"Is making someone a meal when they collapse on your floor from starvation, therapy? Well, I'd say, yeah, it is."

Counselling Psychologists experiences of adapting therapy with clients experiencing poverty: An Interpretative Phenomenological Analysis.

by

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in Counselling Psychology at London Metropolitan University

Supervised by Dr Raffaello Antonino

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Declaration

I hereby declare that the work submitted in this thesis is entirely the result of my own investigation, except where otherwise stated.

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Date: 28/01/22

"God, grant me the serenity to accept the things I cannot change,

courage to change the things I can,

and wisdom to know the difference." Reinhold Niebuhr (1892–1971).

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Abstract

Background: Roughly 14 million people (1 in 5) are estimated to live in poverty in the UK (JRF, 2017). Those in poverty are more likely to experience mental health problems compared to their wealthier counterparts (Collins et al., 2011). Researchers found that when therapy is tailored to be sensitive to poverty, focuses on economic stressors or when therapists are considerate of economic difficulties, it is more helpful.

Rationale: Research exploring the perspectives of individuals providing therapy for those in poverty is limited. However, previous work has shown that how UK Psychologists conceptualise the relationship between poverty and mental health impacts the therapeutic interventions used (Sams, 2008). The perspective of US psychologists revealed that significant therapeutic adaptions are often made (Borges, 2014). In comparison, data indicates that UK psychotherapists also make adaptations, yet these are less extreme than in the US (Ballo, 2020). With poverty in the UK set to increase (Belfield et al., 2017), there is a need to provide appropriate interventions, especially as Counselling Psychologists often work in organisations/ sectors providing therapy to those in poverty (DCoP, 2018; Rethink Mental Illness, 2020). CoP's commitment to social justice and diversity leads to Counselling Psychologists being well positioned to devise effective interventions (Eleftheriadou, 2010, Cooper, 2009). However, the perspectives of UK Counselling Psychologists are almost completely absent. Therefore, this research aims to investigate how Counselling Psychologists tailor therapy to facilitate therapeutic work with those in poverty.

Methodology and main findings: Interpretative phenomenological analysis (IPA) was used for the current research. Six semi-structured interviews were conducted with Counselling Psychologists working with those experiencing poverty. Three

superordinate themes emerged from the analysis: Awareness of the relationship between poverty and mental health, Resources that are drawn upon, and Adapting practice in the light of economic differentials.

Conclusions and implications: This study highlighted that traditional and/or manualised ways of delivering therapy to those experiencing poverty may not be helpful or appropriate for this population. The present findings highlight the importance of flexibility within therapeutic work. A significant finding to emerge was that the more extreme the experience of poverty was for the client, the more extreme the therapeutic boundary adaptation. The discussion describes these findings in relation to the wider literature and explores implications for Counselling Psychology Training, Practice and the Wider Community.

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Part 1: Introduction:

1.1 Introduction

This literature review begins with my reflexive statement, looking at biases that may influence the review process while describing ways I have attempted to address this. The concept of poverty is introduced detailing potential difficulties associated with its understanding before providing the UK government's definition. Prevalence statistics are presented. This sets the background before further evaluating the link between poverty and mental health.

Types of mental health difficulties faced by those experiencing poverty will be presented, then evaluated by discussing ways these relationships have been understood theoretically. This is followed by an attempt to explain these relationships by identifying possible mechanisms that may reduce a person' mental well-being. Barriers to therapy that may be faced by people experiencing poverty will then be detailed. Potential incompatibilities between Cognitive Behavioural protocol driven therapy and people experiencing poverty will be discussed before presenting research highlighting adapted therapy for those experiencing poverty is effective.

The Critical Literature Review (CLR) then shifts focus regarding potential influences on Counselling Psychologists work with people living below the poverty line, such as training, attitudes, personal beliefs and social background. Culturally specific therapeutic adaptations will be examined before looking at poverty related therapeutic adaptations. Finally, two specific papers will be presented and critiqued. The first paper focuses on psychologists understanding of the relationship between poverty and mental health and the second is a study on how US psychologists work with those experiencing poverty. Finally, a rationale that guides this study is

provided by highlighting gaps in the literature. Relevance to Counselling Psychology will be provided, before proposing the research question.

1.2 Reflexive statement

Every researcher contributes to meaning during the research process and must acknowledge that it is unfeasible to reman 'outside of' the subject matter (Nightingale & Cromby, 1999, p. 228). Nightingale and Cromby suggest that reflexivity urges the researcher to consider the manner in which their own *"involvement with a particular study influences, acts upon and informs such research"* (Nightingale & Cromby, 1999, p. 228). It is essential to provide a reflective account of my position within this research to reduce potential biases, beliefs, and assumptions that may affect this process. (Strawbridge & Woolfe, 2010). Providing this level of transparency enables readers to interpret how I, the writer, may have influenced this process. This has been suggested to not only increase validity, but also adds to the rigor and trustworthiness of the research (Etherington, 2004; Morrow, 2007; See section 3.4 Qualitative trustworthiness and rigour).

Finlay (2002) states that what drives research is our interest in it. It therefore seems important to disclose what has drawn me towards this subject area. Most specifically my first-hand experiences of poverty, but also delivering therapy to those experiencing poverty as a trainee Counselling Psychologist.

I have experienced homelessness and spent several years entirely reliant on benefits as a single mother. These experiences have influenced my practice as a trainee Counselling Psychologist, as I listen for when clients are talking about their own issues with poverty. For example, in every assessment I always ask if clients are under any financial pressure and whether they have secure housing. It is also common for me to use advocacy within my therapeutic work such as making phone calls or writing letters. These experiences have ultimately instilled in me the importance of social

justice, which is well suited to the ethos of Counselling Psychology. While Inter-subjectivity can enrich research, acknowledging my personal involvement, is part of researching ethically (Finlay, 2002; Willig, 2012).

