siefert et al., 2000; Wierzbicki & Pekarik, 1993). Fourth, for those low-income individuals who do access mental health treatment, data on treatment effectiveness are limited, and those studies that do exist present mixed results, at best.

In recent years, a number of researchers have begun to take important steps towards framing and refining mental health interventions to make them more easily accessible and potentially useful to low-income communities. From a conceptual perspective, they have pointed to a potential mismatch between the nature of mainstream treatment approaches, often developed with Caucasian, middle-class populations in mind,
and the cultural and contextual realities of marginalized groups (e.g., Goodman et al., 2010; Goodman et al., 2013; Le, Zmuda, Perry, & Munoz, 2010; Miranda, Bernal et al., 2005; Smyth, Goodman, & Glenn, 2010). Focusing specifically on impoverished low-income women, for example, Goodman and colleagues have noted how low-income women may be especially sensitized to the power dynamics present in the therapy office given the intense and pervasive disempowerment they face in their daily lives, and they argue that the absence of attention to external sources of distress in mainstream practice may be particularly problematic for those who face a host of chronic and acute stressors every day (Goodman, Glenn, Bohlig, Banyard, & Borges, 2009). Further, as the next chapter will elaborate, a number of researchers have demonstrated that when tailored to meet the specific needs of impoverished individuals, mental health interventions can be highly effective for this population (e.g., Ammerman et al., 2005; Grote, Swartz, Geibel, Zuckoff, Houck, & Frank, 2009; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung et al., 2003).

Yet, these attempts are somewhat hampered by the absence of research on how low-income individuals actually perceive and experience mental health treatment once they engage in it, and what may have made it effective or helpful (or not), from their perspectives. This represents an important oversight since the perceptions and experiences of low-income consumers of mental health services represent a potentially vital resource for those interested in improving mental health practices for this population. By offering insight into their own complex mental health difficulties and how current intervention practices may or may not address them effectively, low-income individuals can illuminate existing quantitative findings, and suggest pathways towards
the development of interventions that are more accessible, meaningful, and finally, effective.

**Our Study**

The present study aimed to fill this significant gap in the literature by exploring low-income women’s experiences within outpatient psychotherapy. We intended to understand this experience as broadly as possible, but were especially interested in how the poverty-related issues in their lives shape their experience of psychotherapy and what they perceived to be most effective and meaningful. This study focused on women specifically for several reasons: they are disproportionately represented among those living in poverty, with a rate that is approximately 38% higher than that for men (Christopher, England, Smeeding, & Phillips, 2002), they may experience poverty differently than do men, given the stress, powerlessness, and isolation they face, especially in their mothering roles (Brodsky & De Vet, 2000; Dodson, 1998; Goodman et al., 2007; see Chapter 2 for a more detailed discussion), they seek mental health intervention at much higher rates than men (e.g., Fiorentine, Anglin, Gil-Rivas, & Taylor, 1997), and they may experience such intervention very differently.

This study used a qualitative methodology to render an in-depth understanding of low-income women’s experience of outpatient psychotherapy. We selected a qualitative approach for three linked reasons. First, qualitative methods are useful to explore topics for which little research has been conducted previously, as it can bring forth new and/or unexpected information (Creswell, 1998; Morrow, 2007). Second, qualitative research uses language as a tool to access data that may not be observable or measurable by traditional quantitative approaches (Morrow, 2007). Third, qualitative methods tend to
lend themselves to use with oppressed or marginalized groups, as they provide opportunities for individuals within these groups – who are largely under-represented or potentially misrepresented in the literature – to give voice to their own experiences (Hage, 2006).

Specifically, this study used qualitative description, a specific data collection and analysis method within the larger category of qualitative research. This method aims to glean a comprehensive description of participants’ experiences, with less inference on the part of the researcher (Sandelowski, 2005). Qualitative description is structured to render a “rich, straight description” of the phenomenon of interest (Neergaard, Oleson, Andersen, & Sondergaard, 2009, p. 2) by collecting data directly from subjects – in their own words – and thereby is able to elucidate the potentially complex and contextually-embedded aspects of the phenomenon that may have previously been poorly understood (Sullivan-Bolyai et al., 2005). Because this methodology aims to stay as close to the words of participants as possible, it can be particularly useful for the development and/or refinement of interventions targeting under-represented groups.

Maximum variation sampling was employed to obtain a diverse sample of participants with a range of experiences with outpatient psychotherapy (Sandelowski, 2000). Participants were recruited through recruitment flyers (See Appendix A for Recruitment Flyer) posted throughout the community, as well as through snowball sampling. Individual interviews were used to elicit women’s full range of experience with outpatient psychotherapy. We continued to recruit participants until we achieved theoretical saturation, whereby new data ceased to add any new information to the findings (Morrow, 2007). Although it is impossible to predict how many interviews will
be necessary for saturation to be reached, qualitative researchers typically aim for a
sample size of 10-12 participants (Hill, Thompson, & Williams, 1997). For the present
study, saturation was reached within a sample of 10 participants.

Interview transcripts were coded using conventional qualitative content analysis, a
type of analysis that involves the classification of large amounts of text in order to
summarize the informational contents of the data in a more efficient manner (Downe-
Wamboldt, 1992). Data analysis was data-derived; that is, we systematically identified
and applied codes as they emerged from the data (Sandelowski, 2000). No pre-existing
coding schemas were imposed, though coding did unfold within the backdrop of feminist
therapy theories and knowledge of prior literature on this topic (Milne & Oberle, 2005).
Data was first coded into in vivo codes, followed by categories, and then clusters, to
render a broad, rich description of the phenomenon (Charmaz, 2005). Throughout the
process, we engaged in regular colleague checks to ensure that the codes, categories,
clusters, and inter-relationships were accurately representative of the data and are
logically grouped (Milne & Oberle, 2005). We also took a series of steps (described in
detail in Chapter 3) to ensure the authenticity, credibility, criticality, and integrity of our
findings.

It is imperative that the research, program development, and policymaking
practices that directly affect low-income individuals do not take place without their
involvement. As has become the mantra of many disability rights activists, “Nothing
about us without us” (Charlton, 1998). We hope that the current exploration was able to
amplify low-income women’s voices, and suggest a path towards improving their
experience of mental health interventions and, ultimately, the quality of their lives.
Chapter 2: Literature Review

Women are disproportionately represented among individuals living in poverty in this country, with a poverty rate that is approximately 38% higher than that for men (Christopher et al., 2002). Poverty, in turn, is associated with a range of mental health problems including depression (Siefert, et al., 2000), PTSD (Vest et al., 2002; Vogel & Marshall, 2001), substance abuse (James et al., 2003; Ziberman et al., 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999).

Despite these mental health concerns, low-income women are less apt to access mental health services than their middle-income counterparts, and when they do, they are more likely to drop out of treatment prematurely (Garfield, 1994; Miranda, Azocar, Komaromy, & Golding, 1998; Nadeem, Lange, & Miranda, 2008; Siefert et al., 2000). The reasons researchers offer for relatively low levels of access and high drop out rates have tended to cluster around individual-level variables such as transportation or childcare difficulties, mistrust of the system, or culture-based reluctance to engage the system (e.g., Abrams, Dornig, & Curran, 2009; Beeber et al., 2007; Levy & O’Hara, 2010; Maynard et al., 1997; Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003).

However, less attention has been given to the relevance or utility of mental health treatment for this population, given the range of poverty-related hardships they face (Goodman, Smyth, & Banyard, 2010). Although the research on treatment effectiveness for this specific group has presented inconsistent findings, a handful of studies have demonstrated positive outcomes when mental health interventions are tailored specifically to address the contextual stressors in low-income women’s lives (e.g., Ammerman et al., 2005; Grote et al., 2009; Miranda, Azocar, Organista, Dwyer, &
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Areane, 2003; Miranda, Chung et al., 2003). These latter findings suggest the possibility that if appropriately modified, mental health services might better meet the specific needs of low-income women.

Despite the importance of these findings, the perspective of the low-income women who have participated in treatment has been noticeably absent from the literature, leaving researchers and practitioners with a limited understanding of how this group experiences mental health intervention and therefore how services might be modified. The present study aimed to address this gap by exploring low-income women’s experiences with outpatient mental health psychotherapy, with a specific focus on how poverty intersects with therapy practices and overall experiences. This exploration aimed to contribute to improvements in mental health services for a large group of women who are currently under- and possibly ill-served.

This chapter begins with an overview of poverty in the United States, focusing on women’s poverty. Second, it describes the stressors associated with women’s poverty, and the mental health difficulties that may arise as a result. Third, this chapter explores scholarship on psychotherapy with poor clients, exploring the historical context of current practices, the proportion of low-income women who access services, barriers to treatment, and treatment outcomes. The chapter concludes with a description of how several dimensions of feminist therapy theory – including considerations of power and of external sources of suffering, respectively – help frame the proposed study.

Poverty in the United States: Overview

Since 2000, poverty rates have steadily increased, with approximately 14.3 percent of the U.S. population now living in poverty (U.S. Census, 2009). Based on the
federal government’s 2009 poverty threshold of an annual income of less than $10,830 for an individual, and an annual income of less than $18,310 for a family composed of one adult and two children, 39.8 million people were living in poverty, the highest poverty level since 1993 (US Census, 2009). Family and child poverty rates have risen especially quickly, with over 15 million American children now living in families below the poverty level (Wight, Chau, & Aratani, 2011). Further, as high as these numbers are, they leave out the many individuals and families that live just above the poverty line, despite research indicating that the current cost of living, and therefore the minimum amount of money necessary to make ends meet, far exceeds these cutoffs (Boushey, 2002; Opinion Dynamics Corporation, 2001; Thibos et al., 2007).

As the number of poor individuals and families has continued to increase, so has the gap between the poor and the rich (Bernstein, McNichol, Mishel, & Zahradnik, 2000). Over the past 20 years, the average income of the poorest fifth of the population has decreased 6% while the average income of the top fifth has increased 30%, a trend that has been referred to as “economic apartheid” (Collins & Yeskel, 2005). Thus, not only are more people in the United States living in poverty, but our nation’s poor are becoming increasingly poor over time.

Indeed, it is much more difficult to stretch a dollar these days. As the costs of housing, health care, and education have increased over time, the value of the minimum wage has steeply declined (Bernstein & Shapiro, 2006). United States workers now work more hours per year than workers in any other industrialized nations, yet with fewer supports, such as subsidized child care, paid leave, and vacation time (Heymann, 2000). It is therefore no wonder that Laura Smith describes the core experience of poverty as not
having enough income to consistently support basic individual and family needs like shelter, food, clothing and other requirements (Smith, 2010).

**Poverty and race/ethnicity.** Minority populations are the hardest hit by poverty. While 8.6% of Caucasian Americans meet poverty standards, 25.6% of Hispanics, 26.1% of African Americans, 12.5% of Asian and Pacific Islanders, and 31% of Native Americans on reservations are considered poor (U.S. Census, 2009). For every dollar owned by White families, families of color, on average, own less than a dime (Lui, Robles, Leondar-Ross, Brewer, & Adamsom, 2006). Further, a disproportionate number of people of color live within areas of concentrated poverty, where access to educational, recreational, nutritional, and social resources are more limited (Evans, 2004). Twenty-seven percent of African American youth and 13% of Latino youth grow up in areas identified as “severely distressed,” as compared to only about 1% of non-Hispanic White youth. Within their communities, students of color experience worse educational quality and fewer years of schooling than White children, and in turn, fewer opportunities for employment (Shapiro, 2004).

**Poverty and gender.** Women are also disproportionately represented among individuals living in poverty in this country (U.S. Census, 2009). In the United States, the poverty rate for women is approximately 38% higher than that for men (Christopher et al., 2002). This represents the greatest gender gap in rates of poverty of any major industrialized nations. Further, women of color are vastly overrepresented within the population of women in poverty. Compared with 11% of White women, 25% of African-American women and 23% of Latina women are poor (Center for American Progress, 2007). Almost 40% of single African-American and Latina mothers struggle with
poverty, and mothers who are ethnic minorities are at a substantially greater risk for experiencing long-term poverty (Thibos et al., 2007).

Overall, almost one third (29.9%) of families with a female head of household have incomes that place them below the official poverty line (U.S. Census Bureau, 2009). But the federal poverty guidelines vastly underestimate how much is required for a single mother with children to support her family. For example, in 2001, a single mother with two children was considered poor only when her annual income fell below $14,269 (U.S. Census Bureau, 2002). This number was calculated using the same formula developed in 1964 based upon national expenditure patterns of U.S. citizens in 1955 (Thibos et al., 2007). Although each year the poverty threshold is adjusted for inflation using the Consumer Price Index, these adjustments do not take into account changing expenditure patterns or differential inflation, such as the relative reduction in food expenditures and the relative increase in childcare expenditures and housing and healthcare costs. A current estimate of a minimum budget for a mother with two children, based upon present-day expenditure patterns and inflation rates, is $40,674 (Ms. Foundation for Women, 2001). Although this is only one estimate, it highlights the extreme disparity between federal standards of poverty and real-world needs. It appears that a significant proportion of women are in fact living with insufficient income to meet their most basic needs, and yet they are not “counted” as impoverished according to federal standards.

**Stressors Associated with Women’s Poverty**

Given the high rates of poverty among women, it is important to understand how poverty shapes women’s experiences. This section reviews research on the major stressors associated with women’s poverty, including traumatic life events, chronic stress,
stigma, social isolation, and powerlessness. The next section describes the mental health outcomes of these difficulties.

**Traumatic life events.** Poor women are far more likely than non-poor women to experience a broad range of life events that are traumatic and uncontrollable (Belle, Doucet, Harris, Miller, & Tan, 2000). For example, low-income women are disproportionately likely to experience marital dissolution, imprisonment of spouses, infant mortality, community violence, and other crimes (Bausman & Goe, 2004; Belle et al., 2000; Greif, 2005). Household income is also one of the most salient predictors of intimate partner violence, with lower incomes linked to a higher likelihood of violence (Cunradi, Caetano, & Schafer, 2002; Vest et al., 2002). One study of female welfare recipients found the lifetime prevalence of domestic violence to be as high as 67% (Tolman & Rosen, 2001), whereas another study found that 83% of women living in poverty have been physically or sexually assaulted within their lifetimes (Bassuk et al., 1998).

Repeated exposure to stressful and threatening environments has been linked to the development of affective responses such as hopelessness, hostility, anger, fear, anxiety, and low self-esteem, as well as behavioral responses such as chronic vigilance, attributions of negative intent, and isolation (Chen & Matthews, 2003; Gallo & Matthews, 2003). These emotional and behavioral patterns can exact a psychological toll on low-income women. For example, the fear that many low-income individuals report as a result of the high prevalence of community violence within their neighborhoods is associated with symptoms of anxiety and depression (Stafford, Chandola, & Marmot, 2007). Further, 88% of low-income women with histories of domestic violence reported
clinically significant levels of depression (Bell & Goodman, 2001) and the rates of PTSD in low-income urban women are two to four times higher than in the general population of women (Gill et al., 2009).

**Stressful life conditions.** Low-income women’s experiences with traumatic stressors occur within the context of chronic stressful life conditions related to ongoing deprivation. Poor individuals are more than three times as likely to live in substandard quality housing than those who are not poor, including housing with poor structural quality, insufficient insulation, and/or lack of plumbing (U.S. Census, 2001). Inadequate living conditions such as these have been associated with increased rates of depression, anxiety, and other indicators of psychological distress in low-income populations (e.g., American Psychological Association [APA], 2007; Evans, Wells, & Moch, 2003).

A myriad of physical health problems are also linked to poverty. Public health research has found that low-income women have higher rates of mortality, as well as osteoarthritis, hypertension, cervical cancer, coronary heart disease, AIDS/HIV infection, and other chronic health conditions (Adler & Coriell, 1997). Low-income women are also at a higher risk for obesity and diabetes, asthma, arthritis, and osteoporosis (Everson, Maty, Lynch, & Kaplan, 2002; Groh, 2007; Hoffman & Hatch, 2000). For low-income women, age-related decline in physical functioning occurs at twice the rate of non-poor women (Ross & Mirowsky, 2001). Not surprisingly, poor women tend to be sicker and are more likely to have disabilities, which limits their capacity for activity and in turn, impacts their abilities to obtain and maintain employment (Falik & Collins, 1996; Groh, 2007; Olson & Pavetti, 1997). As a result, low-income women subsequently experience increased financial strains and decreased opportunities for social and economic mobility.
When low-income women are mothers, the daily stress they experience is compounded by the responsibilities associated with caregiving. Many low-income women remain unwaveringly committed to “doing better” for their own children, and put forth great effort to serve as positive role models (Brodsky & DeVet, 2000; Dodson, 1998; Frame & Berrick, 2003). Yet, poor mothers often experience a sense of inadequacy and failure because they cannot provide their children with the opportunities and tools they need (Dodson 1998; Frame & Berrick, 2003; Lowe & Weisner, 2004). The demands of trying to make ends meet on a day-to-day basis often leave low-income mothers feeling tired, depleted, and less available to their children than they wish they could be (Frame & Berrick, 2003). Many low-income mothers report maintaining a constant state of anxiety and vigilance, anticipating that harm to their children is just around the corner in crime-ridden neighborhoods (Brodsky & DeVet, 2000; Dodson, 1998; Frame & Berrick, 2004; Lowe & Weisner, 2004).

Given this range of hardships, low-income women must turn to a variety of systems to obtain the resources necessary for survival, many of which are stressful to access or maintain. Not only do the complex rules and limitations within programs and systems create hardships for poor women, but so too does the inherent power imbalance between those seeking assistance and those who are the gatekeepers to needed resources (Dodson, 1998). Indeed, research indicates that low-income women are often confronted with sexual harassment, coercion, and even abuse as they attempt to access the services to which they are entitled (e.g., Reed, Collinsworth, & Fitzgerald, 2005; The Urban Institute, 2002). A qualitative exploration of low-income women’s experience with systems, for example, indicated that in the process of requesting food stamps, housing repairs, or even
a required signature or authorization, many were propositioned by men in power, such as social workers, landlords, and counselors, who offered services in exchange for sex (Dodson, 1998). One empirical study that focused on residential sexual harassment found that approximately 25% of poor women endorsed experiences of sexual harassment (Novac, 1994). However, the researcher noted that this estimate may be a significant underestimate of women’s experiences, as it was based upon only one typology of sexual harassment.

**Stigma and discrimination.** As low-income women contend with both acute stressors and chronic life conditions, they must do so within a sociopolitical climate that discriminates against, stigmatizes, and shames them for their social location. As Belle and Doucet note, “poverty is deeply discrediting within US society” (2003, p.107). Stigmatizing attitudes and stereotypes abound that attribute poverty to personal characteristics rather than to oppressive sociopolitical structures and systems. For example, a study of college students examined beliefs about impoverished vs. middle class individuals. The respondents endorsed substantially more negative traits for the poor than for the middle class; descriptors associated with the poor included: unmotivated, uneducated, unpleasant, dirty, angry, stupid, criminal, violent, immoral, alcoholic, and abusive (Cozzarelli, Wilkinson, & Tagler, 2001).

Women receiving public assistance are a subgroup of low-income individuals who are particularly stigmatized. This is exemplified by the stereotype of the “welfare queen,” a woman who is lazy, unmotivated, and takes advantage of public assistance (e.g., Rice, 2000). A study of individuals’ responses to 17 different stereotyped groups found that welfare recipients were the only group that was both “disliked” and
“disrespected” (Fiske, Xu, Cuddy, & Glick, 1999). Negative perceptions of women on welfare are also perpetuated by women receiving welfare themselves. For example, a study of women receiving public assistance found that many of the women interviewed created a marked delineation between themselves and others, blaming other women for relying on welfare out of weakness, whereas ascribing their own needs to external circumstances beyond their control (Seccombe, James, & Walters, 1998). The negative perceptions of low-income women—coming from both within and outside of their own group—can become internalized by low-income women over time (Moane, 2003). Thus, the external oppression poor women experience becomes internalized, resulting in feelings of shame, isolation, guilt, insecurity, and worry.

Social isolation. Social support can be defined as instrumental and/or emotional assistance exchanged within the context of interpersonal relationships (Goodman, Smyth, Borges, & Singer, 2009). Emotional support refers to the provision of encouragement, advice, and/or empathy, and instrumental support consists of material and/or practical aid offered by others (Kocot & Goodman, 2003). Social support, in general, can be an important buffer against the experiences of stress and the consequences of stressful life events, and not surprisingly, is a major predictor of physical and emotional well-being (Groh, 2007; Mickelson & Kubzansky, 2003). For low-income women in particular, social networks can be the source of key pragmatic assistance that can lessen the negative impact of a particular stressor and/or prevent it from becoming a chronically stressful condition (Mickelson & Kubzansky, 2003).