I have recognised that social justice advocacy is an important part of my identity, and I am emotionally involved with this topic. This may lead to assumptions, not solely the positive implications I have asserted above. Therefore, without reflexivity, my preconceptions could potentially bias this research.

My main assumption is that economic inequalities are an unacknowledged phenomenon within the therapeutic relationship and rarely worked with. This assumption has arisen from personal experiences of this topic being rarely discussed amongst colleagues and within my own personal therapy. This assumption could affect the literature review process in multiple ways. I may be drawn towards material which resonates with my own material or confirms these preconceptions. There is a possibility that this means I am more drawn to articles stipulating the need for poverty related contextual factors to be acknowledged. This may highlight my 'agenda' to prove the above, resulting in providing a one sided and unbalanced literature review. This could also mean that I could miss literature which provides alternative perspectives. I have attempted to limit the potential for biases and assumptions to affect the literature review process in two ways. Firstly, by approaching topics within the literature and asking myself 'is there another way of looking at this?' and searching alternative viewpoints. Secondly, by asking colleagues/ supervisors to read through drafts and provide feedback on the perceived balance of the review. This process has been suggested to aid reflexivity (Munhall, 2007).

My commitment to social justice is interwoven with my belief that those experiencing poverty are marginalised within society; this evokes sadness in me. This bias to defend those experiencing poverty could have a multitude of implications other than leading the direction of my literature

review. For example, I need to be aware that projecting my own material is assuming that my experiences are similar to anyone who has experienced poverty. There is a danger that this could lead to positioning Counselling Psychologists as the rescuers and those experiencing poverty as noble victims. This dichotomous thinking may disregard their strength and potential and may perpetuate negative stereotypes associated with poverty.

Therefore, it is vital that I closely monitor my feelings throughout the research process. In seeking to avoid such bias I have attempted to 'bracket' (Smith, Flowers & Larkin, 2009) these thoughts by reflecting on my changing worldview and social class positioning throughout my training. While I share cultural norms, values or mannerisms that indicate I am from a working-class background I no longer experience poverty; I am also afforded many middle-class privileges such as my education.

This experiential learning has forced me to take heed of my ontological position and has accentuated my belief that I have adopted a truly phenomenological stance within my worldview and interactions with others. Thus, I believe the experience of poverty is unique to the individual and deeply complex. Despite being able to reflect on this, I believe choosing to focus on a psychologist's perspective as opposed to clients experiencing poverty has prevented me from becoming too emotionally entangled with the research topic which Kasket (2012) suggests can taint the research. This is because the privilege I have acquired as a doctoral student is a relatively new aspect of my identity, allowing me some psychological distance from previous views of myself. Keeping a reflexive diary has also provided me with some distancing. Personal therapy has given me a place to gain perspective, while supervision has provided me with encouragement and constructive feedback.

Part 2. Critical Literature Review

2.1 Poverty

This literature review begins by introducing the concept of poverty. Firstly, by describing potential difficulties associated with understanding the concept of poverty before explaining how the UK government defines and measures two indicators of poverty: relative and absolute poverty. This will then be expanded on introducing the reader to key terms that will be used throughout the thesis and providing a rationale for this. Thereafter, the section presents prevalence statistics of poverty in the UK, while identifying population groups most affected by poverty. This initial discussion sets a background for further evaluation of the link between poverty and mental health.

2.1.2 Difficulties conceptualising poverty

Before providing the UK government's (2017) definition of poverty, it seems necessary to highlight varied ways poverty is used by researchers. The use of varied definitions is argued to be one of the leading problems in understanding poverty (Liu, 2004). Some definitions of poverty are used synonymously with phrases such as social exclusion (Morgan et al., 2007) and some have terminological overlaps with socio-economic concepts such as social class (Smith et al., 2013). This confusion is evident in a review of CoP literature which highlighted over 400 different terms were used to describe 'social class', such as 'poverty', 'economic disadvantage' and 'economic deprivation.' (Lui et al., 2004). The lack of methodological and theoretical clarity perpetuates this confusion. To make sense of this confusion, the UK Government's definition of poverty will be adopted, which is examined in the next section.

2.1.3 Defining poverty in the UK

The UK government (2017) defines and measures poverty in terms of relative and absolute poverty. Relative poverty is the minimum income needed for an individual to maintain an average standard of living in a particular country (Hagenaars, 2014). To establish whether individuals are living in relative poverty, the UK government considers its population's median income, which is calculated based on a midpoint that divides the distribution of income into two equal groups, where one half of people have an income that is above this midpoint, and where the other half has an income that is below this midpoint (Stewart, 2017). The UK government then calculates 60% of this median income and concludes that relative poverty occurs among individuals who earn less than this amount (Clark, 2017). According to Joseph Rowntree Foundation, (2017) that is a weekly income of £144 for single individuals, £248 for couples without children, £297 for single parents with children, and £401 for couples with children.

In contrast, absolute poverty is defined as not having an income sufficient for maintaining basic standards of living, including access to food, shelter, and clothing (Hagenaars, 2014). According to Chen and Ravallion (2017), there are four indictors of absolute poverty, which relate to living standards, financial security, health, and housing indicators (Table 1). The UK government, however, does not measure absolute poverty in terms of the relativity of people's income to a fixed standard of living. Instead, absolute poverty is defined as having an income that is below 60% of median income in comparison to the median income in 2010/11 (Stewart, 2017). Calculated this way, absolute income allows a measurement of poverty that is constant over time – however, it fails to consider the degree to which people can maintain the basic standards of living (Madden, 2010). It is the measurement of relative, rather than absolute poverty, that is formally adopted in the UK (UK Government, 2017).