Some low-income women are able to be a part of social networks that provide emotional and/or practical support, identifying these connections as imperative to their
survival and wellbeing (Groh, 2007; Lowe & Weisner, 2004). However, while low-income women are more likely to need the resources generated by social networks, it is very often the case that poverty diminishes the utility of these networks because of the “contagion of stress” they create (Belle, & Doucet, 2003; Wilkins, 1974). Often, receiving help from others within a network carries with it the expectation of reciprocation, which is time-consuming, burdensome, and stressful unto itself (Edin & Lein, 1997). Consequently, low-income women may refrain from soliciting support from others, so as to avoid the pressure of having to “return the favor” down the line (Goodman et al., 2008; Mickelson & Kubzansky, 2003). It is not surprising, then, that lower income levels are associated with increased rates of social isolation and lower levels of emotional support (Smyth, 2009). Social isolation, in turn, has been identified as a risk factor for mental health problems, particularly depression, for low-income women (Coiro, 2010).

**Powerlessness.** Acute and chronic life stressors, coupled with elevated levels of stigma and social isolation in poor women’s lives often allow for fewer opportunities for control (Lachman & Weaver, 1998), and when women do try to address these difficulties directly, they are forced to turn to bureaucratic institutions that are often unresponsive, or responsive in ways that create new stressors and double binds (Dodson, 1998).

Repeated experiences with such failures and double-binds can over time result in both real and perceived powerlessness (Goodman et al., 2007; Hägglund & Ahlström, 2007). Powerlessness can be understood in this context as an overall lack of choice or decision-making power within one’s life (Goodman et al., 2010; Young, 2000). Affective responses to experiences of powerlessness may include fear, hopelessness, anger, and
shame (e.g., Chen & Matthews, 2003; Gallo & Matthews, 2003; Moane, 2003). Over time, experiences of powerlessness can become internalized as part of one’s identity, resulting in feelings of inferiority, self-doubt and low self-worth (Moane, 2003). Thus it is not surprising that chronic stressful and disempowering experiences are associated with mental health difficulties, particularly depression, among poor women (Monroe & Hadjiyannakis, 2002; Sapolsky, 2004).

**Mental Health Outcomes Associated with Women’s Poverty**

The Surgeon General’s Report on Mental Health: Culture, Race and Ethnicity (2001) indicated that living in poverty is one of the most measurable risk factors for mental illness, with individuals in the lowest strata of income, education, and occupation two to three times more likely than those in the highest strata to suffer from mental illness. Indeed, the United States National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) found that almost all mental health diagnoses spanning both Axis I and Axis II of the *DSM* were associated with lower income levels, with the exception of agoraphobia, narcissistic personality disorder, and obsessive-compulsive disorder (Sareen, Afifi, McMillan, & Asmundson, 2011). Further, the percentages of low-income individuals experiencing mental health problems has grown over time, increasing from 21% in 1998 to 43% in 2004 (Ganong et al., 2008).

Low-income women, in particular, experience mental health problems at significantly higher rates than both middle-income men and women (e.g., Kessler, 2003). They are more likely to suffer from depression (Siefert et al., 2000), posttraumatic stress (Vest et al., 2002; Vogel & Marshall, 2001), substance abuse (James et al., 2003; Ziberman et al., 2003), and anxiety (Brown & Moran, 1997; Miranda & Green, 1999).
Depression is one of the strongest correlates of poverty (Belle & Doucet, 2003). Approximately one-third of current and recent female welfare recipients who are mothers meet the diagnostic criteria for depression, and about 40% of low-income, single African American mothers report symptoms consistent with a diagnosis of depression (Ciro, 2001; Siefert et al., 2000). The cruel irony of these statistics is that the symptoms central to a diagnosis of depression (e.g., decreased energy and motivation, feelings of helplessness and hopelessness) may make the task of seeking and utilizing assistance and support to improve one’s circumstances – such as psychotherapy, vocational training, public assistance -- all the more difficult (Levy & O’Hara, 2010).

Women in poor neighborhoods are also at high risk for substance use and abuse (Williams, Epstein, Botvin, & Ifill-Williams, 1999). The National Survey on Drug Use and Health found that 8.9% of women living in poverty were classified as in need of substance abuse treatment (Substance Abuse and Mental Health Services Administration (SAMHSA), 2010). Poor women with depression are at particularly high risk for substance abuse, exhibiting greater incidences of heavy drinking and alcohol dependence (Ziberman et al., 2003).

Finally, low-income women experience higher rates PTSD than the general population, which is not surprising given the elevated rates with which women are exposed to traumatic experiences. A study of low-income mothers found that 83% had been physically or sexually assaulted during their lives, and more than one third had experienced PTSD (Bassuk, Buckner, Perloff, & Bassuk, 1998). As noted earlier, the rates of PTSD in low-income urban women are two to four times higher than in the general population of women (Gill et al., 2009).
Psychotherapy and the Poor

Historical Context. The first time that our nation focused on the mental health difficulties of the poor was during the Community Mental Health Center movement of the 1960s, when federal funding was directed towards mental health research and the construction of 2,000 community mental health centers across the nation (Albee & Gulotta, 1997). During this time, former APA president George Albee called upon psychologists to address the needs of the poor through increased training and practice (Albee, 1969). This call to action by both the federal government and the governing body of psychologists occurred in part as a response to research showing that therapists held negative perceptions of poor individuals’ capacities to use therapy effectively, benefit from it, and fully commit to the process (e.g., Graff, Kenig, & Radoff, 1971). Further, research indicated that therapists perceived low-income clients as hostile, crude, and a waste of supervisory time (Affleck & Garfield, 1961; Baum, Felzer, D’Zmura, & Shumaker, 1966). Given these attitudes, it is not surprising that research conducted at the time demonstrated high treatment dropout rates among low-income clients (e.g., Affleck & Garfield, 1961; Graff et al., 1971).

As community mental health centers sprang up across the country, a small group of scholars began to conduct research to challenge the perception that low-income individuals could not benefit from outpatient psychotherapy. For example, Lorion (1973; 1974) and Jones (1974) published research indicating that poor individuals did have an interest in talk therapy, were capable of participating in it, and could experience positive benefits. Based on these findings, the researchers concluded that the problems inherent
to doing psychotherapy with poor clients may largely lie within the therapists’ own biases and lack of training.

Unfortunately, the momentum that began in the 1960s and 1970s waned in the 1980s, as funding for community mental health centers decreased and the field shifted to a focus on biological bases of mental illness (Smith, 2005). Although a growing emphasis on multicultural competence among therapists showed promise for a resurgence of investment into the research and treatment of poor populations, class was often backgrounded in research on the role of therapists’ and clients’ social locations. An analysis of the major counseling journals between 1981 and 2000, for example, indicated that only 18% of the articles incorporated social class as a variable, and often only in passing within the methods section (Liu et al., 2004). The small body of research that did explore low-income clients, however, indicated that clients continued to initiate treatment at lower rates than their higher income counterparts and to drop out at higher rates (e.g., Greeno, Anderson, Shear, & Mike, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

In response to these disturbing findings, as well as the general absence of literature on low-income communities’ mental health or mental health practice with low-income individuals, in 2000, APA published the Resolution on Poverty and Socioeconomic Status (2000). This document outlined the detrimental effects of poverty on physical and mental health and charged psychologists to “better understand the causes of poverty and its impact…to help prevent and reduce the prevalence of poverty and to effectively treat and address the needs of low-income individuals and families” (p. 3).

Despite the relative dearth of research on mental health practice with low-income clients, the next sections discuss the small body of research that does exist on this topic,
highlighting the proportion of low-income women who seek mental health treatment, and what we know about barriers to treatment and treatment outcomes within this population.

**The proportion of low-income women who access mental health services.**

Poor women rarely pursue or engage in mental health treatment (Miranda, Azocar, Komaromy, & Golding, 1998; Siefert et al., 2000). One large-scale study of low-income women with reported mental health symptomology found that only 10% of the 1,893 participants were engaged in any form of mental health treatment (Nadeem et al., 2008). Less than 5% of the immigrant participants reported using mental health services. Further, the percentages of minority low-income women engaged in treatment is markedly smaller than it is for majority women (USDHHS, 2001). It is perhaps not surprising that low-income women so rarely use mental health services given the barriers to treatment and unclear effectiveness of mainstream approaches, described next.

**Barriers to treatment.** Research demonstrates that low-income individuals face a range of practical barriers to accessing mental health treatment, such as the cost of such treatment, lack of insurance, and child care needs (Maynard et al., 1997). Many clinics provide services during hours that do not accommodate the work schedules of individuals who work in low-wage positions that are inflexible or who work double shifts, and the time commitment and financial costs associated with public transportation often preclude poor individuals from participating in mental health treatment (Beeber et al., 2007; Levy & O’Hara, 2010). Further, low-income individuals have so many competing priorities to contend with each day that taking the necessary steps to seek out and regularly attend treatment can seem more burdensome than helpful (Hall, 2001). For example, a study of rural low-income women found that the women identified the need to manage acute
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stressors as a greater priority than addressing their mental health needs (Jesse, Dolbier, & Blanchard, 2008). Studies have shown that low-income women often do not even seek out psychotherapy until they are in the throes of crisis (e.g., Chalifoux, 1996). More often than not, these crises are directly tied to some external stressor or combination of stressors. As Chalifoux (1996) noted in her study of working-class women, “none of the women went to therapy for reasons directly connected to personal growth or insight. They went because some external situation had pushed them to the end of their ropes” (p. 25).

When poor individuals do make it to the office of a mental health agency, there are often fewer clinicians who are willing or able to provide services at lower rates of reimbursement, and clients often face long wait times for appointments (Liberman et al., 2006). Research shows that the longer a client has to wait for services, the more likely he or she is to withdraw from treatment altogether (Barrett, Chua, & Thompson, 2007; Saporito, Barrett, McCarthy, Iacoviello, & Barber, 2003). Potential clients may be further discouraged by the lack of choice they are afforded in selecting a clinician, and the high staff turnover rates that are common to community mental health centers (Chalifoux, 1996). Finally, mental health treatment settings often require multiple intake appointments before a client can even begin working with their assigned clinician, a condition that is difficult for low-income clients to fulfill and may further prolong their ability to receive help (Liberman et al., 2006).

In addition to these practical barriers, many low-income women experience emotional barriers to pursuing and maintaining treatment. Poor women have often had a myriad of negative experiences with authority figures – many of them occupying some
sort of “helping” position – and accordingly are highly attuned to signs that a therapist may be disrespectful, lacking empathy, and unhelpful (Abrams, Dornig, & Curran, 2009; Dodson, 1998). They may also be especially sensitive to whether or not the therapist can understand their situations given class differences. For example, in her interviews of working-class women, Chalifoux (1996) found that many women withheld information or modified what they shared due to their feelings that their therapists, who they perceived to be of a higher class, would not understand. As one woman noted,

I’m trying to recount my life story and tie it up in sweet little ribbons and make it appropriate…I know a therapist is supposed to be non-judgmental but – and this is a definite class thing – I leave things out. If I thought somebody was equal to me, I would say more than I would to someone above me. I don’t think she is going to understand (p. 25).

Perceived stigma associated with mental illness can also be a strong deterrent. In a study of low-income women with depression from diverse ethnic groups, 51% of participants worried about what others would think of their depression, 40% were embarrassed to discuss it with others, and 26% did not think mental health care could help them and/or did not want to pursue it (Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003).

Despite these myriad obstacles, some low-income women do manage to engage, at least somewhat, with the process of psychotherapy. The next section discusses what happens when they do.

**Treatment outcomes.** A small group of studies spanning the last few decades have examined treatment outcomes for low-income clients. These findings tend to be
mixed and difficult to interpret in the aggregate, as the constructs “low-income” and “outcome” have been defined inconsistently (Falconnier, 2009; Levy & O’Hara, 2010). Further, many studies have used attrition rates as a proxy for outcome, finding that attrition increases as income level decreases (e.g., Falconnier, 2009; Garfield, 1994; Wierzbicki & Pekarik, 1993). Although this finding has been robust across numerous studies, it offers little information about why attrition rates are high among low-income clients, or how low-income individuals fare when they do engage in treatment.

When outcomes other than attrition are examined, the literature demonstrates inconsistent findings. Extant research – though minimal – can be divided into four categories: one recent study shows poorer treatment outcomes for low-income clients when compared to their higher-income counterparts, another set of studies illustrates no relationship between socioeconomic status and outcome, and a third set demonstrates positive treatment outcomes for low-income clients over time. Finally, a fourth set of qualitative studies reveal clients’ own perspectives on some of the dimensions of psychotherapy with low-income clients that both contribute to and detract from positive outcomes.

**Poorer outcomes.** Regarding poorer outcomes, Falconnier (2009) used data from the Treatment of Depression Collaborative Research Program (TDCRP) of the National Institute of Mental Health (NIMH; Elkin, 1994), to explore the role of SES on treatment outcomes. The 239 adult predominantly White participants were randomly assigned to CBT, behavioral therapy, interpersonal therapy, or pharmacotherapy to treat their depression. Socioeconomic status was measured through use of the Hollingshead Index of Social Position (ISP; 1971), which categorized participants into five different
socioeconomic classes. The results showed that both poor and working class clients showed fewer reductions in depressive symptomatology as well as fewer gains in general overall function compared to upper and middle class clients across all treatment conditions.

**Similar outcomes.** A second group of studies comparing treatment outcomes across social class levels found no significant association between socioeconomic status and treatment outcome. In an early series of clinical trials for treatment of major depression, for example, there was no relationship between SES and depressive symptoms post-treatment whether the intervention was interpersonal psychotherapy (Rounsaville, Weissman, & Prusoff, 1981), medication, or a problem-solving intervention (Mynors-Wallis & Gath 1997). More recently, a study by McLeod, Johnston, and Griffin (2000) examined the effectiveness of time-limited psychotherapy with predominantly White poor and non-poor clients and found little difference between groups in the degree to which they perceived therapy to be effective. Contrary to the findings of prior research, attrition was not a significant issue for the low-income individuals in this latter study, a finding that the authors attributed to the concerted efforts made by clinic staff to provide outreach to low-income clients. These single-study findings are further supported by a 2002 review of the literature on client-related predictors of cognitive therapy outcomes, which found no relationship between education or occupation and outcome (Hamilton & Dobson, 2002).

**Positive outcomes.** Finally, a third set of studies exploring psychotherapy outcomes with low-income clients focused on pre- to post-treatment change within groups of low-income clients. These studies demonstrated significant positive changes in
low-income individuals’ post-intervention symptomatology, when compared to their baseline functioning (e.g., Ammerman et al., 2005; Azocar, Miranda, & Dwyer, 1996; Grote et al., 2009; Miranda, Chung, et al., 2003; Miranda et al., 2006). Most of these studies focused on the treatment of depression among low-income women using CBT as the base intervention; some examined the effectiveness of a particular intervention, whereas others compared one treatment modality to another. Each study measured outcome in terms of patient’s responses to self-report inventories. Importantly, most of the studies reporting positive outcomes of treatment for low-income populations examined interventions that were developed, modified, or adapted to target directly some aspect of the context of poor individual’s lives.

Falconnier and Elkin (2008), for example, explored the extent to which direct acknowledgement of clients’ economic situations within the discourse between therapist and client contributed to positive outcomes for clients. Their sample consisted of predominantly female, White clients diagnosed with major depression, who were either low-income or middle income. They found, interestingly, that direct exploration of clients’ economic stressors was associated with reductions in depressive symptoms and increases in global assessments of functioning across both treatment conditions (CBT and interpersonal therapy) and across both income levels.

A handful of studies have investigated the effectiveness of providing clients with supports to help them access therapy. One study, for example, showed that providing home-based services to low-income White and African American mothers with depression yielded high levels of engagement as well as positive treatment outcomes (Ammerman et al., 2005). All (100%) of study participants attended eight or more home
visits, and 77% attended all 15 visits. Participants reported a significant reduction in depressive symptoms as well as general improvements in functioning in home and/or work settings.

Another set of studies explored the impact on treatment outcomes of providing supplementary supports to help clients get to therapy, such as transportation to and from psychotherapy appointments, home visits if requested, childcare, and flexible scheduling options. Specifically, they randomly assigned 267 predominantly Black and Latina low-income women taking part in Women, Infants, and Children (WIC) subsidy programs and/or Title X family planning clinics to one of three interventions: a CBT intervention plus supplementary supports, a medication intervention plus supplementary supports, or a community referral control group (Miranda, Chung et al., 2003). Participants assigned to the community referral group received psychoeducation about depression and available mental health treatments in the community, but not the supplementary supports. Whereas only 9% of the women in the community referral condition participated in four or more psychotherapy sessions, 53% of the women in the CBT condition completed four or more sessions, and 75% of women in the medication treatment group engaged in nine or more weeks of medication treatment. In describing the disparity in treatment participation between treatment groups and the community referral group, the researchers noted:

The results show that few impoverished women engage in community care that is available to them…Without the outreach, child care, and transportation, and flexible scheduling of care offered, few impoverished women are likely to receive appropriate treatment for depression (Miranda, Chung, et al., 2003, p. 63).
Further, those in one of the intervention groups achieved lower levels of depressive symptoms and higher levels of social functioning, as compared to their control group counterparts.

Finally, a few studies have gone beyond making therapy more accessible to explore the effectiveness of helping clients with their external needs by adding a case management component to the more traditional mental health treatment offered. Case management involves the assessment of clients’ external stressors and instrumental needs, whether or not they are related to treatment engagement, followed by intervention to address these issues. Specifically, Miranda, Azocar and colleagues (2003) examined dropout rate and treatment outcome for 200 ethnically diverse low-income individuals randomly assigned to traditional CBT versus CBT supplemented with case management. The researchers found that overall, participants receiving CBT plus case management attended more CBT sessions and were less likely to drop out of treatment. Six months post-treatment, participants in the CBT plus case management group experienced fewer depressive symptoms and higher levels of social adjustment than those in the comparison group. It should be noted here that despite these positive outcomes, even the CBT plus case management intervention was not as successful as interventions for middle-class clients often are. As Falconnier (2009) points out, in the Miranda, Azocar et al. study, mean posttreatment depression scores were in the “moderately depressed range” of the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) as compared to studies represented in previous reviews of CBT outcome studies based on middle-class patients (e.g., Dobson, 1989) in which posttreatment mean scores on the same inventory ranged
from “not depressed” to “mildly depressed.” Still, the case management plus CBT intervention was nevertheless associated with some improvement.

In a similar random assignment study, Grote et al., (2009) compared the impact of enhanced usual care to enhanced brief interpersonal psychotherapy in a sample of 53 African-American and White low-income pregnant women with depression. Brief interpersonal psychotherapy consisted of an engagement session, eight therapy sessions, and after birth, biweekly or monthly maintenance sessions up to six months post-partum. As a part of the intervention, clinicians collaborated with participants to address practical, psychological, and cultural barriers to care. Rooted in motivational interviewing techniques (Miller & Rollnick, 2002), this approach afforded participants a great deal of personal choice and control, so that they were instrumental in guiding the goals and the course of treatment. For example, if a participant identified her depression as having been triggered by the loss of her job, her clinician might help her to find job training or new employment, in addition to addressing her emotions and interpersonal difficulties surrounding her job loss. Enhanced usual care consisted of psychoeducation, encouragement to initiate treatment at a local behavioral health center, and follow-up contact. Notably, both groups were offered free access to transportation and childcare during appointments. Compared to the enhanced usual care group, participants in the intervention group demonstrated significantly higher rates of treatment engagement and retention, and reported greater depressive symptom reduction and improvements in social functioning.

Researchers speculated that the success of these two interventions was related to two factors. First, by attending to the stressors and challenges that contribute to or
exacerbate mental health symptoms, the provider demonstrated a more comprehensive understanding of the individual, her challenges, and her needs, which in turn increased her credibility as a practitioner and promoted “buy-in” by the client (Grote et al., 2007; Levy & O’Hara, 2010). Second, by addressing contextual stressors, providers enabled 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).

Indeed, in their extensive review of the literature on psychotherapeutic interventions for low-income women, Levy and O’Hara (2010), noted that “the most effective studies overall made significant, sustained efforts to simultaneously reduce the negative effects practical, psychological, and cultural barriers have on low-income women who seek mental healthcare” (p. 946).

**Qualitative perspectives on contributors to positive and negative outcomes.** Two qualitative studies on, respectively, working class and low-income clients’ experiences of psychotherapy resonate remarkably with these quantitative results. Chalifoux (1996) interviewed six working class women who had participated in outpatient psychotherapy. Participants reported that therapists’ lack of sensitivity to issues of class in treatment impacted the therapeutic relationship and experience of therapy overall. For example, the women expressed frustration that solutions that therapists tended to offer were often not consistent with what was actually feasible for them to implement given their financial situations. As one participant stated, “Don’t [therapists] have any concept that freedom of choice takes money? At that point, I simply couldn’t feed and clothe my children, and have a fulfilling marriage as well. That option was just out of my reality” (p. 25).
Similarly, in Thompson et al.’s (2012) study of 16 low-income male and female clients, participants reported an association between positive experiences in therapy and therapists’ willingness to integrate class-related issues into in-session activities and homework assignments. Participants appreciated when therapists supported them emotionally, (e.g. discussing the emotional impact of poverty) as well as instrumentally (e.g., helping in the search for housing and public assistance resources.) These qualitative studies lend further support to the notion that there exists a potential mismatch between the mental health needs of low-income individuals and traditional approaches to psychotherapy.