Table 1

Indicators of absolute poverty [Source: Chen & Ravallion, 2017]

LIVING STANDARD INDICATORS
Inability to afford protein-rich foods every second day
Inability to keep one's home warm
Inability to afford clothing
Inability to prevent leaking roof and rotten windows and floor
Inability to afford an annual holiday away from home
FINANCIAL SECURITY INDICATORS
Inability to resolve unexpected financial expenses
Inability to make ends meet
HEALTH INDICATORS
Inability to afford medical examination or treatment
Inability to afford dental examination or treatment
HOUSING INDICATORS
Inability to pay mortgage or rent payments
Pronounced financial burden of the total housing cost

2.1.4 Use of terms 'poverty' and 'low-income' in the thesis.

It is important to introduce key terms which will be used throughout the thesis and to provide a rationale for this. Particularly given the difficulties conceptualising poverty as described above. Within the recruitment materials people experiencing poverty were referred to as 'low-income clients' (Appendix B (i) - Participant Information Sheet 2). This term was broken down into a series of markers which indicate whether a person is experiencing poverty within the UK social context. This was used as an aid for the participants to identify how a person experiencing poverty in the UK may be defined. This was based on the notion that

therapists may not necessarily know their client's poverty status in detail. In addition, a person's financial circumstances are often not transparent, and therapists may not know the income of clients. This was important for several reasons: Firstly, because the phenomena explored is the lived experiences of how Counselling Psychologists adapt therapy with those who are economically deprived within the UK. Secondly, to ensure there was clarity as to how the research defines poverty, to increase the validity of the research. Finally, to ensure homogeneity within the sample (See Methodology chapter for further discussion). Therefore, to be explicit, the term 'low-income client' will be understood synonymously with references made towards 'those experiencing poverty', 'clients experiencing poverty' or 'people experiencing poverty.'

2.1.5 Overview of poverty in the United Kingdom

In 2012, the UK had higher rates of relative and absolute poverty compared to other members of the European Union (Office for National Statistics, 2015). These rates decreased until 2017, when they started rising again (Cribb, Hood, Joyce, & Keiller, 2017). This recent rise has been attributed to the 2017 changes in the benefit system, resulting in many individuals and families not being able to claim benefits (Elgot, 2017). Currently, up to 14 million people (1 in 5) are estimated to live in poverty in the UK (JRF, 2017). Future projections suggest poverty will increase in the next ten years (Belfield et al., 2017). The groups most affected are children, pensioners and working age parents (JRF, 2017). Furthermore, working age parents make up the highest proportion of within therapy client groups in the UK (Doward, 2010). This suggests that mental health practitioners (including Counselling Psychologists) may commonly need to work with clients affected by poverty.

2.1.6 Poverty, gender and race.

Poverty in the UK is also disproportionately distributed with regards to ethnicity, race and gender. With 50% of working age Bangladeshi's living in poverty

compared to 45% of Pakistani's, 37% of Black African's / Black Caribbean's, 35% of Chinese, and 25% of Asian's. This contrasts with 19% of White[1] people living in poverty, (UK Poverty, 2017). Furthermore, 20% of women experience poverty compared to 18% of men. (The Department of Work and pensions, 2018[2]). These statistics highlight that there may be varying factors that require consideration when contemplating how poverty may impact a person's identity.

Intersectionality theory (Schulz & Mullings, 2007) proposes that overlapping social identities work together synergistically, often compounding one another (Borges, 2014). The field of CoP has begun to pay attention to how group identities intersect (Grzanka et al.,2003; Constantine, 2002). It is argued that considering aspects of identity singularly (i.e race) can oversimplify various factors that may impact a person's life (Smith, 2010). The lack of discussion surrounding how economic factors may also impact their identity or psychological wellbeing is concerning, especially considering its established relationship to these specific backgrounds. In *Counselling Psychology* (2017) Nkanasa-Dwamena dedicates a chapter to 'Issues of race and ethnicity in Counselling Psychology.' She discusses, how awareness of intersectionality and positions of privilege can help Counselling Psychologists better understand their clients. It is concerning that there was no mention of economic inequality within this discussion. The association between poverty and mental health will now be explored.

2.2 Poverty and mental health

This sections aim is to discuss the association between poverty and mental health by reviewing types of mental health problems that may be experienced by those experiencing poverty. Thereafter, the section evaluates this association by discussing theoretical ways this relationship has been understood. This is followed

[1] There was no indication as to what types of white groups these were.

2 Both findings failed to address whether the poverty experienced was relative or absolute.

by an attempt to explain the relationship between poverty and mental health, by identifying mechanisms through which poverty may reduce a person's mental well-being and vice versa.

2.2.1 The association between poverty and mental health

Studies suggest that poverty is related to a higher prevalence of mental health problems (Weich & Lewis, 1998a; Santiago, Wadsworth, & Stump, 2011). Furthermore, poverty is linked to a higher risk of developing depression and anxiety (Collins et al., 2011). These results have been obtained in studies exploring people's experiences of living in poverty (Underlid, 2007), both cross-sectional studies that correlated poorer standards of living with the prevalence of mental health disorders (Weich & Lewis, 1998b, Fryer et al.,2003), and in longitudinal studies assessing those experiencing poverty's mental health over time (Butterworth, Rodgers, & Windsor, 2009). Systematic literature reviews support these findings confirming that the link between poverty and depression/anxiety as being a robust finding (Lund et al., 2010).

2.2.2 Critical evaluation of the link between poverty and mental health

When discussing the association between poverty and mental health, it is important to highlight that most of the literature comes from a positivist tradition, looking at relationships between variables causally[2]. Therefore, the main theories attempt to establish whether poverty reduces a person's mental health, or whether poor mental health increases poverty.