In sum, low-income women have significant and pervasive mental health difficulties, mediated in part by the traumatic life events, chronic stress, stigma, social isolation, and powerlessness they face on a daily basis. Yet, research indicates that this population often does not fully access mental health treatment. Existing research elucidates some of the reasons for this situation, highlighting the many obstacles the poor face in initiating and maintaining treatment. Further, treatment outcomes for this population – though only measured by a handful of studies – tend to be mixed, with newer, innovative approaches that help clients address external as well as internal stressors demonstrating more positive results. These findings are enormously important, pointing to a large gap between the nature of traditional mental health intervention and the needs of low-income populations; yet only the two qualitative studies described above have explored this question by asking working class women and low-income men and women themselves about their experience of the process of psychotherapy. The current study set out to expand this latter body of research by focusing specifically on low-
income women’s experiences of psychotherapy, to further illuminate the treatment experiences and needs of this particularly high-risk population. As the empirical studies discussed in this chapter indicated, low-income women’s instrumental needs play a significant role in treatment engagement and outcomes, and therefore represent an important area of focus for the present study. The salience of power within the therapeutic relationship has also been hinted at within the current body of research, though none of these studies directly explored how it may be uniquely experienced and navigated by low-income women and their therapists. Feminist therapy theory provides an important framework by which the role of power within the therapeutic relationship can be understood, and thus provided an important conceptual backdrop to data collection and analysis.

**Building on Feminist Therapy Theory to Consider the Role of Power**

Although the empirical research described above demonstrates that client outcomes improve when therapists address the economic context of their lives, it provides relatively little guidance on how low-income clients may experience the relational aspects of therapy, in particular the issue of how power is negotiated in the therapy office.

As noted earlier, low-income women 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). Thus, many low-income women may come into the therapy office highly sensitized to how power will be addressed there. In other words, they may view their experience of therapy through the lens of how power is handled. One specific dimension of power that may be particularly
salient in psychotherapy with low-income women is how the therapist negotiates power in the development of the therapeutic relationship.

Feminist theorists have shown how in mainstream treatment modalities, a hierarchy often exists between therapist and client (e.g., Balmforth, 2009; Heller, 1985; Miller & Stiver, 1997). Mainstream approaches position the therapist as the “expert,” with whom resides all knowledge of the etiology of emotional distress and how the change process works (Brown, 2009). Whereas the therapist is in his or her own territory and knows in advance the structure and format of therapy (Balmforth, 2009), the client comes to treatment seeking help from the therapist usually feeling vulnerable and lacking control in some dimension of her life.

Perhaps some low-income women come to treatment with a real desire to give over certain kinds of power to the therapist. This choice could be shaped by cultural and/or spiritual beliefs about healers and healing relationships (e.g., Heller, 1985) or simply by the desire to give up the burden of having to be in control, at least for a short time. For some low-income women, however, a sense of giving up power in the therapeutic relationship may replicate the disempowering dynamic they have experienced with the various people from whom they need vital resources, including the many social service workers who tell them what they need to do to get a job, receive public assistance, or qualify for subsidized housing (Abrams, Dornig, & Curran, 2009). These women may wish to view the therapeutic relationship as a place – maybe the only place – where they can be in control. Indeed, one study of ethnic minority women in psychotherapy, the vast majority of whom were impoverished, found that when the women were actively
involved in making decisions about their treatment they were more likely to adhere to treatment and their clinical outcomes improved (Ward, 2007).

One critical dimension of the negotiation of power in the psychotherapeutic relationship is the setting of boundaries by the therapist. In traditional therapy, the boundaries between therapist and client tend to be fairly rigid and well-defined, with the therapist positioned in a role that is presumably emotionally neutral and minimizes self-disclosure (Brown, 2009). Rooted in the psychoanalytic notion of the “opaque screen,” this particular stance presumably enables the therapist to remain as “objective” as possible, and compels the client to reveal more about herself without “contamination” of the therapeutic material by the therapist’s own self-disclosures or emotionally-laden responses (Wachtel, 1993). In essence, clear and unbending boundaries are used within most therapeutic modalities to keep the focus of therapy on the client, not the therapist (e.g., Epstein, 1994). Therapists are generally taught to avoid revealing personal information, both voluntarily or if requested by the client, and to limit outside contact that goes beyond the 50-minute hour.

Feminist therapy theorists have critiqued this relational stance, pointing out its clear potential for increasing clients’ sense of disempowerment, especially when clients feel disempowered already in their lives. Judith Jordan (2000), for example, identifies the obvious implication of the neutral stance -- that the client must make herself transparent and vulnerable to an unfamiliar person, without any reciprocity in return. She notes:

Nonengagement and relative anonymity of the therapist pose several problems…the nonresponsiveness of the therapist often reinforces the patient’s
relational images of relational incompetence, of not mattering; it leads to
unauthentic relating and locks patients into a sense that their feelings and thoughts
do not matter (Jordan, 2000, p. 1010).

Indeed, working class women in Chalifoux’s (1996) study expressed feeling distrustful
and ashamed when therapists did not engage in any sort of personal disclosure. The
author states:

None of the women had felt at ease to discuss their values and lifestyles in terms
of class because none of the therapists had been comfortable to discuss such
matters. A truly empathic relationship would require that level of comfort (p. 25).

By contrast, some feminist therapy theorists argue that a more flexible
establishment of boundaries may be helpful, whereby the overlap of the lives of therapists
and their clients are acknowledged and often used in therapy, “helping to bring another
level of meaning to the therapeutic exchange” (Brabeck, 2003, p. 303). Given that so
many low-income women come into therapy feeling disempowered and perhaps “not
mattering,” they may be especially attuned to how therapists understand and negotiate
boundaries. This study explored this question with participants.

**Current Study and Research Focus**

As poverty rates continue to increase in the United States (U.S. Census, 2009), it
is imperative that mental health service providers understand the needs of poor
individuals. Women experience poverty at higher rates than men, and thus comprise a
particularly vulnerable subgroup of the nation’s poor (e.g., Thibos et al., 2007).
Although the insidious effects of poverty on the mental health of low-income women has
been well-documented (e.g., Miranda & Green, 1999; Siefert et al., 2000; Vest et al.,
Little is known about how impoverished women fare within mental health treatment. The small body of literature that does exist demonstrates inconsistent findings, though a few intriguing studies demonstrate positive treatment outcomes for low-income women with depression when interventions are modified to address the contextual stressors they face. Further, concepts borrowed from feminist theory suggest that low-income women may be especially sensitized to the inevitable power dynamics present in the therapy office. Still, within the small body of research examining low-income women and psychotherapy, the voices of the women themselves are for the most part absent. As has become the mantra of many disability rights activists “Nothing about us without us” (Charlton, 1998). It is imperative that the research, program development, and policymaking practices that directly affect low-income women do not take place without their involvement. Low-income women who have participated in psychotherapy are a rich resource – if not the most important resource – in elucidating the helpful and problematic aspects of mainstream mental health practices. Integrating the voices of low-income women within mental health research can thus offer a deeper, more comprehensive understanding of how poverty shapes the experience of treatment, and in turn, why attrition rates are so high and treatment outcomes so inconclusive for this particular group. Insight into issues such as these is vital to guiding the development and/or refinement of mental health interventions, so that they are more meaningful, relevant, and generally effective in reducing mental health disparities for low-income women.
Chapter 3: Methodology

The present study used a qualitative approach to understand low-income women’s experiences with psychotherapy. We chose a qualitative methodology for three overlapping reasons. First, qualitative methods are particularly useful to explore topics for which little to no research has been conducted previously (Morrow, 2007). Limited information exists currently as to what low-income women experience in therapy and how they experience it. Examining this phenomenon through a qualitative lens can bring forth new and/or unexpected information and insights (Creswell, 1998). Second, qualitative research uses language as a tool to access data that may not be observable or measurable by traditional quantitative approaches (Morrow, 2007). Extant research on this topic is largely limited to quantitative assessments of barriers to mental health treatment, dropout rates, and treatment outcomes; use of languaged data to elucidate the nature and meaning of participants’ experiences with psychotherapy will provide an important supplement to prior literature. Third, qualitative methods tend to lend themselves to use with oppressed or marginalized groups, as they provide opportunities for individuals within these groups – who are largely under-represented or potentially mis-represented in the literature -- to give voice to their own experience (Hage, 2006).

This study used individual interviews to explore women’s experiences.

The next three sections describe: 1) the nature and goals of qualitative description, one particular methodology within the category of qualitative research, 2) the key steps of the research process itself, and 3) the mechanisms used to ensure the trustworthiness of the data.
Rationale for Use of Qualitative Description

Within the broad umbrella of qualitative research methodologies, this study employed qualitative description. Qualitative description aims to glean a comprehensive description of participants’ experiences, presented in a manner that utilizes participants’ own language to convey their thoughts, ideas, beliefs, and experiences (Sandelowski, 2000).

This study used qualitative description rather than another qualitative methodology for two linked reasons. First, this method deviates from other qualitative methods such as phenomenology, grounded theory, or ethnography in that it involves less inference on the part of the researcher. The outcome of data analysis is largely “rich, straight description of an experience or an event” (Neergaard et al., 2009, p. 2). This does not mean, however, that no conceptual or interpretive work takes place. Although description, rather than interpretation, is the aim of qualitative descriptive research, interpretation is always present, and the researcher must be mindful of the manner in which her own perspectives, along with the research process itself, influence or transform the data (Sandelowski, 2005). Ultimately, the goal is to obtain interpretation that is lower-inference. Given the lack of prior research in this domain, this type of lower-inference analysis made sense as it afforded the opportunity to create a broad, rich description of participants’ experiences from their own perspectives (Sandelowski, 2000).

Second, because qualitative description aims to stay as close to the words of participants as possible, it can be particularly useful for the development and/or refinement of interventions targeting underrepresented or marginalized communities who do not have a voice in the development of programs and services to address their needs.
(Ponterotto, 2005; Smith, 2005). Indeed, by generating a descriptive summary of a phenomenon in the words of those experiencing it firsthand, qualitative descriptive methods facilitate the production of information that is easily understood by participants, laypeople, scholars, and practitioners and that can lay the groundwork for subsequent collaboration on the development of theory and intervention.

**Research Process**

The next section describes each of the elements of the research process used in this study, including sampling, recruitment, data collection, and data analysis. All aspects of the research process were approved by Boston College’s Office for Research Protection’s Institutional Review Board.

**Sampling.** Within qualitative research, sampling methods can be broadly described as “purposeful sampling” (e.g., Patton, 1990; Sandelowski, 1995). Purposeful sampling is used to identify participants who can offer in-depth information about the issues of central importance to the study (Sandelowski, 2000). In the present study, maximum variation sampling was the specific type of purposeful sampling employed to obtain a diverse sample of participants with a range of experiences with outpatient psychotherapy. Maximum variation sampling allows for the exploration of both common and unique experiences that may be related to the characteristics of the person as well as the phenomenon of interest.

Sampling within qualitative research is an evolving, recursive process, occurring in tandem with the data analysis process (Milne & Oberle, 2005). I continued to recruit participants until I achieved theoretical saturation, whereby new data ceased to add any...
new information to the findings (Morrow, 2007). Ten participants were sufficient for theoretical saturation to be reached.

**Recruitment.** Two strategies were used to recruit participants: snowball sampling and flyers.

*Snowball sampling.* First, we used snowball sampling. This method entails gaining access to participants via referral by other participants who have participated in the study (Noy, 2008). It is a particularly useful tool for gaining access to groups that may experience stigma and/or marginalization, as it builds on extant social relationships and networks within these groups to enable the researcher to gain access to participants who due to their social location, may be more apt to remain otherwise “hidden” from access by scholars.

To begin the snowball sampling process, the faculty member serving as my dissertation chair provided me with the contact information of several women who met my inclusion criteria (see below) and granted permission for me to be in contact. As a Boston College faculty member who has been involved in both research and program development with low-income women, she has developed ties to low-income women in various communities which enabled me to initially gain access to this population. During my contact with the women referred by my professor, I asked them to contact other potential participants and to provide them with my contact information so that they could contact me about participating.

*Flyers.* Second, we posted flyers throughout the community at women’s shelters, multiservice centers, soup kitchens, community mental health centers, and public housing developments. These flyers contained a description of the study, my role as researcher,
the general criteria for inclusion, and my phone number (see Appendix A for sample flyer).

**Inclusion/exclusion criteria.** For inclusion in the study, women had to be over the age of 18, able to speak English, and living below the poverty line for a minimum of one year (as defined by the federal government’s yearly income standards for assessing poverty level, and as determined through participant self-report). Participants who were full-time students, and therefore may have been living in poverty solely due to their student status, were not included. Participants must have participated in a minimum of three sessions of individual outpatient psychotherapy, beyond an intake session, at some point within the past three years. We selected a minimum of three sessions due to research findings that have demonstrated that the therapeutic relationship between therapist and client generally develops within the first three sessions (e.g., Eaton, Abeles, & Gutfreund, 1988). The aim of these criteria was to allow for the recruitment of a broad range of participants, including those who have completed a stint of therapy, those who are currently participating in outpatient psychotherapy, and those who have dropped out for various reasons.

For the purposes of this study, outpatient psychotherapy – which is the most common and ubiquitous form of mental health treatment accessed (National Institute of Mental Health, 2010) -- was defined as mental health treatment focused on improving functioning, reducing emotional distress, and/or alleviating psychological symptoms that occur within regularly scheduled visits with a trained psychotherapist within a clinic or office setting. Alternative forms of psychotherapy, such as group therapy, inpatient therapy, drug and alcohol rehabilitation, advocacy/case management (by itself), or
expressive arts therapy were not included within this definition, as these forms of therapy entail unique structures, formats, and processes.

Some outpatient mental health centers perform an intake assessment as the first session of treatment, which generally consists of focused questions aimed at gathering background and diagnostic information. Because this activity is more structured and formulaic, often taking an interview-like format, participants were only included if they had taken part in at least three therapy sessions beyond an intake assessment. Further, participants who had been court-mandated for outpatient psychotherapy, and had therefore not voluntarily entered into therapy and/or terminated therapy, were not included. Three prospective participants who contacted me were screened out because they did not meet criteria for inclusion. One woman was a full-time student, and two women reported incomes that were above the federal poverty guidelines used within this study.

**Data Collection**

We employed individual interviews to elicit women’s full range of experience with psychotherapy. All participants received a $25 gift card as appreciation for participating in the study.

Whether I contacted participants through flyers, through my advisor, or through another participant, once I received their phone call, I called back to initiate a brief phone conversation. I left a message with a return phone number (a designated line in my advisor’s office) only if I was calling a personal cell phone, not a home phone. Once I made contact with the potential participant, I introduced the study, provided a brief
description of the interview process, and conducted a screening to ensure that the participant met the eligibility criteria (See Appendix B for the Screening Questionnaire).

I then worked with those participants who remained interested and passed the screening to set up a time and a place to meet to review the informed consent document and to discuss the audiotaping process and, once informed consent was granted, participate in an individual interview.

**Informed consent document.** With regard to confidentiality, the informed consent document clearly stated that no actual names and/or other identifying personal information would be included in the interview transcripts (See Appendix C for the Informed Consent Form). Instead, each participant was offered the opportunity to choose a pseudonym. I randomly assigned a pseudonym to those individuals who did not select their own. Identifying information was stored separately from audiotapes, transcripts, and coding documents, and all data was stored in a locked cabinet in a locked office. The informed consent document explained that no identifying information would be used in any documents or publications generated from this research. If quotes are used in publications, only pseudonyms will be linked to each quote.

The informed consent document also described limits to confidentiality, as well as potential risks and benefits to participation. Limits to confidentiality included if a participant disclosed neglect or abuse to a child, elder, or disabled individual, or provided reason to believe that they were at imminent risk to harm themselves or someone else. Identifiable risks included experiencing strong emotional reactions in response to discussing issues of poverty and mental health treatment. Potential benefits to participation included feelings of hope and altruism surrounding participating in research
aimed at ultimately improving mental health services for underserved populations. If participants became emotionally distraught during their involvement in the interview, the informed consent document explained that with their permission, I would help them contact their therapist or would link them to alternative supports to aid them in their distress. However, no participants became distressed to the point that outside supports were needed during or after the interview.

**Individual interviews.** Research participants were interviewed once, for approximately 60 to 90 minutes. Semi-structured interviews were used to elicit descriptive data regarding participants’ experiences with outpatient therapy. In the instances in which participants had met with more than one therapist, they were asked to speak about the therapist (and therapy) that had been “most meaningful” to them. Occasionally, participants would also include information about their experiences with other therapists. Those data were also included in the study, and information regarding those particular therapists was also included in the table, alongside information about the “target” therapist. An interview guide built upon a set of open-ended questions that centered on several main areas, such as: 1) the participants’ history of psychotherapy use; 2) positive/helpful and negative/unhelpful moments within psychotherapy; 3) the nature of the therapy relationship; and 4) psychotherapy outcomes (See Appendix D for the Interview Guide). Each of these areas was explored with careful attention to how participants’ poverty-related stressors may have shaped their psychotherapy experiences. As part of the interview process, participants were specifically asked to provide stories about their experiences, and probes were used to clarify and expand participants’
responses. As a result, a large proportion of the data existed in the form of rich narratives of the women’s specific experiences related to the general topics under investigation.

It is important to note that the interview guide served as only a guide, and that this researcher flexibly adapted the interview to ensure that the data were consistently participant-driven (Milne & Oberle, 2005). Further, during the interview, I asked clarifying questions to increase the accuracy with which I understood participants’ responses.

**Field notes and transcriptions.** Immediately after each interview I took field notes including general observations about the setting and the course of the interview, as well as specific contextual details regarding how participants responded to the various questions (e.g., affect, tone, nonverbal reactions). While these field notes were not formally coded, they were used throughout the data analysis process to clarify interview content. The tapes were transcribed verbatim by this researcher and professional transcribers. As mentioned previously, pseudonyms were used within audiotapes to protect participants’ identities, and this researcher reviewed all transcriptions in correspondence with the audiotapes, to ensure accuracy of the transcriptions. Upon request, participants were offered copies of their respective interview transcription. All participants were offered the opportunity to discuss with this researcher – in person or by phone – the content of the transcript. Only one participant requested a copy of her interview transcription, and she did not request any changes, clarifications, or removal of any of the material. However, had this been the case, I would have honored her requests.
Data Analysis

Interview transcripts were coded using qualitative content analysis. This method of analysis aims to “provide knowledge and understanding of the phenomenon under study” by classifying large amounts of text into in vivo codes, categories, and clusters in order to summarize the informational contents of the data in a more efficient manner (Downe-Wambolt, 1992, p.314; Sandelowski, 2000). Data analysis is a reflexive and interactive process, whereby the analysis process and emergent findings are continuously modified to accommodate new data and researcher insights (Sandelowski, 2000).

Three approaches to qualitative content analysis exist: directed, summative, and conventional (Hsieh & Shannon, 2005). Directed analysis employs a deductive approach, whereby prior research or theory is used to guide the development of preconceived coding categories that are then applied to the data. Summative content analysis entails the identification and quantification of certain key words and content, as well as subsequent interpretation as to the underlying meanings and usage of words and phrases. In conventional content analysis, codes are inductively derived directly from the data as analysis unfolds.

For the purposes of this study, conventional qualitative content analysis was the most appropriate approach, due to the limited amount of existing theory and/or research literature on the phenomenon, and the approach’s emphasis on staying close to the data, as noted above (Hsieh & Shannon, 2005). Although I built on prior empirical research and feminist therapy theory to generate some (though by no means all) of the interview questions, data analysis was data-derived. I systematically identified and applied codes
as they emerged from the data (Sandelowski, 2000), and did not impose pre-existing coding schemas (Milne & Oberle, 2005).

To begin data analysis, I first listened to each interview in its entirety while reading through the corresponding transcript to immerse myself in the data and to obtain a sense of the whole (Tesch, 1990). I also read my field notes to enrich my understanding of the interview context and experience. I then coded the data, deriving three levels of codes: (1) *in vivo* codes, (2) categories, and (3) concepts/clusters (Charmaz, 2005). For examples of each level of coding, refer to Appendix E. During the coding process, I wrote memos to document ideas, questions, and general reflections about specific codes, broader categories and clusters, and the nature of the coding process (Creswell, 2008). See Appendix F for a sample memo.

For *in vivo* coding, I highlighted the exact words of the participants that identified experiences or ideas that were salient to them by virtue of the frequency with which they were discussed, the manner in which they were conveyed, or the emphasis that participants placed on them (Creswell, 2008). As I coded interviews, I recorded the *in vivo* codes derived, and by the end of this stage of the process, I generated a comprehensive list of all codes derived across interviews.

In the second level of analysis, I looked for commonalities among *in vivo* codes, as multiple codes emerged that though labeled slightly differently, were in fact tapping into the same key idea. I then grouped together codes that appeared to be related into fewer, broader categories, thereby condensing the *in vivo* codes (Hsieh & Shannon, 2005; Morse & Field, 1995). Upon completion of this stage of analysis, I had a list of categories derived from the *in vivo* codes generated within and across interviews. The
categories stayed close to the data, reflecting the “manifest” content of the text (Graneheim & Lundman, 2004).

The final level of analysis consisted of an examination of the categories for relationships and patterns that informed the organization of the data into clusters of categories that were meaningfully related (Hsieh & Shannon, 2005). The clusters were broad in nature, such that they subsumed all relevant categories. The end result of this process was a list of six clusters that interwove the categories together, elucidating the more latent meaning of the text (Graneheim & Lundman, 2004).

As described below, throughout the data analysis process, I consulted with my advisor and two other graduate student consultants to ensure that the codes, categories, clusters, and inter-relationships were accurately representative of the data and were logically grouped (Milne & Oberle, 2005).

**Trustworthiness**

In all research, irrespective of methodology, it is imperative that steps are taken to ensure the high quality of the data obtained. In quantitative research, the concepts of validity and reliability are the benchmarks upon which quality is generally assessed (Popay, Rogers, & Williams, 1998). However, such standards are rooted in a positivistic paradigm and accordingly, tend to be incompatible with the underlying assumptions of qualitative research conducted using a constructivist perspective (Whittemore, Chase, & Mandle, 2001). In the latter case, “the idea of discovering truth through measures of reliability and validity is replaced by the idea of trustworthiness” (Golafshani, 2003, p. 602).
There are numerous, overlapping criteria within qualitative research that may be used to assess the degree to which trustworthiness is upheld within a study (see Lincoln, 1995; Lincoln & Guba, 1985; Marshall, 1990; Maxwell, 1990; Sandelowski, 1986, 1993). Whittemore, Chase, & Mandle (2001) offer a contemporary synthesis of these criteria, describing four main constructs: authenticity, credibility, criticality, and integrity. Below, I outline each of these constructs, and describe the strategies I used to attend to each within the present study.

**Authenticity.** Authenticity refers to the researcher’s careful attention to the participants’ voices and their unique descriptions of experiences in order to remain as true to the phenomenon of interest as possible (Hammersley, 1992). There are three underlying components to authenticity: the participants are free to speak, the participants’ voices are heard, and the participants’ perceptions are accurately represented (Neergaard et al., 2009). During the actual interview process, I promoted authenticity by structuring the interview so that participants were ultimately free to discuss what was important to them; this entailed the use of open-ended questions and a flexible use of the topic guide as a fluid tool rather than a structured questionnaire. I also utilized member checking, whereby I used probes and clarifying questions within the interview when meaning was unclear, to ensure that I was understanding participants’ responses in the manner in which they intended for them to be understood.

The interviews were transcribed by this researcher and a professional transcription service. As mentioned above, once interviews were transcribed, I read each transcription while listening to the audio recording, to ensure that the participants’ words had been transcribed accurately. I also incorporated my field notes into the data analysis process,
to gain a greater sense of the context of the interview, and in turn, afford greater insight into the meaning of participants’ words (Milne & Oberle, 2005). Additionally, I offered to send individuals a copy of their transcribed interview and to meet with them if they wanted to discuss it. One participant requested a copy of her transcription, but did not request a follow-up meeting and did not request any modifications to the transcription.

**Credibility.** Credibility is closely linked to authenticity, and refers to the degree to which the intended goals of a study have been achieved through the collection of the data and its analysis (Lincoln & Guba, 1985; Morrow, 2005). Credibility can be ensured through sampling and recruitment strategies, as well as data analysis procedures (Graneheim & Lundman, 2004).

My recruitment strategies ensured credibility in that my use of maximum variation sampling to obtain a sample of participants with a diversity of person-related characteristics and experiences with therapy rendered a broad, comprehensive reflection of my phenomenon of interest. This aligned with my stated goal to ultimately obtain a “rich, straight description of an experience” (Neergaard et al., 2009; p.2).

To ensure credibility of the data analysis process, I regularly reviewed codes with my faculty advisor and two graduate student consultants who had experience conducting qualitative research. Consultation with my colleagues was imperative to ensure that all relevant data had been included, to attend to and address discrepancies within the data, and to consider alternative understandings of the phenomena of interest (Graneheim & Lundman, 2004; Whittemore et al., 2001). For example, I struggled with coding the following quote from Ginny surrounding therapist self-disclosure:

Yeah [my therapist] did, she told me she was going to Israel. Leaving on vacation
this week to Israel with her 18 year old daughter to go on a trip and I was like I miss that. The only visits I ever get to see with my son are in jail and I love those moments because that’s our quality time together. I know it might sound crazy, but that’s the only time he tells me how he’s feeling. And it feels good to me. And that’s what she told me. I wish I could go on a trip with my son but it is what it is. I can’t change what he is now. I love him for who he is, and that’s it. And she was like, yeah, she shares stuff with me like that.

I felt that this quote reflected the client’s underlying appreciation for her therapist’s self-disclosure; but my colleague believed it conveyed more about the client’s awareness of – and perhaps sadness about – the differences between her life and that of her therapist’s.

My colleague and I discussed the quote within the context of the broader interview and field notes and we came to agree that the participant was saying both things, given the context in which she was speaking.

A final way in which credibility was achieved was through data triangulation, whereby multiple sources of data, such as field notes and individual interviews were integrated into the data analysis process to add multidimensionality to the data (Denzin, 1978), thereby enriching the final description of the phenomena rendered.

Criticality. Criticality pertains to the critical evaluation and justification of the decisions and procedures implemented within the study to uphold its overall integrity (Milne & Oberle, 2005). In the present study, criticality was maintained through the use of an audit trail that documented the rationale, process, and steps involved in implementing and refining the data collection and analysis processes as they jointly unfolded. Consultation with my faculty supervisor and graduate student consultants took
place throughout the study, and these colleagues had access to the audit trail. The memos that I generated throughout the data analysis process also informed the content of the audit trail. The audit trail served as an important safeguard to elucidate and in turn, mitigate, sources of researcher bias that could risk distorting the final outcome if not addressed.

**Integrity.** Though qualitative description aims to stay as true to the data as possible, it is inevitable that some degree of interpretation will occur. Integrity within this study therefore pertains to measures taken to assure that interpretations were grounded in the data to the extent possible, and that the researchers were aware of potential biases that may shape their interpretations (Marshall, 1990; Whittemore et al., 2001).

To ensure that interpretations were grounded in the data, I continuously engaged in consultation with my colleagues regarding my subjectivity as researcher and its impact on the data. To guard against unconscious shaping of the data, I regularly engaged in reflexivity to reflect on my values, assumptions, and beliefs and how they could influence the research process (Lietz, Langer, & Furman, 2005). Focusing on these issues helped me as researcher as well as the readers of my work to understand the lens through which I viewed participants and the phenomenon of interest (Morrow, 2005). In the following section, I explore my background and how it informs my proposed research.

**Personal identity and philosophy.** I am a Caucasian, middle-class woman who embraces liberal political ideals. Because my parents so strongly wanted me to have an excellent education, they worked very hard to send me to an elite private school, and subsequently an elite private college, where I was surrounded by individuals with a great
deal of social and economic privilege. Though I never personally experienced
déprivation of my basic material needs at any point in my lifetime, my middle class status
actually set me apart from most of my fellow students in high school and many in
college. I have always been keenly aware of the disparity between my own economic
status and that of my wealthier peers. Indeed, I have continued to struggle with my
personal feelings of resentment towards others with greater wealth and privilege by virtue
of their family’s economic and social location, experiencing frustration that some things
come so easily to some, whereas others have to work so hard and often get so little.

Grappling with my reactions to the economic inequities I have experienced in my
own life has helped me to contemplate the experience of those who endure even greater
economic injustice in their day-to-day lives – our nation’s poor. Over time, this
reflection has shifted into a desire for action, guided by, in part, my training within a
doctoral program which embraces a strong social justice orientation. I initiated this study
with the aim of using it as a vehicle to give voice to individuals living in poverty.

My specific interest in working with low-income women stemmed from my prior
clinical work providing home-based therapy to children and families. Most of these
families were low-income and headed by single mothers. Although the children were
usually the identified clients, I often worked very closely with their mothers. The longer
I worked with these women, the more deeply I came to understand the multitude of
chronic and acute stressors with which they contended, and the mental health difficulties
that they faced as a result. Despite their need for mental health treatment for issues such
as anxiety, depression, and PTSD, most of these women were not involved in long-term
psychotherapy. When we talked about why not, some women listed the range of practical
obstacles that prevented them from considering psychotherapy. But others told me that they had given it a try, and found that what psychotherapy had to offer did not match up to their own needs in some way. For example, one woman described how her therapist’s recommendations were not realistic in light of her family’s day-to-day stressors; a complex behavioral plan for her children would be virtually impossible to implement given her inability to be home consistently when working double shifts to make ends meet. Another mother reported that it would be difficult to “sit and talk about feelings for an hour” when that time could be better spent tending to more pressing matters, such as obtaining fuel assistance or food stamps. In light of my experiences with these mothers, I couldn’t help but wonder if outpatient psychotherapy was somehow “missing the boat,” with one of the populations that needed it the most.

As mentioned previously, economic disparity is a phenomenon that I have experienced personally, and as a result, have been particularly attuned to throughout my life. I am cognizant of it within my interactions with others, including those that take place within the therapeutic context. This awareness informs everything from the way that I dress as a therapist (I tend to steer clear of flashy jewelry or expensive name brand clothing) to the way in which I conceptualize the needs, strengths, and goals of each of my clients. For me, it is an extremely salient component of treatment that is inextricably intertwined with issues such as gender, race/ethnicity, culture, sexual orientation, etc. It is also a source of bias I bring to the study, as other therapists, due to their personal beliefs and/or theoretical orientation, may not agree with this particular standpoint. Moreover, I need to be careful not to assume that low-income clients generally want or
need their poverty status implicitly or explicitly incorporated into mental health
treatment.

As a consumer of outpatient psychotherapy myself, I have had both positive and
negative experiences within therapy and across therapists. This perspective has helped
me to understand the therapeutic process more deeply, as opposed to strictly on a
conceptual level. However, I needed to be mindful to not infer meaning of others’
experiences largely by comparing or confusing them with my own.

In sum, all researchers have a unique standpoint or lens that influences how they
approach, interpret, and report the work that they do (e.g., Collins, 1990). In the above
section, I explored aspects of my own experience, beliefs, and values that undoubtedly
impacted how I understood the experiences of study participants. Reflexivity was an
ongoing process throughout the study; the aim was not to identify potential sources of
bias to then repudiate them, but rather to understand and own how they may have been
shaping the research process.

Summary

The present study used a qualitative methodology to explore low-income
women’s experiences in psychotherapy; in particular, how poverty shapes this experience
and effects what participants perceived to be helpful and meaningful. Qualitative
description was selected as the methodology of choice due to its emphasis on staying
close to the data, with less researcher inference than other qualitative methodologies
(Sandelowski, 2000). Recruitment and sampling procedures aimed to obtain a sample that
could scale both wide and deep in terms of experiences with therapy (Sandelowski,
1995). Participants who met the criteria for inclusion engaged in semi-structured
interviews that were based upon a topic guide focusing on participants’ history of psychotherapy, helpful and unhelpful experiences in treatment, the nature of the therapeutic relationship, psychotherapy outcomes, and recommendations for researchers, practitioners, and policymakers. Using conventional qualitative content analysis to analyze the data, we derived three levels of codes: in vivo codes, categories, and clusters. The constructs of authenticity, credibility, criticality, and integrity were used as benchmarks of trustworthiness within the study (Whittemore, Chase, & Mandle, 2001). In the next section, we explore the results of the data analysis process.

**Chapter 4: Findings**

This chapter describes the results of a qualitative descriptive study of ten low-income women’s experiences with outpatient psychotherapy, including how poverty shaped their psychotherapy experiences, and what they perceived to be most effective and meaningful within their treatment. The first section discusses the characteristics of the sample; the second describes each of the derived clusters, along with the categories that comprise them. As each participant chose a pseudonym at the start of their respective interview, I will refer to these names when providing a direct quote. Also, specific terms are used to denote the numeric range of participants who described any given experience. Following the suggestion of Chang, Voils, Sandelowski, Hasselblad, & Crandell (2009), “few” describes 1-2 participants, “some” describes 3-5 participants, and “most” describes more than half (6-10) of participants.

**Participants**

As Table 1 in Appendix G indicates, participant ages ranged from 25 to 54, with three women in their 20s, two in their 30s, four in their 40s, and one in her 50s. Six of
the women identified as mothers. In terms of race/ethnicity, five identified as African-American, two as Caucasian, two as multi-racial, and one as Latina. All participants identified their therapists as White, with the exception of two participants who described their therapists as African American and Latina, respectively. Thus, only two therapist-client dyads discussed in the study were “matched” in terms of a shared race/ethnicity between both individuals. Participants identified all but two therapists as female. Every participant received at least one form of public assistance, and their yearly incomes (including public assistance) ranged from $4,104 to $20,000. Duration of psychotherapy participation ranged from six months to 22 years. Almost all those who had participated in psychotherapy for over one year had worked with more than one therapist and had experienced gaps in treatment, with the exception of two women who had worked with the same therapist for nine years and 20 years, respectively. Depression was the most common mental health diagnosis that participants reported, with seven out of 10 naming or describing this diagnosis. Other diagnoses identified or described by participants included: posttraumatic stress disorder (PTSD), bipolar disorder, bereavement, substance abuse, panic disorder, anxiety, obsessive compulsive disorder (OCD), and schizotypal personality disorder.

Contextualizing the Findings

Six broad clusters were derived from the data, each of which is described within the next section. Poverty is foreground within the first three clusters, which center on whether and how therapists acknowledged its role in participants’ lives, provided sensitive and relevant assistance to address it, and increased participants’ own capacities to cope with it. Poverty is perhaps background within the latter three clusters, which
elucidate the relational frame that is necessary for low-income women to engage with and benefit from mental health treatment.

**Overview of Clusters**

The six broad categories that were derived from the data include: 1) Awareness; 2) Flexibility and Instrumental Support; 3) Building Strengths; 4) Respect and Dignity; 5) Shared Power; and 6) Authenticity. Each cluster comprised a series of categories, and the categories comprised smaller codes.

**Awareness.** Every single participant highlighted how important it was for their therapist to understand deeply what it means to struggle every day with the material hardships of poverty. Specifically, participants spoke about: 1) the importance of the therapist’s awareness of clients’ needs related to simple survival, and 2) how the therapist’s social location might be related to that awareness.

**Therapist is aware of survival-related needs.** Most participants described how meaningful, comforting, and practically useful it was when their therapists “got” the nature of the emotional and practical hardships they faced in trying to meet their most crucial needs, such as obtaining housing and food. Participants gave a number of examples of what it meant to “get” the lived experience of poverty, such as when therapists named these stressors, recognized their priority in the women’s lives, and/or seemed attuned to what interventions and/or recommendations were realistic, given the myriad constraints they faced.

Regarding the latter, some participants paid close to attention to how much their therapists understood what was possible for them to change given their class status. For example, Mary described how though her current living situation triggers her PTSD
symptoms and inhibits her sleep, she is not in a position to leave her apartment. She appreciates that her therapist takes her housing limitations into consideration when tailoring treatment interventions: “I don’t live in an ideal housing situation, but it’s what I have to deal with and he’s sensitive to that.”

Conversely, some participants shared experiences in therapy where the therapist had shown a lack of awareness of survival-based needs, and/or a lack of awareness of what was possible for the client to change or achieve within their lives. Participants experienced these moments as disconnections within the therapeutic relationship, and/or simply being generally unhelpful to their treatment.

For example, Chiara described, with great frustration, how her therapist seemed out of touch with the realities of her day-to-day existence by recommending that she address her profound fatigue by simply sleeping more:

…it was basically “okay, well, um, you should be able to get to sleep,” and that’s just what it is…um and it was like, well, maybe I can’t because I have kids, one. Two, I have all these stresses and at the time I wasn’t coping with them and I felt like my mind was like a highway…and so it was like you don’t understand I would like to sleep but I can’t sleep! You know and just telling me that I should sleep is not helping!

Similarly, Mary expressed her frustration with her previous therapist, who recommended she engage in social activities that were beyond the scope of what was financially possible:

She would push me to make changes that I couldn’t, I just wasn’t ready or wasn’t able to make. And some of them had to do with those social stressors where she
wouldn’t be able to grasp that some things were unavailable to me, some other types of higher income entertainments and friends and socializing.

**Therapist has exposure to low-income communities.** Some participants indicated that when therapists had previous, substantive exposure to low-income communities, they tended to show a greater capacity to empathize with the depth and extent of clients’ poverty-related experiences. Conversely, in the absence of such experiences, their capacity to truly understand their clients was compromised. As Lina stated:

> Sometimes it’s hard to put yourself in somebody else’s shoes, and if you come from a privileged family or you have money and you don’t have the experience of working with a particular population or culture, you can make a lot of mistakes. You’re going to assume things or you’re going to expect things and that tapped in a lot into my feeling of being inadequate and feelings of being bad because I had this notion that somehow I was wrong.

Often, perceived differences in privilege caused participants to be especially skeptical of therapists’ abilities to understand their experiences. Therapists had further to go, in those cases, to show that they understood clients’ experiences. Some participants, such as Janelle, questioned the capacity of her therapist to help her, given her own “rough background” in comparison to the therapist as “someone who comes from the suburbs and has lived a lily perfect life.” In particular, participants with White therapists described instances in which their therapist had behaved in a “hoity toity” manner that they experienced as off-putting. However, it was only participants of color who raised the role of race/ethnicity within perceived differences in privilege. For example, Mary, a
White participant, spoke of how “intimidating” it felt when her White therapist dressed in flashy attire:

…this [therapist], she was so ornate. She looked like she stepped out of a Newbury Street boutique with her jewelry and everything. That’s what I was saying when I said that there was that chasm between us…and then when the [client] comes in their street clothes it sets up…that power relationship.

Janelle, a multi-racial participant, repeatedly referred to her strong bond with her White therapist throughout her interview. However, she also noted that the fact that they were not the same ethnicity or race was a potential obstacles to mutual connection and understanding:

She’s, okay so she’s an English woman, and she’s a White woman. So those two right there are big barriers, you know, for different worlds. And I believe she did come from England, so very different worlds. But she doesn’t, I don’t feel like she looks down on me for anything. If anything I feel like she sympathizes with my, maybe empathizes. I hate sympathy; so she probably empathizes with my plight, things I’ve gone through.”

**Flexibility and instrumental support.** Beyond awareness, all participants emphasized that therapists needed to respond in specific ways to the material conditions of poverty. Specific practices noted by participants included: 1) creating flexibility in the structure and format of treatment, and 2) providing instrumental support and advocacy.

**Structure of therapy is flexible.** Given the multitude of stressors participants faced simply getting to therapy – e.g. navigating co-pays, transportation, childcare,
and/or the inflexible schedules of low-wage jobs -- getting to therapy at all, let alone at a fixed time and place, proved challenging for many. Therapists’ willingness to accommodate participants’ needs in this regard was not only appreciated, but often necessary for long-term treatment to be sustainable. For example, Lina questioned her interest in continuing treatment with her current therapist, due to her therapist’s rigidity surrounding punctuality:

Sometime I feel like I want to get another therapist… I was about to call her supervisor and say I think I need somebody else because she was… I try to make my appointments. If I’m going to be late, I’m always keeping contact and there were problems sometimes, not having a car and stuff like that, but most of the time I keep my appointments and she would say, “Well, if you’re more than,” whatever minutes, “late, then I won’t be able to see you.”

Jenny was among several participants who addressed the importance of her therapist’s flexibility regarding her children, noting that without this accommodation, she would likely be unable to attend therapy sessions:

With her I usually make it while my daughter’s in school or when I don’t have class. And if my daughter don’t have school she, she’s a therapist so I could bring my daughter in with me. And she have like art supplies and coloring books so while I’m talking to her my daughter could be painting, or coloring, or reading a book. So my daughter could be occupied while I’m having session with her…It’s better cause not every therapist have that in their office. Either the child probably wouldn’t be able to come, or have to sit outside, or you have to reschedule.
Flexibility can also extend to the cost of treatment. Ginny described how the cost of co-pays can be prohibitive to initiating and/or sustaining treatment. Her therapist helped to reduce her co-pays to a more manageable amount: “And I didn’t think I could go to counseling because of my insurance. But I got, you know, she in matter of fact just changed my insurance to make sure that I only pay five dollars co-pay instead of 20.”