Two competing theories have been postulated to conceptualise the relationship between mental health and poverty. The first "social drift theory" hypothesises that a person's poor mental health impacts their ability, functioning and

[2] This is not in line with my own epistemological positioning, which favours a phenomenological exploration of the lived experience of Counselling Psychologists regarding how and if their practice changes when working with clients living below the poverty line.

attainment resulting in a 'drift' in their social class positioning. The second, "social causation theory" argues that the psychological impact of poverty increases a person's chances of developing mental health problems, which is mediated by factors such as stress, malnutrition, stigmatisation, and hopelessness (Patel & Kleinman, 2003).

Goldberg and Morrison, (1963) found that psychosis was more prevalent in those from low social class positions, and that there was no link between their fathers' social class and development of their psychosis. This may suggest that a persons' social class positioning declined after developing psychosis. Furthermore, Hudson (2005) attempted to examine the *"the underlying causal structure"* (p.1) of the inverse relationship between socio-economic status (SES) and mental illness by analysing a longitudinal database for acute psychiatric hospitalisation alongside census data. The study found a strong correlation between their level of economic deprivation and the risk of developing a mental health problem or psychiatric hospitalisation, regardless of the SES indicator used or the mental health difficulty examined. Both studies would thus appear to support the social drift hypothesis.

Sariaslan's (2016) research also supported the social drift hypothesis with those experiencing schizophrenia. However, Sariaslan's (2016) concluded that it was predominantly genetic factors that predicted this 'drift.' This explanation differs largely from other studies that emphasise the importance of environmental influences in the social drift of those with schizophrenia (Hudson, 2005; Lapouse, Monk, & Terris, 1996, Wadsworth & Achenbach, 2005).

In contrast, social causation theory argues that the impact of poverty increases the development of mental health problems (Patel & Kleinman, 2003; Lund et al., 2010). This theory is commonly used to explain the association between poverty and conditions such as depression, anxiety, and substance abuse disorders (Lund et al., 2010). Dohrenwend et al., (1992) examined links between poverty and mental health via a large-scale Israeli epidemiological study. Dohrenwend et al's.,

(1992) findings suggest that he social drift hypothesis accounts for the relationship between schizophrenia and poverty. Depression, anti-social personality disorder and substance abuse seemed to be the result of poverty itself and better explained by the social causation theory.

The variance in findings highlights that different mental health problems may have different relationships to poverty. Prominent researchers argue that the association between poverty and mental health tends to be bi-directional, affecting each other on a reciprocal basis, rather than one causing the other on an exclusive basis (Fryer, 1998, Lund et al., 2011, Payne, 2012).

2.2.3 Why is there a relationship between poverty and mental health?

Many factors can explain the relationship between poverty and mental health, suggesting possible mechanisms by which poverty may reduce a person's mental well-being or vice versa (Stigma, discrimination, hopelessness, stressful life conditions, traumatic life events and chronic health problems). These factors will now be reviewed.

2.2.4 Stigma, discrimination and hopelessness:

Epidemiological studies suggest that high rates of mental health disorders among people living in poverty can be attributed to experiences of stigmatisation (Patel & Kleinmann, 2003). This is suggested to be the result of negative perceptions, stereotypes and discrimination (Lang, 2011). Fiske's Stereotype Content Model (SCM; 2002) shows consistent findings both nationally and internationally of those experiencing poverty being regarded as having low competence and warmth. Fiske (2007) also found via MRI scanning that the same brains patterns *"reliably implicated in disgust toward nonhuman objects such as garbage, mutilation or human waste"* (p.157); were strongly activated in participants by a photograph of a homeless man.

Crisis' (2018) statistical report documented that rates of homelessness in the UK have doubled in the last five years (170,000 families and individual's sofa

surfing, living on the streets or hostels, and 12,300 sleeping in cars or tents). Furthermore, those who are homeless are 17 times more likely to endure violence compared to the general public. Qualitative accounts confirm these experiences impacted the homeless person's self-worth, mental wellbeing and sense of isolation which made it more difficult for them to escape homelessness. A possible consequence of derogatory stereotypes and discrimination may result in internalisation of shame, which can increase the likelihood of experiencing depression, anxiety, and social exclusion (Belle & Doucet, 2000; 2003). This can arise when an individual attributes their experience of poverty as a sign of personal weakness (Moane, 2003).

2.2.5 Stressful life conditions and Traumatic life events:

Those experiencing poverty contend with a multitude of stressors. They experience financial instability, unpredictability of employment and poor life conditions such as homelessness or poor-quality housing (Tunstall, 2013). This instability may be heightened due to high living costs and the strain connected to benefits cuts, delays or sanctions (Narayan, Chambers, Shah, & Petesch, 2010). This instability often leads to food insecurity (Horning et al, 2021). Furthermore, they are also more likely to experience a variety of types of trauma (domestic and sexual violence) compared to the general population (Bassuk et al., 1998; Breiding, Basile, Klevens, & Smith, 2017; Cunradi, Caetano, & Schafer, 2002; Doherty, & Stansfield, 2019; Golu, 2014; Kothari, 2015; Loya, 2014; Slabbert, 2017; Vest, Catlin, Chen, & Brownson, 2002).

2.2.6 Chronic health problems:

Health problems amongst those experiencing poverty is an expression of the phenomenon termed the health/ wealth gradient (Hurd & Kapteyn, 2003) This phenomenon represents the positive relationship between poverty and health. With health improving in line with wealth. (Evans et al., 2012). Those experiencing poverty are more likely to experience health conditions such as high blood pressure, heart disease, arthritis, cancer and Aids/ HIV than their richer counterparts (Adler &

Coriell, 1997). The Institute of Health equity (2019) explain that no single variable can explain this gradient. It is a myriad of factors such as *"material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political, cultural and social context in which they sit."* (p.11, Institute of Health equity, 2019). While this section recognises the necessity of mental health services for those living below the poverty line, the next section discusses difficulties they may face prior to therapy and during it.