Of all the forms of flexibility described none was more salient than therapists’ willingness to “go above and beyond” the work that took place within the office, face-to-face. Most participants described with gratitude and appreciation the time therapists spent outside of sessions, calling participants to check in, or researching and obtaining supports that could benefit their clients. Therapists’ efforts to go above and beyond yielded helpful results in terms of beneficial resources, but just as importantly, served to strengthen the therapeutic relationship by showing participants that their therapist was genuinely committed to helping them, even beyond the 50 minutes allotted for their sessions each week.

Chiara described her appreciation for her therapist’s willingness to respond quickly to her practical needs, without necessarily waiting until their next session: 

If I bring up something to her, “like oh I need, you know, um help with this or I want to try to get in to this training or whatever you know,” during the session, again she’ll try to come up with the information that you know best suits my situation and then call me and say, “remember we was talking about da da da, you know I came across this or this email got sent to me I’m gonna send it to you.” Similarly, Jenny expressed her appreciation that her therapist took time outside of the session to track down helpful information, “Like the accident for my brother, she ended
up finding information for the lawsuit. She didn’t have to do it, but she, I didn’t ask her to do it, she went out of her way and did it.”

Chiara described how her therapist’s efforts outside of sessions demonstrated her therapist’s regard for her as a person and her commitment to their work: “So I think I matter a lot because I feel like if I didn’t, she wouldn’t take the extra step, you know it would just be our sessions and that’s it, you know.” Janelle also experienced her therapist’s outreach as indicative of her care for Janelle as a person, not just another case in her caseload: “She calls me on her days off. That right there in itself.”

Even if participants didn’t choose to take advantage of this form of flexibility, they appreciated knowing that they could if they needed to. By contrast, participants viewed the absence of such flexibility as highly unhelpful, and even alienating.

**Therapist provides instrumental support.** Every single participant spoke of the tremendous difficulties they endured trying to obtain basic necessities such as housing, transportation, food, childcare, and employment. Meeting each of these needs required knowledge about what resources were available, how to get them, and how to advocate for oneself when faced with “bumps in the road.” When therapists took an active role in providing practical support to help participants navigate these challenges participants felt understood, supported, and hopeful. Participants described instrumental support as therapists’ provision of information, basic material items (e.g., relaxation tapes, formula, clothing), psychoeducation, assistance with paperwork, linkage to resources, or advocacy.

Chiara described multiple ways in which her therapist provided information and material support within sessions:
You know, she’ll, she plays a part in everything, you know, “I remember you didn’t really have enough money so what I’m gonna try to do is get you a T pass. You know then it’ll be a little easier for you to get to x,” you know and so little stuff like that. Even like, clothing, you know she knows it’s financially hard for me regardless. So in everything that comes, “Oh well I heard this new place called Cradles to Crayons, you know whatever, or “these things came by the office, I remember you said you was going job searching but you really didn’t have enough…so this could work while you do your job searching…go through these clothes.”

Similarly, Ginny spoke with gratitude for her therapist’s help within sessions to complete complicated but important bureaucratic tasks: “…she helped me write a letter for taxes, she helped me apply for Mass Health because my job didn’t change my insurance…I’m grateful for her.”

Almost all participants described how helpful it was for therapists to link them with resources that addressed directly the material conditions of living in poverty. For example, Janelle stated: “She does a lot extra for me. She’ll look up information for me if I need it, find someone who I can talk to if I need something. Whatever it is that I need…she would find someone in her rolodex for me to call.” Similarly, Chiara stated:

And every piece of stress that I mentioned, um, you know she’s aware of and she’s helped me kind of um, kinda walk through it, get through it. Um from finances, learning how to budget, or you know learning what’s available out there, from child care, um you know helping me find out what child care I’m eligible for and so forth, um even food.
Beyond referrals, almost half of participants spoke of instances in which therapists had advocated on their behalf, writing letters or calling individuals or agencies to support them in obtaining needed resources. Often the advocacy broke down barriers (both real and perceived) that prevented participants from getting the help they needed from various institutions. For example, Jessica described her involvement in the church as a vital support, but when her housing situation changed, she was unable to access the church due to significant transportation challenges. Her therapist advocated for the church to arrange transportation for her:

He called the church because I had no way of getting there...and so he called and he got me transportation and they have a bus, a church bus, and he had made arrangements for them to come and pick me up and take me to church and take me back home.

Similarly, Lina and Janelle described their therapists’ help in writing letters to support them in obtaining employment or remaining in school:

At least trying to help me like I wanted to do something about my record because I lost a couple of jobs because of my record. I wanted to go back to work and I did this training in interpreting and I couldn’t work because of my record and it stays with you…she wrote letters supporting me (Lina).

My mom died my first semester in college, right about midterms. And the teacher had the nerve to give me a D in one class. I got A’s in all my other classes and I was absent for the week that she died…I never had time to grieve or anything. My grades went down after that semester. And she wrote a letter to help keep me
in school so that I could work it out. And it worked; I stayed there until I ran out of money (Janelle).

Interestingly, providing practical support and advocacy can take therapists and clients into the realm of the law. Three participants spoke about their appreciation of therapists who enforced their own power judiciously and with great sensitivity to their clients’ poverty-related challenges. For example, Lina described how even when her therapist felt the necessity to report her to social services, it felt helpful as opposed to punitive:

Mary Jane reported me to [social services] and even though she did that, I felt respected and that she really cared about me and that she was doing it out of care, out of caring for me, not because she was like, “Oh, I’m going to get you in trouble,” or whatever.

In this instance, Lina perceived the therapist’s engagement in mandated reporting to social services as an attempt to help her and her family negotiate stressors that had progressed beyond her control. Other women perceived it to be helpful that their therapist responded to their situations by changing them, rather than simply reporting them to social services: “You know, there were times where I didn’t have much food in the house, you know, and there could have been times where she, you know made it could have possibly reported it [but instead, she helped me figure out how to access food].” (Chiara) Chiara was grateful that her therapist helped her to address the poverty-related stressors that were underlying what other therapists would have deemed as “neglect,” as opposed to involving another agency that she did not feel could adequately address the issue at hand.
While most participants described helpful moments when practical support was provided in treatment, almost half described the absence of practical support as unhelpful to the treatment process. For example, Janelle described how simply “talking” in sessions fails to adequately address her poverty-related needs, which are at the root of her mental health challenges:

What is it that you are going to be able to do? Because talking may help, yes, but talking isn’t going to provide me with food. Talking isn’t going to get me a job. Talking isn’t going to get me housing, unless I’m talking myself into these situations.

Similarly, Lina negatively described a prior experience in treatment when the therapist did not incorporate practical support: “I had a therapist that wasn’t really about that (instrumental support). She was more about feelings and just validating and that didn’t work well with me.” Chiara also found the absence of practical support as counter-productive to adequately addressing her presenting concerns, which she described as “feeling overwhelmed and depressed:”

Um…I wish they would have helped me approach the situation, you know, the same way my present therapist is doing now. If I’m low on food, you know it’s, “Okay, come on we’ll have a session in the car headed for the food pantry,” or “here, you know, I have a gift card let’s head to the store, we’ll talk in the midst of being in there.” You know, just providing me with the resources that I don’t know of. You know, cause obviously if I knew them I wouldn’t be in a lot of, you know, having struggles with a lot of the things that I have struggles with.
Building strengths. Participants spoke of how meaningful it was when therapists recognized existing or potential strengths -- in the form of emotional resources, skills, and strategies -- with which they did or could manage poverty-related adversity. Given that so many of their interactions focused on what they did not have in their lives, it was surprising and empowering to hear someone talk about what they did have. Specifically, participants highlighted the value of therapists: 1) validating existing strengths; and 2) supporting the development of new ones.

Therapist validates existing strengths. Regarding validation of existing strengths, a few participants described how their therapist’s acknowledgement of their strengths helped them to feel better about themselves and their ability to bounce back from poverty-related challenges. Giselle stated:

I got this feeling, because she would kind of prop me up a little bit when I would come at her with all of this negative self talk. She would say “no, no, no but look at this over here. You can do this and you can do that.” She would really encourage me and I would say “Do you think anyone could ever love me?” And she would say “Oh God yeah.” And she would say “And here’s why.” I remember that one session that we had, she would just make me feel like I wasn’t such a loser.

Similarly, Ginny commented on how meaningful it was to hear her therapist reflect upon her resilience: “But my background of my family history, he’s like ‘I’m surprised that you are where you are today.’ It felt good.”

Therapist supports development of new skills and strengths. Beyond validation, participants described a complex process by which therapists helped them develop new
skills to deal with the stress of poverty. This process began with the development of a keener self-awareness, and/or a greater sense of worthiness or deservingness. These building blocks then set the stage for developing new skills or coping tools. Regarding the role of self-awareness, for example, Victoria, described how therapy helped her come to understand “the source of my anger and frustration,” which in turn helped her shift away from drinking as a way to cope with distress:

[Therapy] helped me recognize my behaviors and how to change my situation for the better…Around my alcoholism, I had to start going to 12-step programs and talking about my feelings.

Several participants spoke movingly about the role of self-worth as a precursor to building new strengths. Jessica, for example, stated:

When I first started going to him I didn't even want to do anything. I didn't want to get dressed, I didn't want to put on make-up, I didn't want to do my hair, I just had, I was so weak, I was just so fed up I had no energy and I started going to him and talking and I started to feel better about myself and I started to be able to deal with my situation.

Similarly, Victoria found that her increased self-esteem mobilized her to be able to address her challenges: “Therapy helped increase my self-esteem so I'm employable now. My self-esteem is higher so I'm able to speak up for myself and take charge of my own life.”

Giselle provided a specific example of how her therapist promoted self-awareness, self-worth, and skill-building:
I went to her one time and I said “I don’t know how to pay bills. I don’t know how to—nobody taught me how to do this stuff.” And she was like “Yes, you do. You do know how to pay bills. You look at the bill and you see how much money you have and then you pay it.” I would do it and I would come back and say “Yeah, I paid my bills.” She would just kind of let me do it and in that way she taught me that “yeah, you don’t need your family to show you that you’re okay, you’re cool. On your own you can figure out that you’re smart enough to handle your life. You’ve got this.

**Respect and dignity.** All participants spoke of the tremendous importance of being treated with respect and dignity by their therapist. Participants described a range of therapist behaviors that contributed to their feeling of being respected, which fell within two main categories: 1) creating a real space for them to be heard and understood, and 2) indicating through their responses that they did not judge.

*Therapist creates space for client to be heard and understood.* Participants noticed and appreciated when the therapeutic context afforded a place where participants could speak, be listened to, and be understood. Sometimes it was the only place where this happened, and when it was absent, participants felt frustrated, misunderstood, and disengaged. In contrasting her current therapist with past therapists, Chiara states:

And they all heard me saying everything I was saying but they weren’t actually listening to what I was saying. You know? And I feel like that’s what makes the one that I have now stand out from all of them…because she not only heard me but she listened, you know.
During a discussion of how her prior therapist would make recommendations that were not possible given her financial limitations, Mary was asked what she wished this therapist had done differently. Mary responded, "listened to me more." When Giselle was asked what she looks for in selecting a therapist, she stated, "someone who will listen to me and not just point their finger at me and say, ‘here is what is wrong with you and I know all.’"

When they felt heard, participants could really open up about their experiences, which in turn made those experiences easier to bear. Jessica stated, "I felt better just talking about it, I felt like a weight was lifted off me. I felt like I could deal with my life one step at a time.” Ginny was initially dubious about opening up about her life to a therapist, but now finds the shared discourse between her and her therapist to be beneficial:

It’s wonderful, we click. You know, we can talk. Like she’s not a stranger to me. Even though that first day when I went in there I thought she was and I wasn’t going to open up to her but she’s got that warm hearted feeling when you go into her office that you feel welcome…so it’s a good feeling to go in there and sit down and for her to talk to you, it makes you feel so much better…so just talking to someone and just being myself…Just being genuine feels good. To let it off.

*Therapist is non-judgmental.* Many participants described prior experiences of feeling judged -- by providers, by gatekeepers to needed resources, and/or by society at large. It was critical that therapists countered this experience by showing open-mindedness in their interactions with clients. For example, while Janelle and her therapist come “from different worlds,” she reported that one of the most important
aspects of their relationship was that, “I don’t feel like she looks down on me for
anything.” In describing what in particular she finds helpful about her therapist, Mary
stated simply, “he doesn’t judge at all.”

By contrast, Yahoto spoke of painful experiences with previous therapists in
which she felt that she was “being looked down upon, financially, educationally… you
know not being taken seriously in general because of education or financial reasons.”
Given the judgment Lina felt has been imposed by others -- as well as herself -- she
described just how important it is that therapy be a space where judgment is absent:

I want [the therapist] to understand where I’m coming from and not to judge me.
I’m not there to be judged. I’m already being judged by everybody else and my
own guilt trips about whatever I’m doing that I know is not right, so I think that’s
enough.

**Shared power.** Given the disempowerment that participants regularly
experienced as a result of their poverty, it was not surprising that the issue of power –
how it was understood, managed, and used by the therapist -- was key to the development
of the therapeutic relationship. Participants highlighted marked differences in their
experience of treatment when therapists wielded power *over* them versus shared power
*with* them specifically through their handling of 1) the issue of expertise; 2) use of a
medical model; and 3) collaborative decision-making within treatment, all of which
contributed to 4) participants’ perceptions of their own power within the relationship.

**Therapist does not identify as expert.** Some participants provided examples of
negative experiences in which their therapist had identified as the expert within the
therapeutic relationship, conveying a perspective that he or she ultimately “knew what
was best” for the client. Yahoto, for example, reported frustration that her own perspective was often devalued or overlooked by her therapist, which she attributed to her social location:

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.” You know, and then, but you’re you and you know yourself. You know?

Giselle contrasted her past therapist to her current therapist in the way that they negotiated their roles, and in turn, their power:

And [my past therapist] also had this “I’m the doctor, you’re the patient” kind of thing. “What I say goes. I know you better than you know yourself.” Which creeps me out…I just remember feeling like; the difference was that [my current therapist] wasn’t looking down on me. She wasn’t looking down on me as “You’re the patient. I’m the doctor. I know everything. You just sit there and listen to my wisdom.”

_Therapist avoids medical model._ The extent to which therapists used medical language and diagnostic labeling within sessions, as well as the emphasis they placed on medication as a first line treatment, also contributed to participants’ feeling of disempowerment. Regarding the issue of language and labeling, participants spoke of instances in which they felt confused by their therapist’s use of jargon, but felt embarrassed to ask for the terminology to be explained. As Chiara stated:

Everything’s not medical. If you use a medical big word -- because they do some, of them I’ve dealt with. And you’re like, “what?” Then they’re like, “Okay?” and
you’re trying to be like, “Okay.” And you leave like, “What the hell did they just say?” I just agreed to something and I don’t even know what they just said!

Giselle shared a similar experience: “She would just sort of say these things and she wouldn’t explain what those terms really meant. So I was sitting there thinking “What is wrong with me?’”

In addition to terminology often generating confusion in participants, the women also reported feeling uncomfortable with the manner in which therapists seemed quick to “label” them in diagnostic terms. As Giselle stated:

That’s what I had a problem with, I didn’t like that I kind of felt like a guinea pig. I would go to one doctor and they would say one thing. And they would slap a label on me. I’d go to another doctor and they would slap a label on me…So I’m thinking okay here is another label I have to overcome.

Some participants found it disempowering when therapists relied on medication as the primary means of treatment for their problems, as this seemed like an overly-simplistic fix for issues that required a whole lot more. As Chiara stated:

It’s like, “Oh well, you have this so we’re gonna give you this.” It’s like no, well sometimes it doesn’t take medicine. You know the medicine is simply just masking whatever issue you have going on… It’s like, okay, I’m sad so if I take this pill it’s going to leverage out my depression and I’m not going to feel sad for a couple hours and then, you know like, no, I’m still dealing with my issues. You know what I’m saying? It’s like the medicine’s not helping me put food on the table. And it’s not helping me pay my rent on time. Or it’s not helping me, you know, get into school. It’s not helping me with stuff like that.
Perceived pressure to take medication also created tension in the therapeutic relationship, whereby participants struggled to assert their perspective as to what would be helpful while also feeling the need to comply with their therapist’s recommendation. Giselle commented on this dynamic: “[My therapists] probably think to themselves ‘Oh she’ll come to her sense.’ And I do. But at the time when they’re resisting me and they’re saying ‘Yes, you need this’ -- it doesn’t feel good.

**Therapist collaborates with client.** Underlying all discussions of power was participants’ perceptions that a good relationship entailed creating a true partnership:

So I feel like it’s more equal, even where there is other situations or other issues we’ll both throw something on the table and be like, “oh okay and well I can try this.” And she’ll be like, “Oh well maybe when you’re trying that you can also try this.” So you know it’s like brainstorming together it’s not just she say something and I’m like, “Okay, that’s what I’m gonna do,” or I say something and she’s like, “Alright, that’s fine go ahead and do it.” So you know I think we have that mutual respect for each other and we know that we both play a role into solving my issues. (Chiara).

Victoria and Ginny also described the collaborative approach their therapists took in helping them address their problems:

She helps me to discuss it. I talk with her, talk about and she helps me come to my own conclusion how am I to handle it (Victoria).

She just, she helps. She don’t act like she’s in control. She helps. She asks me, “what can I do for you that will less your stress?” And I tell her. And that’s why I go to her (Ginny).
**Impact of shared power within the relationship.** Those participants who described therapists’ efforts to create a true collaboration also noted the resultant sense of power and control they felt in the therapeutic relationship. Whether this meant power over what to disclose to the therapist, power to decide whether or not to attend a particular session, or power to determine the focus and nature of treatment, all participants noted its importance. Ginny and Giselle, for example, spoke about the power to direct the course of their treatment:

> I always feel like I’m in charge. I always tell her. Like this is what I need done. And this is the paperwork I got. And can you help me with this, or like… I go in with everything to her (Ginny).

> That’s another thing that I feel good about is that I can actually be in control of my own psychotherapy and who I see and what goes on there (Giselle).

Similarly, Jenny reported that she liked that she was “in charge” of the therapy sessions, because her therapist “leaves the floor open up to me.”

Other participants described the importance of determining what to share with their therapist:

> Oh yes, I definitely have power because I have the power of telling him or not telling him. I have control over what I tell, because one time I said to him, it was an issue with my boyfriend at the time and I said oh but I don't want to discuss that because that's personal and he laughed. He was like “that's personal? I'm your therapist!” I have power (Jessica)

Still other participants felt strongly that their power existed in their capacity to choose whether or not to attend sessions, or when to end a session:
I feel like I had all of [the power]. Honestly, and I say that because I pulled out on her. You know what I’m saying? Um, when it there was an appointment made, if I went, I went, If I didn’t, I didn’t. You know so I kinda feel like I kinda controlled that to an extent (Chiara).

As Janelle stated, “I always feel like I have power. I always feel like whenever I want to get up and leave, I can do that” (Janelle).

**Authenticity.** Participants were highly attuned to the extent to which therapists shared their true selves in the therapeutic context. These expressions of authenticity were typically viewed as indicators of genuine care and concern for the client, and tended to strengthen the therapeutic relationship in meaningful ways. The form that such sharing entailed varied, including 1) small gestures suggesting that the therapist cared about the client; 2) displays of genuine emotion during meaningful moments; 3) personal self-disclosures about the therapist’s life; and 4) honest and direct feedback during difficult moments, all of which contributed to 5) a reduction in participants’ sense of isolation.

*Through small gestures, therapist displays care.* All participants spoke favorably of times in which they felt that their therapist displayed a real sense of care and concern through small gestures indicating a shared humanity. Such gestures ranged from complimenting the participant on her appearance to helping her children get ready to brave the cold after a winter session, to giving her a hug:

She says she likes my nails. She says I look nice sometimes. Like you look nice in that color. She’s a warm hearted person (Ginny).
Yeah. When my daughters were little, too, my therapist, Mary Jane, I could see how she would put their little coats on and made sure their hat was on because it was cold outside. She would help me get them ready to get out there (Lina).

And in describing how she knows that her therapist cared for her as a person, Lina said, “My therapist even hugs me. Uh huh, and kisses me. Not all the time, but if she hasn’t seen me for a while and she gets personal.”

Reflecting on how much these gestures meant to her, Janelle stated:

She makes me feel like she cares. And I think people seem to forget in this world, compassion is not a given. It’s something that is, it’s a hot commodity. Everyone wants it; they may act like they don’t want it. I may act like I don’t want it. But compassion is nice. It’s nice to feel like someone cares, that someone is thinking about you.

Although all participants indicated that a personal approach brought them closer to their therapist, a few participants described how an impersonal approach by therapists can be experienced as distancing. For example, Chiara and Janelle spoke of how previous therapists felt as if they were simply “going through the motions” of their job in a way that felt cold and unrelatable:

You know, just because you know here I am thinking that okay she is my therapist she should generally have concerns about me and you know what we need to fix. And that wasn’t the case you know. It was, she was just so kinda like she was so just kinda computer slash robotized it was hard for her to peel that back and actually look at it as a person. You know what I’m saying? Versus just her job. You know (Chiara).

Chiara later advised:
And stop the whole “call me Dr....” No that sometimes can be intimidating too.

“My name’s Bobby but they call me Bob. You know, so call me Bob”. You know what I’m saying? You know, you gotta make them feel comfortable.

**Therapist shows emotion.** Some participants highlighted therapists’ expressions of emotions as critical to their sense of being really cared about. These participants provided many examples of times when their therapists joined with them during moments of levity and/or sorrow. Although the actual exchanges may have been fleeting, they were memorable and increased the sense of closeness participants experienced within the relationship. For example, when asked how she knows that she matters to her therapist, Janelle described her therapist’s show of tears surrounding the loss of Janelle’s mother: “The fact that she shed tears when my mother passed away and she held my baby when I came to the hospital to visit her. She’s cried with me.” Similarly, Jessica was moved by her therapist’s expression of sorrow when Jessica was suffering deeply in her life: “He would cry...Yeah, I thought that was, it made me feel like you know, he really cares.”

Jessica and Yahoto similarly reported feeling cared for and connected to their therapist in moments in which they both shared laughter with their therapist within a session. For Yahoto, that laughter was a sign of respect on the part of the therapist:

It feels helpful when they make me laugh...It really helps me to talk....The therapist can naturally if they have a knack for making you laugh I think it’s like, it’s kind of like there is some stigma attached to being poor, or whatever, low income, and if they respect you enough to just to joke around with you, um, I think when somebody does joke around with you it’s a sign of respect. You know, they at least think you’re gonna get the joke, you know? So, that relieves some of
at least the stigma associated with being poor and you know, whatever, laughter is
the best medicine so it can help with a lot of things.

**Therapist self-discloses about her own life.** Most participants reported some
degree of self-disclosure on the part of therapist. Most of those in helping roles did not
disclose much, so therapists’ transparency was both unexpected and meaningful. Perhaps
the two most important effects of therapist self-disclosure were that they “leveled the
playing field” in terms of power within the therapeutic relationship, and they reduced
participant’s overall sense of isolation and stigma. It is important to note, however, that
not every participant wanted maximum self-disclosure. Indeed, most recognized the
importance of balance in terms of therapist transparency.

Regarding the ways that therapist transparency leveled the playing field, Victoria,
Jenny, and Lina spoke directly about the role of self-disclosure in reducing the power
differential within the relationship. Jenny, for example, indicated that she felt it was
important that therapists share personal information about themselves so that the
relationship feels more equal, as opposed to one-directional:

> It’s better to know certain stuff about who you’re dealing with cause when you
don’t know nothing about the person, it’s like why should I tell you stuff if I don’t
know nothing about you. If it’s a professor fine, that’s a professor, it’s like I don’t
need to know nothing about you …. But if I’m gonna deal with you for a couple
of months or a year or two I need to know something about you, when you’re
gonna try to know my whole lifetime.

In terms of reducing isolation, both Ginny and Jenny reported feeling a closeness
and shared humanity with their therapist when the therapist revealed that she herself was
a parent; both indicated that this increased their mutual understanding of one another. In other instances, therapists disclosed specific information about their own mental health challenges, sharing about their diagnoses, histories of domestic violence, and/or substance abuse recovery. These disclosures had powerful impacts on the women. Chiara spoke of how hearing about her therapist’s past challenges made her feel less isolated and alone in her own struggles:

You know, so she opens up also when it comes to those situations just to kinda, um and it makes me feel…it doesn’t make me feel like I am the only one feeling that way or the only one ever gone through that situation, you know what I’m saying?

Giselle and Lina also reported that their therapists’ disclosures of their mental health issues decreased their sense of stigma and isolation, and further, instilled a sense of hope in their capacity to successfully work through their challenges:

She really made me feel like; she would tell me, not in an unethical kind of way but just, she would say “I’ve been there too.” Kind of thing, “You’re not alone. This isn’t unique. Everyone has been through this and you’re going to get through this because other people have gotten through this too, including myself” (Giselle).

Yeah, so that was good to know, like, oh my God, there are other people that are going through this and, yeah, you can get help and you can get through this. She’s an example of it and also that they know firsthand what you’re going through, because I think that the other therapist was judging me (Lina).
A few participants, however, experienced their therapist’s self-disclosures to be unhelpful, particularly when it shifted the focus of the session on to the therapist. As Giselle stated:

I don’t really like it when therapists talk a lot about themselves. I’ve had one like that, it didn’t last very long...Yeah, I was like; it’s not about you right now, please. Even if you think you’re helping or relating or whatever, it doesn’t feel comfortable.

Ultimately, most participants demonstrated a keen awareness of the complexity of establishing and maintaining the right balance regarding therapists’ sharing of personal information. As Giselle stated, “I don’t want to know too much about her just enough so that I know she can kind of relate to me, maybe even on a superficial level.”

Janelle indicated that she liked to know personal details about her therapist, but also understood that this can get tricky:

Sometimes because her and I are so close, I’ve known her for 20 years, I feel like I would like to know certain things about her but I understand the boundaries. It doesn’t make me feel any type of way that I don’t know these things. I understand that it must be hard for her to cross her personal life in with her work life.

**Therapist deals with difficult issues honestly and directly.** Some participants spoke of their genuine appreciation for their therapist’s honest and direct communications, even if they were frustrating or painful to hear. Ginny commented, “Well whatever she wants me to know, she’ll tell me. You know, she’s very honest with me.” Giselle reflected positively on her experience with a prior therapist, “She was very honest with me...very above board.” Based upon this experience, she reported that what
she looks for in future therapists is “someone who recognizes my strengths and kind of focuses on them but if they see me going in a certain direction that’s really not okay then they’ll call me on it.” Similar to Giselle, Janelle appreciated when her therapist was direct and held her accountable:

With her she was always—she pulls no punches. She almost gives it to me like I need it. Like, “what do you think that you need to go do right now? To be honest, I don’t think this is best idea or what’s the best one that you’ve had yet?” I’m an aggressive person by nature. And if I think I can say anything or do anything, it’s almost like I need someone to be “Oh, slow your roll. Don’t talk fast, don’t do that.” And she does that.

**Authenticity reduces isolation.** In some way or another, almost all participants alluded to the isolation that accompanies poverty. Because their therapists’ authenticity made the relationship feel more “real” in some sense, it also made them feel less alone. Some even described the therapeutic relationship as “feeling like a friend or family member:”

They get to be part of, I don’t know, your family, your team of people, especially if you don’t have a lot of family around. They become… I don’t know what I would do without my therapist (Lina).

My mother and my grandmother died in the same year, in 2004. And my grandfather had died in 1999. Those were the three people I was raised with. We all lived in a house together and by the time I was 18 they were all deceased. So for me to have this woman who has been in my life since I was five years old and has basically went through my whole leukemia struggle with me, it felt, she’s
always been a rock, like a - I don’t want to call her a mother because she hasn’t
done all those types of things. But she has always been like, if I were a part of that
Big Sister program, she would have been my big sister, you know…She’s the
other woman besides my mom that I would be able to call to ask if this was the
right way to do this [referring to asking for input about caring for an infant]
(Janelle).

Similarly, Chiara and Jessica described how their therapist’s authenticity has enabled
them to feel more comfortable relating to him or her, because their therapist feels more
like a friend:

Unlike a lot of therapists that I’ve had, they come across very text book. You
know, so she doesn’t seem, she doesn’t come across that way. You know, she
comes across like if I was hanging out with a friend. (Chiara)

Like I can come in and I can just be myself. I've told him so many personal
things about myself it's like we're good friends and I come to his office and yeah,
feel like he's my friend. (Jessica)

Summary

Qualitative content analysis of the 10 participants’ interviews yielded six broad
clusters, each comprised of categories that subsumed the first-level, in-vivo codes.
Awareness pertained to participants’ sense that their therapist truly “got” their lived
experience of poverty in a real way, which in some instances, may have been informed
by prior personal and/or professional experiences with poverty. Flexibility and
Instrumental Support reflected efforts on the part of the therapist to address the practical,
poverty-related needs of the women. With so much emphasis (by society, other
providers, and the women themselves) on the deficits within low-income women’s lives, therapists’ efforts to Build Strengths, through validating existing strengths and supporting the development of new ones, was very meaningful to participants. Respect and Dignity pertained to the ways in which participants felt that their therapist cultivated an atmosphere of respect; specifically through creating space for the client to be heard and understood without judgment. Given the ongoing experience of powerlessness that low-income women contend with in their daily experience, participants were particularly attuned to how therapists did (or did not) Share Power in the relationship through their handling of issues of authority and collaboration. Finally, Authenticity pertained to the nature and extent to which therapists shared of themselves in treatment, ranging from showing genuine care for their clients through various gestures, revealing emotional reactions and personal experiences, and providing honest and direct feedback.

The next chapter considers the findings within the context of current research and theory, and explores their broader implications for research, practice, and training.

**Chapter 5: Discussion**

In the United States, women are disproportionately represented among those living in poverty (U.S. Census, 2009). Compared to those not living in poverty, low-income women are more likely to experience traumatic life events (Belle, Doucet, Harris, Miller, & Tan, 2000), stressful life conditions (e.g., U.S. Census, 2001), higher rates of physical health issues/medical conditions (e.g., Everson, Maty, Lynch, & Kaplan, 2002; Groh, 2007; Hoffman & Hatch, 2000), stigma and discrimination (Cozzarelli, Wilkinson, & Tagler, 2001; Fiske, Xu, Cuddy, & Glick, 1999), social isolation (Smyth, 2009), and powerlessness (Dodson, 1998; Goodman et al., 2007; Gagglund & Ahlstrom, 2007). It is
clear that poverty deeply affects the psychological experience of low-income women, and not surprisingly is associated with a higher prevalence of mental health issues as compared to both middle-income men and women (e.g., Kessler, 2003).

It is therefore critically important to understand the unique mental health needs of low-income women and to adapt mental health services to meet those needs. The stage is set for expanding knowledge in this area; in 2000, the APA published the Resolution on Poverty and Socioeconomic Status, charging psychologists to “better understand the causes of poverty and its impact...to help prevent and reduce the prevalence of poverty and to effectively treat and address the needs of low-income individuals and families” (p.3). There is growing attention to health disparities among different socioeconomic groups, with scholars and practitioners alike invested in understanding and reducing them (e.g., Beeber et al. 2007; Miranda, McGuire, Williams, & Wang, 2008; Institute of Medicine, 2002; Nadeem, Lange, & Miranda, 2008; Siefert, Bowman, Heflin, Danziger, & Williams, 2000; USDHHS, 2002). And as the movement toward enhancing the multicultural competence of mental health providers continues to gain momentum, scholars are calling for an expansion of multicultural training into the realm of poverty and class (e.g., Goodman et al., 2013; Smith, 2009; Stabb & Reimers, 2013). As we endeavor to better address the mental health needs of low-income individuals, both through the training of practitioners and the refinement of psychotherapy theory and practice, it is crucial that we understand what low-income clients themselves find most helpful.

The present study aimed to contribute to this effort by exploring the experience of low-income women in outpatient mental health treatment. Using a qualitative descriptive
methodology, we interviewed 10 low-income women who are currently in or have engaged in therapy within the past three years. We wanted to understand how poverty shapes low-income women’s experiences of therapy and what aspects of therapy they find most meaningful and effective.

A qualitative content analysis of the interview transcripts produced a rich description of meaningful therapy, the components of which are described next. We conclude with a discussion of the implications of these results for feminist scholarship, clinical practice, training, and research.

**Components of Meaningful Therapy**

The data that emerged from our qualitative interviews can be distilled into six clusters. Participants found their therapy to be meaningful and effective when the therapist: 1) was aware of the nature of poverty and poverty-related stressors, 2) provided instrumental support and demonstrated flexibility, 3) emphasized building strengths, 4) demonstrated respect and afforded dignity to the client, 5) attempted to share power, and 6) demonstrated authenticity. These clusters, in turn, coalesced into three overarching themes: Awareness, Practices, and Relational Quality. Overarching themes and accompanying clusters are depicted in Figure 1. This section discusses each overarching theme respectively.
**Figure 1.** Relationship among themes and clusters

**Awareness.** Every single participant spoke about her keen awareness of the class difference between herself and her therapist. Only participants of color who had been paired with a White therapist identified race/ethnicity as a component of differences in privilege. Perceived differences between therapist and client sometimes triggered feelings of alienation and caused participants to question the capacity of their therapists to understand their experiences. The only thing that loosened or severed the tight connection between perceived class differences and the experience of alienation was some sort of explicit indication that the therapist understood what it meant to live with scarcity, systemic oppression, and dramatic constraints on choice. Participants in this study expressed a longing for their therapists to be aware of the “whole picture” – which included their internal psychological needs, their external practical needs, and the way these intertwined.
Indeed, throughout the study, participants alluded to or spoke directly about their therapists “getting it,” by which they meant that the therapist in some way understood her client’s struggles related to poverty. Such indications could be direct, as when a therapist validated the reality of a client’s poverty-related difficulties, communicated an understanding that treatment goals would need to fit within these constraints, described prior personal or professional experience with poverty, or talked about poverty in a knowledgeable and empathic way. Or, indications could be indirect, as when the therapist welcomed or even initiated a focus on her client’s practical needs. When therapists showed that they really “got it” clients felt more deeply understood, less alone, and more confident that therapy could help them. These findings are consistent with earlier research on psychotherapy with low-income clients showing that low-income clients are highly attuned to class differences between themselves and their therapists (e.g., Balmforth, 2009; Chalifoux, 2006; Thompson et al., 2012), and that when clinicians incorporate content surrounding economic challenges into treatment, therapy yields more positive outcomes (e.g., Grote et al., 2009; Falconnier & Elkin, 2008; Thompson, Cole, & Nitzarim, 2012).

**Practices.** Beyond awareness, therapists’ willingness to respond directly and actively to participants’ poverty-related needs contributed enormously to their perception of therapy as useful. Key necessary practices named by most or all participants included providing instrumental support and showing flexibility, and building strengths.

**Instrumental support and flexibility.** Of all the findings, the role of instrumental support and flexibility stood out as perhaps most uniquely salient to low-income women, given the greater practical and concrete stressors they must contend with relative to their
higher-income peers. Almost all participants described the importance of therapist flexibility, especially in the provision of instrumental support. Indications of the presence or absence of therapist flexibility were often present from the start. For example, most participants spoke of the myriad obstacles they faced as they tried to attend regular appointments, including transportation or childcare difficulties, challenging work schedules, and overwhelming co-pays. Therapists’ willingness to problem-solve on these issues, rather than judge or interpret, was critical and even necessary for the work to go forward.

But beyond problem-solving around appointment attendance, most participants described how meaningful it was when their therapists went “above and beyond” the work that took place within the 50-minute hour in the therapy office to spend more time with (or for) them. How this time was spent ranged from therapists making themselves available to talk by phone outside of sessions to researching resources and supports that might be helpful, to simply “checking in” when they were concerned about their clients. These seemingly small efforts enhanced therapy in large ways, particularly by strengthening the therapeutic relationship and in turn, increasing treatment engagement.

Almost all participants also highlighted the equation between good therapy and therapist provision of instrumental or practical support to address clients’ concrete poverty-linked challenges. Participants described practical support as therapists’ provision of information, basic material items (e.g., relaxation tapes, formula, clothing), psychoeducation, assistance with paperwork, linking clients with resources, or providing advocacy. When therapists did not offer such support, many participants felt that therapy seemed irrelevant to their real lives.
These findings are consistent with earlier research demonstrating that for low-income clients, practical support provided as a core part of therapy was associated with higher levels of treatment engagement, greater reductions in depressive symptomology, and greater levels of overall functioning (see Grote et al., 2009; Miranda, Chung, et al., 2003; Miranda, Azocar, et al., 2003). Participants in this study offer nuance to these findings, however, by describing the emotional impact of their therapists’ instrumental support. When such support was a natural part of the therapy process, participants felt less alone in the very domains that caused them the greatest stress and pain. In a similar vein, participants in another qualitative study of low-income individuals who had participated in mental health treatment expressed profound gratitude for their therapists’ efforts to provide practical support (Thompson et al., 2012). These findings underscore the emotional and relational significance of therapists’ efforts to address directly the material realities of poverty, and points to the importance of integration of these activities and more traditional psychological intervention within a single role.

One unique dimension of practical support about which some participants spoke had to do with the therapist’s role in relation to the law. Participants cited numerous incidents in which their therapists were put in a position where they had to exercise their legal authority -- to report individuals to social services, or to hospitalize clients, for example. Several participants described therapists’ handling of these events as critical to how or even whether therapy proceeded afterwards. Some participants described occasions in which they felt their therapists used their legal authority judiciously and with sensitivity to the role of clients’ poverty as a contributor to their choices, needs, and decisions. In one case for example, the therapist opted to help her client obtain the
resources necessary to fulfill her parental obligations more effectively, as opposed to reporting the woman to social services for failing to fulfill those obligations. In another instance, the therapist did contact social services, but did so in a way that felt helpful and collaborative, as opposed to punitive. Here too, participants highlighted the emotional and relational salience of therapists’ instrumental actions, again pointing to the tight relationship between emotional and instrumental support in therapy with low-income clients.

**Building on strengths.** Another key practice that most participants highlighted was building on strengths. Participants were acutely aware of the deprivation in their lives, and had grown accustomed to focusing on what was lacking or absent, as opposed to what was already present or within reach. Because most of their interactions with helpers and broader systems tended to focus only on deficits and inadequacies, they served to deepen a dominant narrative of both “having less” and “being less.”

Therapists’ focus on participants’ strengths served as a counterweight to these experiences. Most participants spoke of meaningful moments in which therapists validated that they were important, resilient, and/or deserving of things like love and success. These notions had never been affirmed for some participants, and were long forgotten by others.

Participants also appreciated when their therapist helped them to develop new strengths, in the form of skills and strategies to address the stressors associated with poverty. Examples of such skills and strategies ranged from job interviewing skills and money management practices to healthy coping strategies as a replacement for substance abuse. This finding is consistent with those of prior studies (e.g., Cunningham & Zaya,
2002; Thompson et al., 2012), including one that showed that an intervention that incorporated an emphasis on low-income women’s strengths was more effective in treating the women’s depression than treatment as usual (Grote et al., 2007).

Interestingly, many participants described a similar multi-step process by which therapists helped them develop a greater awareness of their own strengths. Often, the first step was facilitating greater self-awareness more generally, which often led to a sense of worth or deservingness. Once participants felt more secure in the idea that they were entitled to a better life, they were more equipped to engage in the process of developing new skills and coping strategies to deal with issues ranging from emotional distress to job interviewing to money management. These skills, in turn, paved the way for further positive change.

**Relational quality.** Although the therapeutic relationship is always co-created by therapist and client, the therapist’s demeanor, general approach, style of communication, and concrete expectations are key contributors to the establishment of that relationship. Participants were highly attuned to these dynamics and named them as critical determinants of whether or not therapy was effective. Specifically, most or all participants talked about three dimensions of the relationship: respect and dignity, shared power, and authenticity.

**Respect and dignity.** All participants emphasized the importance of being treated with respect and dignity by their therapists. Interestingly, most participants often invoked these words when describing therapists’ willingness to listen deeply and without judgment. Participants described the value of “having the floor” to talk freely about what was important to them, especially when it came to poverty-related challenges. But
“venting” was not necessarily helpful when it fell on deaf ears. Participants not only wanted to talk, they wanted to be truly heard by therapists who made genuine efforts to ensure that they were understanding their clients’ experience without judgment. Participants described how the experience of being heard, understood, and therefore respected by their therapists in some sense dignified their experience and struggle. This then translated into a felt capacity to endure or overcome adversity. By contrast, when participants felt unheard or judged, they described feeling disrespected, hopeless, and disengaged.