2.3 Mental health treatment for those experiencing poverty.

In the UK there are currently organisations/ sectors which provide free psychological therapy to people. These include charities such as Mind and services within IAPT (Mind, 2017; NHS, 2017b). Manning (2016), however, believes that these services are not without their limitations. Stating that they are likely to have insufficiently trained practitioners who are not fully involved with their clients. Furthermore, the time limit of sessions may not be adequate to address a person experiencing poverty's complex needs. It is difficult to obtain an accurate picture regarding how many people experiencing poverty ask for help in the first place. What we do know is that they may experience barriers when obtaining mental health care, such as practical, logistic, and psychological barriers (Larson & Corrigan, 2010). The main practical barriers are lack of money (rendering them unable to afford further therapy outside of free services, difficulties with transportation and unaffordable childcare (Heiman, Mundt, & Womack, 1984**,** Larson & Corrigan, 2010, Diamond & Factor, 1994), Maynard et al., 1997). Practical barriers may be psychological, such as experiencing stigma, feeling embarrassed about attending therapy; worrying what others may think of them (Corrigan et al, 2000, Scholle, Hasket, Hanusa, Pincus, & Kupfer, 2003). Logistical barriers may hinder willingness to attend treatment for those living in rural areas (Larson & Corrigan, 2010). Larson & Corrigan, (2010) argue that these issues are likely to prevent those experiencing

poverty seeking treatment (Larson & Corrigan, 2010). However, these barriers are not unique to those experiencing poverty. Nonetheless, it could be argued that these difficulties may be more strongly experienced by those experiencing poverty. To which they may feel more vulnerable to these barriers/ hinderances in approaching and experiencing therapy.

If they succeed in overcoming these barriers, other challenges may arise during therapy. These barriers and hinderances may be altered by Counselling Psychologists amending their practice to facilitate work with those experiencing poverty. The extent to which they do this forms a major focus of this review and research. Challenges arising in therapy are described in the next section.

2.3.1 Difficulty interpreting outcomes:

Outcome measures with those experiencing poverty are difficult to interpret due to inconsistent definitions of 'Poverty' (Borges, 2014, Falconnier, 2004, 2009; Levy & O'Hara, 2010) and the use of different 'outcome' measures (Falconnier, 2008). In addition, there are only few studies that compare outcomes of therapy based on differential incomes (Falconnier, 2008; Miranda et al., 2006; Rounsaville, Weissman, & Prusoff, 1981; Mcleod, Johnston, & Griffin, 2000; Hamilton & Dobson, 2002). These studies showed mixed results and cannot provide an accurate picture regarding what sort of therapy is effective for those experiencing poverty. before focusing on a different body of research that focuses on tailoring therapy for those experiencing poverty.

2.3.2 Therapeutic change for low-income clients

If a person's financial burdens were eased, it is reasonable to expect that this would lessen strain with regards to their psychological difficulties. It may be that some Counselling Psychologists focus directly on partly addressing these external issues (for example helping motivate the client to seek employment opportunities). However, without empirical evidence this is merely speculation. What is known, is that it is common practice for other health care professions (social workers, key

workers, care coordinators) in the UK to focus on practical issues to help their clients, i.e housing support, skills training, English language help for people suffering from mental health difficulties (Rethink Mental Illness, 2020).

However, therapy might not necessarily focus on these practical issues. Therapy frequently focuses on internal processes such as coping with feelings and acceptance. The therapeutic approaches mentioned in this introduction (CBT and psychodynamic) often have different foci with regards to therapeutic change and how it alleviates distress. Some may focus on alleviating distress by changing intrapsychic processes (Clark, 2005), unless the focus is on staying with the emotion. While all therapeutic approaches help you to live with emotion or pain, they differ in the extent to which they emphasise in staying with the emotion. While protocol driven CBT focuses on altering a problematic cognition. (Beck,1976) their third wave approaches do not seem to have the same foci. Acceptance and Commitment Therapy, (ACT; Hayes, Strosahl, & Wilson, 1999) aims at helping individuals 'live with' their difficult thoughts and feelings as opposed to changing them. In addition to taking committed action that seeks to alter their circumstances. One of the key tenets of ACT is acceptance. Thus, acceptance is viewed as allowing difficult feelings, thoughts, and sensations to be present, as opposed to changing or controlling them (Harris, 2009). Another key tenet of ACT is mindfulness, which advocates practicing awareness on the present moment without judgement (Kabat-Zinn,1982; Hayes, 1999).

There are many instances where ACT is deemed an effective treatment, where no external change is possible (Fashler et., al 2018). For example, cancer patients dealing with incurable diseases or chronic pain patients, who often deal with permanent physical health problems. While only few papers detail the effectiveness of ACT on cancer patients, (Hulbert-Williams et al., 2015; Graham et al., 2016) the findings are favourable. Furthermore, the effectiveness of mindfulness-based interventions on cancer patients is well established alongside ACT with sufferers of

chronic health conditions. (Piet, Würtzen, & Zachariae, 2012; McCracken et al 2013).

For example, Davis, Morina, Powers, Smits, & Emmelkamp, (2014) conducted a meta-analysis of 39 randomized controlled trials to gauge the effectiveness of ACT on mental health problems as well as chronic pain. Findings revealed that ACT is not only effective for reducing anxiety, depression and addiction that is associated with chronic pain, But also with psychosis, diabetes, addictions, HIV and epilepsy.

Boer et al's (2014) study found that those who used catastrophic thinking with regards to their pain related experience had low levels of psychological acceptance. Catastrophic thinking can be understood as irrational and exaggerated thought processes. Therefore, pain related catastrophising can be understood as having an exaggerated negative response towards current or anticipated pain related experiences. Participants who had a higher degree of psychological acceptance catastrophised less about their pain experience.

McCracken et al., (2005) conducted a study on an acceptance- based pain management programme and found not only increased levels of pain acceptance; but also increased levels of physical task persistence, alongside decreased depression, anxiety, psychosocial and physical disability.