**Shared power.** How power was negotiated in the therapeutic relationship was also critical to participants’ experiences of their work with therapists. Most participants valued a treatment process that felt like a joint venture, in which therapist and client were partners in an effort to understand the client and improve her life. By contrast, some participants spoke negatively of experiences in which the therapist identified as the expert in the relationship and operated from a perspective that he or she “knew what was best” for the client, particularly in the context of making diagnoses and/or encouraging the use of medication. When therapists were quick to diagnose, did not take the time to get to know the client within her context, failed to consider the personal, social, and political aspects of the client’s distress or the implications of certain diagnostic labels, or pushed medication as the first line treatment, clients felt diminished and disconnected, which led them to be more likely to disengage from treatment altogether. By contrast, when therapists approached assessment as a shared endeavor, participants in the present study found the process helpful and affirming.
Treatment outcome studies have illustrated a strong link between collaborative therapeutic approaches and positive treatment outcomes (e.g., Norcross, 2002). While it is perhaps fair to suggest that individuals across all economic groups would not want to feel controlled or disempowered within the therapeutic context, low-income women often enter treatment with the added burden of stigma, humiliation at the hands of service providers, and general feelings of powerlessness within day-to-day interactions. As a result, low-income women may be especially attuned to power dynamics and especially sensitive to therapists’ attempts to exert authority, power, and expertise in the relationship. In the face of high rates of attrition for low-income women in treatment (Falconnier, 2009; Garfield, 1994; Wierzbicki & Pekarik, 1993) the present study suggests that a careful navigation of power dynamics and a generally collaborative approach to therapy may be particularly vital to treatment engagement for this population.

**Authenticity.** All participants also underscored the power of the therapist’s willingness to reveal herself in some way – in other words, to be authentic. Therapist authenticity could take many forms: all participants pointed to the importance of small personal gestures demonstrating care and concern -- a compliment, a hug, or helping a mother put coats on her children after a session on a wintry evening. Some described moments in which their therapist expressed genuine emotion in response to something the participant had said or done in a session. Some simply appreciated therapists’ honest and direct communications, even when those communications were painful to hear. Participants wanted to be held accountable for their actions, and did not want their therapists to “sugar coat” what they had to say.
In addition, most participants described therapist self-disclosure as a form of authenticity that was important to them. The relational dynamic felt “less one-sided” when participants learned something about their therapist – such as that she too was a parent or had also struggled in her life. These kinds of self-disclosures served both to “level the playing field” in terms of power, and to reduce participants’ sense of stigma and isolation, particularly when therapists disclosed information about their own challenges. Notably, in the present study, participants did not find all forms of self-disclosure positive or even appropriate, as when the self-disclosure shifted the focus of the session onto the therapist. This unique finding speaks to the complex role that self-disclosures may play within the therapeutic relationship, and the importance of therapist discretion in how they are used. Overall, however, therapist authenticity helped participants feel less alone. Because so many of the women experienced profound isolation as a result of their poverty, their relationship with their therapist was often the closest, safest relationship they could identify in their lives.

**Inter-Relationships among Constructs**

Each of the three domains of therapy practice that participants highlighted – Awareness, Practices/Skills, and Relational Qualities – inform the others in an ongoing feedback loop, as indicated in Figure 1. A therapist’s awareness of the realities of living in poverty strongly informs the practices she uses. For example, a therapist who understands what it means to be worried about getting food on the table may spend time in the session helping her client access food stamps. She may approach the relationship with a heightened sensitivity to the disempowerment that comes from navigating public assistance programs, and may make special efforts to counter that disempowerment
through collaboration in identifying the nature of her client’s difficulties and strategies to address them. As she incorporates instrumental support into her therapy practice, the therapist may learn more about resources and supports for low-income individuals, as well as typical systemic barriers and pitfalls; these will serve to strengthen her awareness of the complex reality of living in poverty and teach her about how to effectively access resources to address her client’s poverty-related needs. As part of the process of engaging in instrumental support and advocacy, this therapist shows her client that she understands her needs and wants to help her address them. As the client begins to feel understood and respected, she may come to trust the therapist and the therapeutic process. The strong, trusting, and mutual relationship that emerges will serve to further expand the therapist’s awareness of the client’s lived experience, in particular, how isolating poverty can be and how important it is to have a therapist who “gets it.” Further, this trusting relationship can pave the way for the client to develop new insights and skills.

**Limitations**

Findings from the present study should be interpreted in light of several limitations. First, although we chose to use a qualitative descriptive methodology in order to develop a rich, nuanced description of low-income women’s experience this methodology also limited the generalizability of the findings. The experiences of ten women cannot represent those of low-income women generally. Second, it is important to note that we interviewed women who had chosen to stick with therapy, at least beyond the first session, despite having had some bad experiences in the past or even with their current therapist. We still know little about the perspectives of low-income clients who do not feel that therapy can be effective. Third, although the sample was relatively
diverse in terms of age, race/ethnicity, parental status, and diagnostic profile, it was limited on a number of demographic dimensions: it was entirely English-speaking - so results may not shed light on the experience of immigrants and others for whom language is a formidable barrier to accessing therapy to begin with, and it was relatively well-educated – possibly because low-income women with higher levels of education may have been more interested in participating in the study, though it is unclear if this is the case. Regardless, it is important to consider that the experience of higher education for many of the participants may have influenced their insights on this topic. Future research should expand to a group of low-income women with a broader range of educational experiences. Fourth, this study did not include extensive analysis of the role of all the dimensions of identity that interact with social class, including race, age, sexual orientation, and ability status; nor did it analyze the impact of shared (or unshared) elements of identity between therapist and client. These dimensions of intersectionality and shared/unshared identity, respectively, may have had great salience to how participants experience the therapeutic relationship and point the way to important directions for future study. Finally, it is possible that women with negative or traumatic experiences chose not to participate in this study so that results are skewed towards women who found meaning in their experience.

Despite these limitations, however, we believe that these findings suggest new ways of thinking about how therapy looks and feels from the perspective of low-income women and how it can be made more relevant and useful to this population. Perhaps most striking are the similarities between our results and those of the only other qualitative study of low-income clients that we know about (Thompson et al., 2012).
Despite differences in our samples across gender (only women vs. men and women), and geographical region (the Northeast vs. the Midwest), and our use of different qualitative methodologies (qualitative description vs. grounded theory), the findings from the two studies bear remarkable resemblance. In general, both studies underscored the importance of bringing poverty-related issues into the therapeutic dialogue, offering both instrumental and emotional support, and providing a therapeutic relationship characterized by therapist authenticity, warmth, and genuine care for her clients as human beings. Together, these two studies lay a solid groundwork for new ways of thinking about the therapeutic encounter. In the next section, findings from the present study are considered within the context of feminist theory, and the study’s broader implications for scholarship, practice, and training are explored at greater length.

**Implications for Feminist Therapy Scholarship, Practice, Training, and Research**

This section describes key implications of this study for feminist scholarship, mental health practice with low-income women, the training of practitioners, and research respectively.

**Implications for feminist therapy scholarship.** A core principle of feminist theory is that the therapist’s deep awareness and understanding of her client’s social context is a vital building block for a growth-fostering and empowering relationship (e.g., Comas-Diaz, 1987, 1988; Comstock et al., 2008). This study provides strong evidence for this claim, demonstrating that for therapists to establish a solid therapeutic alliance with their low-income clients, they must create a relational space in which the internal and external can both be recognized and understood as highly connected dimensions of clients’ lives. This means not only understanding what each individual client is
struggling with in her life, but also developing a more general awareness of how both the material deprivation and the discrimination, exploitation, and social exclusion of poverty shapes peoples’ conception of themselves and the world around them.

Scholars of feminist therapy also contend that in order to be transformative, therapeutic practices must extend beyond a narrow focus on symptom reduction and intrapsychic processes to advocate for the dismantling of oppressive social systems (Birrell & Freyd, 2006). Often in these discussions, feminist theorists are referring to advocacy at “cause-level,” which means at the macro-level. Increasingly, however, social justice oriented counseling and feminist psychologists are pushing for a more formalized recognition of advocacy at the “case-level,” or at the level of the individual (Lens & Gibelman, 2000; Toporek & Liu, 2001). Participants in this study provide concrete support for this emphasis, speaking with great appreciation for therapist advocacy in helping them gain access to resources, navigate systems, or represent their needs and rights. While traditional psychotherapy models might deem these actions to be outside of the recommended therapeutic frame or “distracting” from the more salient focus on intrapsychic processes, participants in this study described the deeply meaningful moments when their therapists recognized the complex intersection of their emotional needs and their practical needs, and tailored their interventions accordingly.

Finally, resonant with the feminist notion of mutuality in the psychotherapeutic relationship, participants in this study emphasized the benefits of therapist transparency and collaboration. In contrast to traditional ideas about boundaries between therapist and client, which hold that the therapist must stay emotionally neutral and avoid self-disclosure, feminist scholars Miller and Stiver (1997) describe mutuality as “a way of
relating… in which each (or all) of the people involved are participating as fully as possible” (p. 43). A collaborative spirit exemplified by transparency and vulnerability on the part of the therapist, they claim, can help clients feel empowered and valued as human beings (Brown, 2009; Jordan, 2000; Wachtel, 1993). Indeed, participants in this study explained that when therapists brought into the therapy relationship aspects of their own lives, or made a special effort to share power in the relationship, participants felt that they “mattered,” a relational experience that is at the core of psychological growth and healing from a feminist perspective. The sense of “mattering” was a newfound experience for some participants, who may have become used to the highly impersonal and distancing relationships they had with institutional gatekeepers, and even friends and family. Indeed, most participants spoke of the profound isolation they experienced due to a dearth of intimate relationships where they felt unconditionally valued. It is not surprising that a therapist’s ability to provide some sort of counterweight to these experiences would be deeply meaningful; some participants even described their therapist as feeling more like a true friend or family member than those that already existed in their lives.

**Implications for general practice.** As the mental health field moves towards the use of manualized treatments as the benchmark of best practice, it is worth considering how these findings -- including the importance to low-income clients of therapist awareness of context, provision of instrumental support, and adoption of a collaborative, transparent approach -- fit or fail to fit with this trajectory.

Although participants in our study took exception to a perceived “textbook” or “cookie cutter” approach by therapists, many manualized treatments dictate therapy
practices that appear to be just that. Treatment is consolidated into 10-15 sessions, with a specific protocol identified for each particular session. While proponents of the use of manualized treatments argue that a strength of these treatments has to do with the uniformity of their delivery and “less reliance on intuitive clinical judgment,” (Wilson, 2007, p. 105) findings from the present study strongly suggest that theoretical orientations and treatment interventions are not necessarily “one size fits all.” To effectively meet the unique needs of low-income women, manualized treatments may have to be applied with considerable flexibility.

At the very least, a flexible application of manualized treatments would involve a high degree of collaboration between therapist and client about the course of treatment. This would include an openness on the part of the therapist to deviate from the protocol spelled out within a particular manual should a client identify a different need or goal that feels more pressing or relevant to focus on within a given session. For example, the manual for Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2008), an evidence-based practice for the treatment of PTSD, identifies a series of 12 sessions that include psychoeducation, in-session activities, and homework assignments to facilitate a cognitively-based processing of the trauma. Client behaviors such as failing to complete the homework, missing sessions, and/or shifting the focus of the session off of the task at hand are often viewed as “avoidance” of processing the trauma and are considered to be interfering with the treatment process.

However, a woman who is struggling to work two jobs and put food on the table may not practically have the time or energy to complete homework assignments according to the identified timetable, and/or may enter a session wishing to focus on her
difficulties obtaining survival-based resources. The need to process her trauma may feel secondary to making sure her children have something to eat for dinner. A therapist flexibly applying this treatment would thus consider how the contextual issues at play impact the needs of her client both in and outside of the therapy office, and would collaborate with the client in identifying what particular treatment interventions would be most helpful in “meeting the client where she is at.” This might require stepping back from the manual for the time being, or integrating aspects of the treatment with practical support. Practical support in treatment would not be seen as detracting from the focus of treatment, but rather enhancing the work by addressing the whole client.

Beyond the challenge of manualized treatment is the issue of navigating boundaries. The treatment interventions that may best suit the needs of low-income women may require the therapist to step outside the traditional boundaries of the therapist role and or even outside the traditional therapy setting. A session that takes place on the way to the food pantry, over the phone, or alongside a client in court may position a therapist within multiple relationships that can indeed complicate the therapeutic process. However, as the findings from our study indicate, these multiple relationships, when negotiated thoughtfully, can significantly enhance low-income women’s connection with their therapist, perceived utility of therapy, and overall level of engagement. We thus echo the sentiments of feminist scholars who argue that boundary crossings are not synonymous with boundary violations; as long as they are done with careful attention to issues of power and privilege, and an overall commitment to the best interest of the client, actions that take the therapist outside of the traditional therapeutic frame may be
clinically indicated (Brown, 1994; Goodman et al., 2007; Goodman et al., 2010; Weintraub & Goodman, 2010).

Recommendations for changes to the practice of psychotherapy cannot be offered without attention to the large-scale policy changes that would make these changes possible. Our current service delivery model tends to offer specific services within separate siloes; for example, practices described as “instrumental support” are typically performed by case managers who work in a range of types of state agencies or community clinics just as practices called “emotional support” are performed by therapists in those same agencies or in other locations. This kind of fragmentation of services compels a parallel fragmentation of experience on the part of the client, who is implicitly asked to treat the “internal” and “external” challenges in her life as separate entities (Smyth et al., 2010). To address both of these domains of experience low-income women must accommodate additional appointments and bureaucracy, which is a tall order given the myriad stressors with which they already contend day to day.

Findings from the present study support prior research indicating that integration of both instrumental and emotional support is not only deeply appreciated, it is also associated with higher levels of treatment engagement and positive therapeutic outcomes (Grote et al., 2009; Miranda, Chung, et al., 2003; Miranda, Azocar, et al., 2003; Thompson et al., 2012. However, the current funding structure for mental health services tends to discourage practitioners from integrating instrumental support into their work. Insurance reimbursement for collaborating with outside providers is limited at best, and advocacy practices performed by therapists are often non-reimbursable. Large-scale policy changes that broaden the scope of the therapist’s role and fund this expanded role
are necessary for low-income women to receive the care that they feel is most effective. Further, there is evidence that a more integrated approach to mental health treatment is actually more cost-effective in the long run (e.g., Simon et al., 2001; Stewart et al., 2003).

**Implications for training.** None of the treatment recommendations we make here can be accomplished without training to increase what has been termed “class competence” (Goodman et al., 2013). Along with a growing number of scholars (for example, see Smith, 2009; Stabb & Reimers, 2013), we strongly recommend that mental health training programs enhance their training models to include a focus on strengthening trainees’ knowledge and awareness of the complex intersection of poverty and mental health (APA, 2000, 2008; Lewis, Arnold, House, & Toporek, 2003). Unfortunately, many practitioners report that they do not feel adequately trained to effectively work with low-income clients (e.g., Smith, Li, Dykema, Hamlet, & Shellman, 2013). As a field, if we do not enhance therapists’ understanding of the experiences and needs of low-income clients, we risk repeating the mistakes of our predecessors, thereby perpetuating the trend of poor treatment engagement for low-income clients.

A critical first step in cultivating awareness of poverty and its impact is for practitioners to examine their own beliefs, biases, and assumptions about the social location of their clients (Goodman et al., in press). Discussion within the multicultural literature has been instrumental in pointing to techniques and strategies by which those in the mental health field can engage in self-examination with regards to issues of race and culture (e.g., Helms & Cook, 1999; Sue & Sue, 2007). However, findings from the present study support the assertion that this degree of therapist reflexivity must also extend to encompass issues of class and economic status (e.g., Lewis, 2010; Smith et al.,
Low-Income Women and Therapy

2008; Weintraub & Goodman, 2010). Self-reflection that includes exploration of class-based privilege and oppression can bring biases and assumptions to the fore, increasing therapists’ capacity to perceive and understand the subtle ways that oppression may emerge or be re-enacted within the relationship (Goodman, Liang et al., in press).

For example, a therapist’s level of self-awareness would drastically impact how she would approach the issue of a low-income client’s repeated cancellations or no-shows to sessions. A therapist who has not done much self-examination in this regard might find herself questioning the client’s investment in treatment, or the client’s capacity to benefit from treatment. The therapist might even feel resentful that someone seemingly so in need of help would reject the very help being offered.

But self-examination on the part of that therapist would involve going beyond her first response to explore more deeply why she is feeling so resentful. She might realize that perhaps her view of the client’s attendance issue is being shaped by the stereotype of low-income individuals as “lazy” or “complacent.” Perhaps, she might realize, her frustration towards her client actually parallels frustration she has towards herself, for feeling overwhelmed or ineffective in helping her client. Regardless, the therapist’s self-knowledge in this instance would be critical to informing the steps she takes to address the issue; instead of bringing frustration and annoyance into the room, she may bring a curiosity and concern about what is hindering treatment involvement; instead of suggesting transfer or termination, she may work collaboratively with the client to find ways to make treatment more accessible.

Trainees will also require guidance on how to integrate instrumental and emotional support, and how to manage complicated boundary issues that may arise in
working with multi-stressed clients. This recommendation does not mean foregoing training on longstanding foundational principles and techniques of diagnosis and treatment - essential building blocks for any practitioner who plans to work within our current mental health system. Rather, it calls for those in training positions to engage in critical analysis with students about how these principles and techniques can be modified or enhanced to better meet the needs of underserved clients. Participants in the current study have offered concrete examples of how to do just that and could continue to be valuable teachers in classrooms as well as therapy offices and research studies.

Finally, trainees will need support to practice the relational style advocated by participants in this study. This will require guidance from faculty and supervisors as to how to re-think the traditional relational framework and make room for a greater use of therapist transparency and creative thinking about therapist boundaries in situations where a part of the therapist’s role is to provide advocacy. The training environment will need to be a safe atmosphere to explore these difficult issues. Scholarly readings, case studies, and modeling by instructors – not just through instructor anecdotes, but also through their interactions with trainees – will help to enhance this particular learning process.

Changes to the structure and content of academics and fieldwork will be required to enable poverty-competent training. Trainees should, for example, be afforded opportunities to work directly with low-income populations to increase their knowledge and experience with this group. Willie et al. (2009) found that the amount of time clinicians had worked with people in poverty was positively correlated their level of comfort in continued work with this population. Also, when it comes to presentations in
course or supervision settings or determining what is to be “counted” in terms of programmatic or licensure requirements, time that trainees spend offering instrumental support (advocacy) should be given as much weight as time spent engaging in a more traditional therapy approach. Finally, faculty will need to model the very competencies they are encouraging their students to develop (Stabb & Reimers, 2013). Those who teach developing clinicians must themselves become well-versed in individual, community, and systemic-level issues associated with poverty and then bring this multilayered approach to classroom instruction and field work.

**Implications for research.** A number of rich directions for future research emerge from these findings. First, although this study illuminated a diverse group of low-income women’s experiences, it did not explore the ways that multiple aspects of identity intersect with class to shape the therapeutic experience. Different subgroups of low-income women may have unique needs, goals, and expectations that warrant further study. For example, how do the experiences of low-income mothers in treatment differ from those who do not assume a caregiving role? How might one’s ethnic identity contribute to how she understands the meaning and purpose of therapy? What are the differences in therapeutic needs and experiences across low-income women with different mental health diagnoses? What about rural or non-English speaking women? What about the experiences of men?

In addition to exploring differences in low-income women’s experience by social location and identity, it is also critical to understand differences according to therapist training, characteristics, and orientations. Such an exploration would provide invaluable information on “what it takes” for therapists to develop the competencies that participants
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deemed helpful. Do certain types of training or theoretical models lend themselves better to therapy with low-income women? What do therapists working with low-income women identify as their needs, strengths, challenges, and gaps in training?

In addition to exploring participant and therapist factors supporting meaningful therapy, it is also important to investigate the extent to which such therapy improves outcomes for low-income women. Such efforts are underway but it is our hope that the nuanced findings provided here can translate into more sensitive interventions that can then be evaluated for effectiveness.

Finally, the results of the current study lend further support to ongoing efforts to explore the experience and mental health impact of poverty. As participants in this study made abundantly clear, only by understanding what our clients struggle with can we effectively address it.

Conclusion

The present study contributes to the literature on poverty and mental health by highlighting “what works” in outpatient psychotherapy with low-income women, through the eyes of the women themselves. Given the high rates of mental illness (Brown & Moran, 1997; James et al., 2003; Miranda & Green, 1999; Siefert et al., 2000; Vest, Catlin, Chen, & Brownson, 2002; Vogel & Marshall, 2001), and low rates of treatment engagement for women in poverty (Falconnier, 2009; Garfield, 1994; Wierzbicki & Pekarik, 1993), gaining insight in to what components of therapy make it helpful, relevant, and worthwhile to stick with is an important step in reducing the extant mental health disparities between women in different economic groups.
The findings demonstrated specific components of effective therapy comprising three main themes: Awareness, Practices, and Relational Qualities. Together, these themes point to the need for therapists to increase their understanding of the realities of living in poverty and thereby align the content and structure of treatment to fit with the complex needs of their clients. As Laura Smith (2010) writes:

Mental health professionals….should modify their practices to fit the needs and social locations of their clients, rather than expecting their clients to either make use of conventional interventions or not be served (p. 108).

Low-income women can and will engage in mental health treatment, when that therapy truly fits their needs as they see them. To ensure that fit, mental health providers need to engage in their own process, both to understand themselves in relation to poverty and to understand the nature of poverty itself. The present study provides scaffolding for competent poverty training and practice that moves beyond the confines of traditional approaches. It is our hope that findings such as these can ultimately translate in to both small- and large-scale transformation within the mental health field, and in turn, narrow the gap in emotional well-being between those who struggle with poverty and those who are lucky enough not to.
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Appendix A: Recruitment Flyer

Do you struggle to make ends meet?

Have you seen a mental health counselor or psychotherapist within the past three years?

You may be eligible to participate in a study exploring low-income women’s experiences with counseling/psychotherapy.

General Requirements for Participation:

- Female, over the age of 18
- English-speaking
- Have struggled to make ends meet
- Have taken part in counseling and/or psychotherapy

If you meet these requirements, we would like to discuss the possibility of interviewing you at a mutually convenient location.

**Interviews will take 60-90 minutes and you will receive a $25 gift card to thank you for participation.**

If you have any questions, or are interested in participating, please contact Meghan Pugach at (617) 552-4006. Feel free to leave a private message at that number and she will get back to you.

**Thank you for your consideration. Please pass this invitation to other women who may be interested in participating.**
Appendix B: Screening Questionnaire

Thank you for your interest in participating in this study. I want to ask you a few questions to make sure that you are eligible for participation. I really appreciate your taking the time to answer these. Please note that all information will remain confidential and no individual or identifying information will be reported.

1. What is your age?
2. What is your highest education level?
3. Are you currently a student?
   a. If so, are you full-time or part-time?
4. Are you working right now?
   a. If so, where?
   b. How many hours do you work, on average, per week?
5. What is your race/ethnicity?
6. What is your living situation?
   a. (circle) Homeless/housed?
   b. Who do you live with? What is their relationship to you? How old are they?
      i. (circle) Single/married/divorced/widowed/living with a partner
      ii. (circle) Parent/guardian/caring for someone in your household
         i. If you are a parent/guardian/caretaker, how old are the individuals for which you are a
            parent/guardian/caretaker?
7. Do you receive any forms of public assistance, such as: Section 8, TANF, WIC, etc.?

*List sources:*

8. From all sources, what is your family’s yearly income?

   a. *If reported income is below threshold (see chart below):* How long has your income been at this level, or, approximately below [insert poverty threshold]?  

### Poverty Thresholds 2009

<table>
<thead>
<tr>
<th>Size of family unit</th>
<th>Weighted Average Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Related Children Under 18 Years</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>1 person</td>
<td>10,956</td>
</tr>
<tr>
<td>…Under 65 years</td>
<td>11,161</td>
</tr>
<tr>
<td>…65 years and older</td>
<td>10,289</td>
</tr>
<tr>
<td>2 people</td>
<td>13,991</td>
</tr>
<tr>
<td>…householder</td>
<td>14,439</td>
</tr>
</tbody>
</table>
9. Have you participated in outpatient mental health counseling or psychotherapy within the past three years? This is defined as: mental health treatment focused on improving functioning, reducing emotional distress, and/or alleviating psychological symptoms that occurs within regularly scheduled visits with a trained psychotherapist within a clinic or office setting.

<table>
<thead>
<tr>
<th>under 65 years</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>...householder</td>
<td>12,982</td>
<td>12,968</td>
<td>14,731</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 years and over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 people</td>
<td>17,098</td>
<td>16,781</td>
<td>17,268</td>
<td>17,285</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 people</td>
<td>21,954</td>
<td>22,128</td>
<td>22,490</td>
<td>21,756</td>
<td>21,832</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 people</td>
<td>25,991</td>
<td>26,686</td>
<td>27,074</td>
<td>26,245</td>
<td>25,603</td>
<td>25,211</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 people</td>
<td>29,405</td>
<td>30,693</td>
<td>30,815</td>
<td>30,180</td>
<td>29,571</td>
<td>28,666</td>
<td>28,130</td>
<td></td>
</tr>
<tr>
<td>7 people</td>
<td>33,372</td>
<td>35,316</td>
<td>35,537</td>
<td>34,777</td>
<td>34,247</td>
<td>33,260</td>
<td>32,108</td>
<td>30,845</td>
</tr>
<tr>
<td>8 people</td>
<td>37,252</td>
<td>39,498</td>
<td>39,847</td>
<td>39,130</td>
<td>38,501</td>
<td>37,610</td>
<td>36,478</td>
<td>35,300</td>
</tr>
<tr>
<td>9 people or more</td>
<td>44,366</td>
<td>47,514</td>
<td>47,744</td>
<td>47,109</td>
<td>46,576</td>
<td>45,701</td>
<td>44,497</td>
<td>43,408</td>
</tr>
</tbody>
</table>

Source: 2009 U.S. Census
If the individual has engaged in outpatient psychotherapy within the past three years, or is currently engaging in outpatient psychotherapy:

a. Was your participation in psychotherapy voluntary, or court-mandated?

b. Different organizations have different policies about starting outpatient psychotherapy. When you began outpatient psychotherapy, did you, to your knowledge, participate in an intake session or sessions? These may have taken place with a different clinician, and/or consisted of answering a lot of questions, verbally or written. An intake session or sessions may have seemed very different from the rest of your therapy sessions.

i. If you participated in an intake session or sessions, how many therapy sessions did you attend after that session/those sessions were completed?

Thank you for your time. I’d love for you to participate in this study. Shall we set up a meeting now at a time and place that is convenient for you? Also, if we arrange a time to meet, may I call you before this takes place to confirm the day and time for the meeting?

OR: I’m really sorry that you are not eligible for participation in this study. I very much appreciate your time.
Appendix C: 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 “Low-Income Women’s Experiences in Outpatient Psychotherapy: A Qualitative Descriptive Analysis”

Investigators: Meghan Pugach, LMHC and Lisa Goodman, Ph.D.

Introduction

- You are being asked to participate in a research study exploring low-income women’s experiences with outpatient psychotherapy.
- You were selected as a possible participant because of your income level and your participation in outpatient psychotherapy, either in the past or at present.
- 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 how low-income women experience outpatient psychotherapy, to shed light on what dimensions of this form of psychotherapy might be most and least effective for low-income women, and in turn, contribute to improvements in mental health services.
- The total number of participants is expected to be between 10 and 12.

Description of the Study Procedures:

- If you agree to be in this study, I would like to interview you to ask you what it was like to participate in outpatient psychotherapy, and how your experiences may have
affected you and your view of psychotherapy. During the interview, I will ask questions about things such as your relationship with your therapist, your hopes and expectations for therapy, things that went well or went poorly within psychotherapy, and recommendations to researchers and providers. The interview should take about 60 to 90 minutes and will be audiotaped. Interviews will take place at a location that is easiest for you, such as in your home or another quiet place near your home. 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:

- Identifiable risks may include experiencing strong emotional reactions in response to discussing issues of poverty and mental health treatment. However, there may be unknown risks also associated with participating in this study. If you became emotionally distraught during your involvement in the interview, with your permission, I will help you contact your therapist or would link you to alternative supports or resources to aid you in your distress.

Benefits of Being in the Study:

- 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.

Payments:

- You will be reimbursed with a $25 gift card for participating in the interview.

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 be used 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 and Meghan Pugach, LMHC). 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 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.

- 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, elder, or disabled individual 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.

**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 or with your current and/or past therapists.
- You are free to withdraw at any time, for whatever reason.

**Contacts and Questions:**

- The researchers conducting this study are Meghan Pugach, LMHC and Lisa Goodman, Ph.D. and. For questions or more information concerning this research you may contact Meghan Pugach at 574.850.0693.
- If you believe you may have suffered a research related injury, contact Dr. Lisa Goodman at 617.552.1725 who will give you further instructions. If you have any questions about your rights as a research subject, you may contact: Dr. Stephen Erickson, 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: (please check boxes below)

☐ 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 a copy of this form.

Signatures/Dates

Study Participant (Print Name): __________________________

Participant or Legal Representative Signature: __________________________ Date ________

Witness/Auditor (Signature): ________________________________ Date ________
Appendix D: Interview Questions

Thank you so much for your participation in this study. Before we begin, please let me know what name, other than your own, you would like for me to use to refer to you during the interview process. This name will be used to protect your privacy, and will be used in all transcribed and written materials that are generated from this interview. If you do not select a different name, I will select one for you.

Participant Pseudonym: ____________________________________________

After the interview has been completed, I would like to follow up with you by sending you a copy of the interview transcript and then maybe discussing it with you – in person or by phone. If you are comfortable with me sending the transcript to you, please let me know where I should send it and how I should follow-up.

Interview

Note: interview questions are provided in bold; all other questions are probes.

I will now be asking you some questions about you and your experiences with psychotherapy. I am especially interested in two things: First: how your economic struggles may have related to whatever brought you into therapy; and second: how those economic struggles were framed and handled by you and by your therapist. Remember, you do not have to respond to any questions that you do not want to.

A lot of people have trouble making ends meet. When you have troubles making ends meet, you may have a lot of other problems too, such as housing problems, childcare issues, transportation difficulties, and/or difficulties getting food on the table, for example. You may not struggle with any of these, but we are interested in general about how these types of things get addressed in psychotherapy. Some people call these things poverty-related stressors, survival issues, or day-to-day challenges. What we are talking about are the things that stem from or follow from financial hardship. Does the term “poverty-related stressors” feel right for you if I were to use it within this interview? Or is there a term you would prefer?

Above, I listed examples of [poverty-related stressors or participants’ preferred term] that individuals may experience. Do you experience any of these? Are there any other stressors related to your financial hardships that ring a bell?
Now I’m going to be asking some questions about your experiences with outpatient psychotherapy. I will be using the term “psychotherapy” and “mental health treatment” interchangeably to mean mental health treatment focused on improving functioning, reducing emotional distress, and/or alleviating psychological symptoms that occurs within regularly scheduled visits with a trained psychotherapist within a clinic or office setting. Do you have any questions about this?

1. History of Psychotherapy Use

- Please give me a rough timeline of your past experiences with mental health treatment. If it would be helpful to you, feel free to use this piece of paper to draw out a timeline of who you worked with, when you worked together, where you worked together, etc.

- [If the participant has been in psychotherapy multiple times]: Tell me about which therapy was most meaningful to you within the past 3 years. Can you tell me the first name of the therapist, or provide a made-up name?

- What brought you in to mental health treatment? To the extent that you feel comfortable, please tell me about the difficulties that you faced at the time and how you ultimately decided to start psychotherapy.

- How did your [poverty-related stressors or alternative term] play a role in these difficulties?

2. Experiences with Psychotherapy

Now I’m going to ask you to tell me some stories that best get at your experience in that particular therapy.
Can you tell me a story about a time when therapy felt particularly helpful to you?

- Can you tell me about what was helpful?
- How did any of the poverty-related stressors or alternative term that you mentioned play a role in this experience?

Can you tell me a story about when therapy felt particularly unhelpful?

- Can you tell me about what was not helpful?
- How did any of the poverty-related stressors or alternative term that you mentioned play a role in this experience?

3. The Psychotherapy Relationship

Can you tell me a story/some stories that best get at your relationship with your therapist?

- How did you figure out what goals you wanted to work on?
- What made it easy to talk about what was on your mind?
- What made it hard to talk about what was on your mind?
- To what extent did you feel in charge of how the therapy session went?
• Can you tell me how your [poverty-related stressors or alternative term] played a part in your relationship?

• To what extent did you feel that your therapist knew about or understood the [poverty-related stressors or alternative term] that you were experiencing in your life?

• How did these issues come up in your therapy?

• How do you feel about the way that they were addressed?

• Tell me about a time when you might have felt “out of sync” with your therapist; perhaps you felt like you weren’t both on the same page in the session.

• In this instance, what did you want, or what were you looking for, that your therapist may not have been giving you?

  o What had you wished your therapist had done differently?
• To what extent did you feel like you mattered to your therapist?

• To what extent did you feel like you knew your therapist as a person?
  o To what extent would you have liked to have known your therapist?

• To what extent did you feel disempowered in the therapy relationship; maybe you felt as though your therapist held all the cards? Tell me a story that illustrates that.

• To what extent did you feel you had power within the therapy relationship; maybe you felt as though you and your therapist were equal partners? Tell me a story that illustrates that.

4. *Psychotherapy Outcomes:*

• To what extent do you feel your psychotherapy has improved your life? Can you tell me about how it has, and how it may not have?

• How has it, if at all, directly affected your [poverty-related issues or alternative term]?
  o To what extent has it affected your [poverty-related issues or alternative term] by giving you tools to deal with these challenges?
5. Final Questions

- What would you like for therapists, researchers, and/or policymakers to know about mental health services for low-income women?

- What was it like for you to participate in the interview today?

- Is there anything you would like to add, anything that I may have left out?
Appendix E: Sample Coding Table

<table>
<thead>
<tr>
<th>Name</th>
<th>Theme (Level 3: Cluster)</th>
<th>Level 2: Category</th>
<th>Level 1: In-Vivo Code</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny</td>
<td>Practices</td>
<td>Flexibility &amp; Instrumental Support</td>
<td>Flexibility surrounding poverty-related stressors is helpful</td>
<td>Participant appreciates that therapist will accommodate bringing children to the session if needed, and notes that not all therapists accommodate this need. With her I usually make [my session] while my daughter’s in school or when I don’t have class. And if my daughter don’t have school she, she said I could bring my daughter in with me. And she have like art supplies and coloring books so while I’m talking to her my daughter could be painting, or coloring, or reading a book. So my daughter could be occupied while I’m having session with her. It’s better cause not every therapist have that in their office. Either the child probably wouldn’t be able to come, or have to sit outside, or you have to reschedule.</td>
</tr>
<tr>
<td>Jessica</td>
<td>Awareness</td>
<td>Awareness of context of poverty</td>
<td>Therapist shows awareness of survival-based needs</td>
<td>Participant’s therapist fulfilled her goals of helping her to put things in their “proper perspective” and prioritize her goals (e.g., focusing on housing first, then disability, etc.) I came to put everything into its proper perspective. When I say that, he helped me to see what was the most important thing. At the time when I first started going to him I didn’t have a place to live so it was housing. Then housing and then, I got the housing and then I was working on disability, so money, having enough income coming in. Okay and then my son and then, you know he helps me to put everything in its proper perspective so he started me off with what was the most important and at the time I was really stressing because I was living at friends' houses and then at my Dad's house and it was just so draining.</td>
</tr>
<tr>
<td>Chiara</td>
<td>Relational Quality</td>
<td>Authenticity</td>
<td>Personal approach to therapy is helpful</td>
<td>Unlike a lot of participant’s previous therapists, her current therapist does not come off as textbook and instead comes across as a friend. Um, honestly her vibe. Her vibe is real like wel, welcoming. It’s real comfortable and you know, calm and collective, um, and she comes across, none textbook. Unlike a lot of therapy, uh therapists that I’ve had, um they come across very textbook. You know, um so she doesn’t seem, she doesn’t come across that way. Ya know, she comes across like if I was hanging out with a friend.</td>
</tr>
</tbody>
</table>


Appendix F: Sample Memo

<table>
<thead>
<tr>
<th>Quote</th>
<th>Memo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janelle: I was depressed. I was upset and I was angry. And the therapist I was seeing thought that I would hurt myself because I would say things like “I want to be with my mother. I don’t care how it’s possible. I want to be with my mother.” And when people hear you say that, I’m not saying I want to kill myself. I am conceited, I love myself so much. I would never want to look unattractive in a casket. That’s how I always looked at it; I wouldn’t do this to myself because I do have that conceit. I was like “I want to be with my mother. There is no way around it. I want to be with her.” And you’re taking it like I want to kill myself and I was like, that’s not what it is. It’s not what it is. If you’ve lost a parent you could understand what I’m saying. It’s not like, you know, it’s just not. It’s not like that. I felt like there was words being putting my mouth. I felt like they were, I felt like they didn’t truly know what it was to be depressed or to be sad. I feel like for anybody who has lost a parent, that’s how you feel…And to be shut away in a psych ward, to me that’s not helping a person. You’re making them feel caged. You’re locking them away with their thoughts.</td>
<td>There seems to be a recurring theme of therapists causing ruptures in the relationship (or inhibiting a relationship from developing in the first place) due to an overly legalistic approach – an emphasis on mandated reporting as opposed to understanding context. I’m thinking this may actually be a code that can stand on its own – I plan to explore this further as coding process continues, and re-think areas where it may have already come up and been coded differently.</td>
</tr>
</tbody>
</table>
## Appendix G: Table of Participant Characteristics

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race/ethnicity</th>
<th>Income</th>
<th>Public Assistance</th>
<th>Education</th>
<th>Living situation</th>
<th>Parent</th>
<th>Self-identified diagnosis</th>
<th>Total time in out-patient therapy</th>
<th>Total number of therapists</th>
<th>Length of time in target therapy</th>
<th>Degree of target therapists</th>
<th>Race/ethnicity &amp; gender of target therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>54</td>
<td>White</td>
<td>$15,840</td>
<td>SSDI, fuel assistance</td>
<td>college</td>
<td>housed</td>
<td>no</td>
<td>PTSD</td>
<td>7 years</td>
<td>3</td>
<td>3 years</td>
<td>social worker and psychologist</td>
<td>White/male</td>
</tr>
<tr>
<td>Victoria</td>
<td>46</td>
<td>African American</td>
<td>$10,000</td>
<td>SSI</td>
<td>10th grade</td>
<td>shelter</td>
<td>no</td>
<td>bipolar disorder, major depression, bereavement, substance abuse</td>
<td>9 years</td>
<td>1</td>
<td>9 years</td>
<td>unknown</td>
<td>White/female</td>
</tr>
<tr>
<td>Jessica</td>
<td>47</td>
<td>African American</td>
<td>$6,000</td>
<td>welfare, food stamps, cash</td>
<td>1 year college</td>
<td>shelter</td>
<td>yes</td>
<td>panic disorder and depression</td>
<td>1 year</td>
<td>1</td>
<td>1 year</td>
<td>psychologist</td>
<td>African American/male</td>
</tr>
<tr>
<td>Giselle</td>
<td>38</td>
<td>African American</td>
<td>$12,000</td>
<td>food stamps</td>
<td>Master’s degree</td>
<td>shelter</td>
<td>no</td>
<td>PTSD and depression</td>
<td>16 years “pretty regularly”</td>
<td>4</td>
<td>2.5 years</td>
<td>social worker</td>
<td>White/female</td>
</tr>
<tr>
<td>Janelle</td>
<td>25</td>
<td>Multiracial</td>
<td>$4,104</td>
<td>TAFDC</td>
<td>3.5 years college</td>
<td>homeless – staying with friends</td>
<td>yes</td>
<td>depression</td>
<td>20 years</td>
<td>1</td>
<td>20 years</td>
<td>psychologist</td>
<td>White/female</td>
</tr>
<tr>
<td>Jenny</td>
<td>28</td>
<td>African American</td>
<td>$15,000</td>
<td>TAFDC, food stamps</td>
<td>Associate’s degree</td>
<td>housed</td>
<td>yes</td>
<td>depression, “relationship challenges”</td>
<td>6 months</td>
<td>1</td>
<td>6 months</td>
<td>unknown</td>
<td>White/female</td>
</tr>
<tr>
<td>Chiara</td>
<td>28</td>
<td>African American</td>
<td>$18,000</td>
<td>WIC, TAFDC</td>
<td>10th grade</td>
<td>housed</td>
<td>yes</td>
<td>depression, anxiety, domestic violence</td>
<td>3 years</td>
<td>3</td>
<td>1 year</td>
<td>unknown</td>
<td>White/female</td>
</tr>
<tr>
<td>Lina</td>
<td>48</td>
<td>Latina</td>
<td>$17,285</td>
<td>subsidized apt, food stamps</td>
<td>4 years college</td>
<td>housed</td>
<td>yes</td>
<td>depression, substance abuse</td>
<td>25 years</td>
<td>2 significant therapists and “a bunch of trainees”</td>
<td>6 years</td>
<td>social worker and psychologist</td>
<td>White, Latina/female, female</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Race</td>
<td>Income</td>
<td>Benefits</td>
<td>Education</td>
<td>Household Status</td>
<td>Medical Conditions</td>
<td>Employment Status</td>
<td>Benefits End Date</td>
<td>Social Worker Type</td>
<td>Social Worker Gender</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yahoto</td>
<td>36</td>
<td>Multi-racial</td>
<td>$9,000</td>
<td>SSDI</td>
<td>no</td>
<td>OCD, Schizotypal Personality Disorder</td>
<td>20 years “on and off”</td>
<td>6 months</td>
<td>Social Worker</td>
<td>White/female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ginny</td>
<td>44</td>
<td>White</td>
<td>$20,000</td>
<td>Section 8, EBT, cash assistance</td>
<td>high school</td>
<td>tenuously housed, (son’s maternal grandmother’s)</td>
<td>Bereavement, ADHD</td>
<td>2 years</td>
<td>Social Worker</td>
<td>White/female</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>