These findings are hopeful if considered with clients experiencing poverty, as they are often dealing with issues which – due to several variables – are very complex and difficult to change. However, the extent to which Counselling Psychologists use the above interventions specifically with poor clients remains understudied. This now brings us to discuss how a therapeutic adaptation can be understood. Thereafter cultural adaptations will be discussed before moving specifically onto studies which describe therapy adapted for people experiencing poverty.

2.4 What is a therapeutic adaptation?

Therapeutic adjustments are likely to be remarkably common but may not be viewed as adjustments. For example, adapting therapy to what the therapist feels would benefit the client most is a type of adaptation (Simon et al., 2009; Petronzi, 2017). However, amending the way therapy is delivered is only possible if the therapist is trained in multiple modalities. Another form of therapeutic adaptation may be excluding therapists with certain features as these may evoke distress for certain client groups (E.g Solace women's aid, Women and Girl's network and NIA ending violence charity exclude male therapists.) Therapist/ client matching is another type of therapeutic adaptation that has been considered within the literature. However, the findings are not favourable as they consistently show this does not improve therapeutic outcome (Shin et al., 2005; Maramba & Nagayama Hall, 2002; Coleman et al.,1995; Atkinson & Lowe, 1995; Cabral, & Smith, 2011). Therapist matching may not even be possible as characteristics of clients may be unavailable prior to therapy. Moreover, in the context of adapting therapy to low-income clients, another possible obstacle to adaptation could be the fact that a person's financial circumstances are often not transparent, and therapists may not know the income of clients. Another type of adaptation commonly used is changing the language of therapy to cater for the client group or deploying an interpreter (Griner & Smith 2006; Martinez & Eddy 2005; Shin & Lukens 2002; Dai et al., 1999; Dubus, 2016; Tutani et al., 2018). While studies advocate the importance of this adaptation it can be difficult to gauge what specific factors account for the therapeutic effectiveness.

2.4.1 Culturally adapted therapy

There is a large body of research which centres on culturally adapted therapy. This has been suggested to be due to potential incongruences between western models of therapy and the worldviews of those from differing ethnic and racial cultural backgrounds (E.g Sue, 1977, Constantine, 2002; D. W. Sue, Arredondo, & McDavis, 1992; Beshai, Dobson, Adel & Hanna, 2016). Furthermore, Counselling Psychology as a disclipline has a well-established interest on the subject

of therapy adapted on the basis of culture (Eleftheriadou, 2015; Lago, 2011). As explained previously, there may be varied definitions of what a cultural adaptation is (e.g. language match). Therefore, cultural adaptation will be understood here as *"a systematic modification of intervention protocols through which consideration of culture and context modifies treatment in accordance with clients' values, contexts, and worldviews"* (Benish, Quintana, & Wampold, 2011 p.1).

There has been considerable research on cultural adaptations (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue, 1998; Sue & Zane, 1987; Bernal, Bonilla, & Bellido, 1995). Much research suggesting it is effective (Smith, Domenech Rodriguez, & Bernal, 2011; Hall et al.,2019). However, many argue it is difficult to evaluate what constitutes its effectiveness due to mediating factors.) Therefore, many meta-analysis' have been undertaken to investigate what factors are influential here (Hall, Ibaraki, Huang, Marti, & Stice, 2016; Hall & Yee, 2014; Smith & Trimble, 2016). For example, Griner and Smith's, (2006) meta-analysis included participant age, clinical status, gender, ethnicity, and level of acculturation. However, Benish, Quintana, & Wampold (2011) meta-analysis suggested that the most important mediating factor in culturally adapted therapy is when the therapeutic explanation of their distress is congruent with the client's cultural view of their illness. Interestingly both studies failed to include the client's socio-economic status or level of income.

2.4.2 Therapy adapted for those experiencing poverty.

Efforts have been made to modify therapy to directly address economic stressors. For example, Ammerman et al. (2005) adjusted CBT by developing In-Home Cognitive Behavioural therapy, to reach low-income first-time mothers with postnatal depression. Mothers who received this adapted version experienced a dramatic reduction in depressive symptoms from before therapy to after therapy was completed.

Azocar, Miranda and Dwyer (1996) made extra adaptions to group CBT to address the needs of their poor clients. Their most successful adaption was supplementing CBT with clinical case management. Meaning that therapists would go beyond traditional CBT interventions by attending to contextual factors such as housing, employment, or relationship problems. This additional support was associated with significantly lower dropout rates, improved functioning and reduced depressive symptoms.

Falconnier and Elkin (2008) investigated the degree to which therapists focus on economic stressors in the first two sessions of therapy in the treatment of depression. Regardless of the client's social class positioning 86% brought up at least one type of economic stress topic (Either work, unemployment or finance related). Findings showed that irrespective of treatment modality, the more therapists approached conversations about economic stress, the better the treatment outcome. They also found therapists often missed opportunities to focus on the impact of economic stress on their depression, by choosing to focus on intrapsychic or relational issues. The authors concluded that this was because the theoretical models used (CBT and IDT) completely neglect economic factors.

Although not adaption specific per se, Goodman (2015) looked at what types of practice low-income women found most helpful in therapy. Participants explained that therapy was significant and helpful when their therapist: 1) showed awareness of the practical and emotional implications of poverty related stress (Being able to name stresses, give recommendations and delivering realistic interventions), 2) had exposure to poverty through work or life experience, 3) allowed therapy structure to be flexible (providing practical support with paperwork, psychoeducation referrals and advocacy); 4) was authentic, 5) focused on their strengths and finally, 6) managed their power well (using self-disclosure, avoiding jargon and not acting like the 'expert.')

These studies show that when therapy is tailored in a way that removes barriers, focuses on economic stressors or when therapists are considerate of these difficulties, this heightens those experiencing poverty's ability to benefit; by allowing them to focus on their psychological functioning. What we do not know, is how Counselling Psychologists in the UK are trained to work with the those experiencing poverty, we will therefore look at CoP training and how prepared Counselling Psychologists may be when working therapeutically with clients experiencing poverty.

2.5 Counselling Psychologists training for work with those experiencing poverty.

We do not only need to consider types of therapy delivered by psychologists to gauge what contributes towards its effectiveness. We must also look at the psychologists themselves, and how their training influences the way they practice with those experiencing poverty. This is discussed below.

2.5.1 Multicultural training.

Multicultural training can be a method used to train therapists to work competently with those experiencing poverty (Hays, 2009).Although some argue that those experiencing poverty should not be regarded as a cultural group in the literal sense (Smith, 2010), there is a large volume of research (Kraus, 2012; Sue, 1978; Koltko- Rivera, 2003, Klar & Kasser, 2009; Miller & Sperry, 1987) that argues that different social-class groups have mutually shared values, world views, cultural norms and values, particularly those from lower socio-economic groups (Fouad & Brown, 2000), and therefore should be taken seriously as a multicultural variable (Lui, 2011).

Multicultural training (MCT) is used commonly, but not in all CoP training in the UK (Eleftheriadou, 2015). This is in contrast to the US who place more emphasis on incorporating poverty within multicultural training (See 'Resolution on Poverty and Socioeconomic status': American Psychological Association, APA,

2000) and have also developed poverty specific training (I-CARE model: Foss et al, 2011) to aid therapists working with those experiencing poverty. Lui (2011) argues that this is concerning as Counselling Psychologists in the UK need expertise in varying interventions with different economic communities.

Studies show that MCT focuses mainly on racial or ethnic issues rather than poverty or social class differences (Toporek & Pope Davis, 2005; Balmforth, 2009). However, Toporek and Pope Davis (2005) found increased MCT enabled Counselling Psychologists to be more likely to explain poverty because of structural inequalities. In contrast, those with limited MCT had fewer sensitive attitudes and believed poverty is the result of individual ineffectiveness. While it is hopeful that MCT can positively influence Counselling Psychologists' practice with those experiencing poverty, our lack of poverty specific training suggests we are neglecting this population in contrast to the US. Furthermore, we cannot be certain whether all Counselling Psychologists feel competent in delivering mainstream therapy or adjusting their practice with those experiencing poverty due to inconsistencies in CoP training programmes. Vera and Speight (2003) state that for Counselling Psychologists to be multiculturally competent they must be committed to social justice. Therefore, how Counselling Psychologists understand and incorporate social justice into their therapeutic work will be discussed below.

2.5.2 Social justice

CoP has a keen interest in social justice (Hartung & Blustein, 2002) influenced by critical, feminist and multicultural movements in psychology (Prillettensky & Nelson, 2002) which can be defined as *"justice in terms of the distribution of wealth, opportunities, and privileges within a society"* (Wikipedia, 2019). However, there is no all-encompassing definition (Pierterse et al., 2009) as writers generally refer to aspects of social justice relevant to their writing, while assuming the reader knows its intended purpose (Fondacaro & Weinberg, 2002).

Cutts' (2013) research explored UK CoP's understanding of social justice and found five out of the six participants showed difficulty defining it, while half had never heard the term during their training. Participants provided descriptions of social justice. Some related it to power and autonomy, while others described it as meeting an individual's basic needs, with two participants making references towards Maslow's hierarchy of needs (Maslow, 1943). Participants commonly defined it with regards to their own personal meaning or experiences of social injustice. These findings mirrored Hore's (2014) study which found only few CoP's engaged in a social justice discourse, due to personal choice and not their training.

Lack of a specific definition makes it difficult to teach in CoP training institutions (Lewis, 2010) and highlights the need for amending (Vera & Speight, 2003, Cutts, 2013). Speight and Vera (2004) argue that social justice is a mere buzzword within CoP, and Cutts (2013) suggests there may be a rhetoric-action gap. Furthermore, participants in Cutts' (2013) study voiced that social justice work was incompatible with the theoretical modalities they worked in.

Many suggest that a set way of doing social justice work is needed (Blustein et al., 2001; Fouad, 2001; Ivey & Collins, 2003; McWhirter, 1998; Sue, 1999). However, this may prove difficult as most literature surrounding social justice is theoretical, with one exception from Goodman (2004) who provides guidelines to do social justice work. They are: *"a) ongoing self-examination, b) sharing power, c) giving voice, d) facilitating consciousness raising, e) building on strengths, and f) leaving clients with the tools for social change"* (Goodman et al., 2004, p. 798).

As noted previously, the social justice agenda is influenced by Critical psychology; With Critical psychology's interest in how psychologists construct and enforce discourses (Parker, 1997) and how this may affect how we determine what is healthy or pathological within mental health (Hore, 2014). Evidence suggests that some Counselling Psychologists use critical psychology discourses when critiquing the relationship between managed care initiatives and the way therapy is delivered

(Moloney & Kelly, 2008, Goodman, Smyth & Baynard, 2010). This was evident at Division of Counselling Psychology's (DCoP; 2017) conference as Strawbridge (2017) reminds us that our division *"had its origins in a) A critique of the medical model of psychological distress…b) a concern with social justice, discrimination and oppression; and c) a challenge to professional power (promoting bottom up rather than top down/equalising power)"* (p.1, Strawbridge, 2017).

While it is hopeful that some Counselling Psychologists incorporate a social justice frame within their therapeutic work (Hore, 2014; Winter & Hanley, 2015) and take a questioning stance with regards to working within a medical model of distress (Stawbridge, 2017), Idowu (2017) found that working within this model caused difficulties for Counselling Psychologists' identity, practice and conflicted with their Counselling Psychology values. Furthermore, Hore's (2014) study found that some CoP's adopt a 'scientific' discourse influenced by their managed care settings. With their favouring of CBT derived not from effectiveness, but because it's evidence-based gold standards holds more power within our current societal power arrangements (Guilfoyle, 2008). Therefore, the adoption of differing discourses means we can only speculate as to how Counselling Psychologists in the UK adapt therapy to meet the unique needs of those experiencing poverty.

Having discussed the difficulties that may come with delivering therapy, such as difficulties understanding outcome measures, potential incompatibilities between protocol driven Cognitive Behavioural therapies and clients experiencing poverty, we have highlighted that there are instances where therapies are deemed effective, where no external change is possible (ACT and mindfulness-based interventions.) Furthermore, when therapy is tailored for the those experiencing poverty, it is successful. While we can assume that some Counselling Psychologists in the UK adopt a social justice frame or are multiculturally competent when working with those experiencing poverty, we cannot be sure as to how they deliver therapy to this population and what extent they make adaptations. Literature suggests that a psychologist's attributes or attitudes may require consideration or

adjusting during therapy with those experiencing poverty. This will be explored further below.

2.6 Psychologist's attitudes and social class background

2.6.1 Attitudes:

Bias can be understood as favouritism, inclination or preference towards an object or person. Bias can be implicit or explicit, meaning we may or may not be consciously aware of these preferences (Boysen, 2010). Classism is defined as any form of oppression, bias, discrimination or prejudice towards a person or group due to their social class status (Pope & Arthur, 2009; Smith, 2005). Classism, ultimately, cannot exist without bias (Cook, 2014).

Many scholars suggest that therapists struggle with addressing the needs of those experiencing poverty due to negative assumptions that arise from believing their difficulties are due to their own inherent qualities (Wadsworth, 2012, Kearney, 2003; Flanagan, 2009; Lui, 2003, 2007, 2011; Lui & Pope-Davis, 2003 Appio, Chambers, & Mao, 2013). Lui (2003, 2007, 2011) argues that this belief derives from 'the social mobility bias' which is the perception that individuals should always strive for upward social mobility. Other writers suggest that therapists may be unwilling to work with those experiencing poverty due to perceiving them as challenging (Ware et al.2014**;** Appio et al., 2013) or believing that therapy cannot help them (Wadsworth, 2012). In contrast, Smith (2010) states that therapists assume those experiencing poverty only require practical help, which implies that they won't benefit from psychological or emotional support. Foss and Generali (2012) West-Olatunji and Gibson (2012) and Kearney (2003) argue that this classism occurs because therapists aren't trained to look at social class bias.

2.6.2 Class background:

Statistics indicate that Counselling Psychologists in the UK earn, on average, between £40,428 to £48,514 on an annual basis (Cutts, 2016). Furthermore, CoP training in the UK is self-funded. This level of income and educational attainment as

social-class indicators would position a psychologist as middle class while affording them with social-class privilege (Liu et al, 2007; Sue & Sue, 1977; Vontress, 2004).

This economic advantage may pose problems if therapists are unaware, they possess this privilege. Nelson, Englar-Carlson, Tierney, & Hau, (2006) argue that even those originally from lower social-class backgrounds have social-class privilege as they no longer experience the realities of poverty due to their current upward mobility and level of education. Liu, Soleck, Hopps, and Dunston, (2014) argue that therapists are unprepared to tackle psychological issues experienced by those experiencing poverty because of their middle-class backgrounds. Their background may result in an over-reliance on middle-class views regarding the development of a therapeutic relationship and conceptualisations of positive outcomes, which may not apply to those experiencing poverty (Kim & Cardemil, 2012).

This literature highlights that psychologists may possess attributes that impact therapy with those experiencing poverty, highlighting considerations, that could be made during therapy. However, as the literature is mostly theoretical it cannot move beyond hypothesis.

2.7 How do psychologists understand the link between mental health and poverty?

Sams (2008) used discourse analysis to explore how clinical psychologists in the UK understand the relationship between poverty and mental health and how this influences therapeutic interventions. The psychologists drew on two discourses (structural inequalities and individual ineffectiveness) as the cause of poverty. Most participants explained poverty as caused by societal inequalities. However, when discussing the relationship between poverty and mental health most participants drew on the individualised discourse.

Structural accounts provided those experiencing poverty with a positive identity yet highlighted their powerless. Individualistic accounts emphasised

individual responsibility but also individual blame. The use of different discourses posed dilemmas for the psychologists, as they desired to understand poverty as a structural inequality yet wished to frame it in a way that allowed the possibility for therapy.

This study highlights the confusion experienced by clinical psychologists in the UK surrounding how to deliver therapy to those experiencing poverty and suggests a bias for delivering traditional therapeutic approaches. We cannot generalise these findings to Counselling Psychologists who have an identity distinct from their sister professionals (Giddings, 2009; Martin, 2006). While Sams' (2008) advises that psychologists need *"more transformative interventions."* (p.75) with those experiencing poverty, this study failed to specify what interventions they gave. This finally leads us towards one paper that provides a first-hand account of therapy with those experiencing poverty from the perspectives of US psychologists. With the aim of finding out how they delivered mainstream therapy and what adaptions they considered helpful with this population. To my knowledge no research exists on similar topics from UK.

2.7.2 How do US Psychologists experience therapy with clients experiencing poverty?

Borges (2014) conducted a qualitative descriptive study with 12 Psychologists (10 clinical, 2 Counselling Psychologists) in the US. Participants varied in gender, ethnicity and historical social class background. The aim of the study was to see how they altered their work with those experiencing poverty and how personal or contextual factors helped or hindered this.

The main findings revealed that psychologists developed unique practice with those experiencing poverty. This consisted of a) flexibility with time or appointments, b) giving clients food and even giving money (8 out of 12 participants described being willing to give money, while 7 out of 10 did so), c) Breaking agency or insurance rules (So clients could access more sessions), d) overlooking session

limits, no-show policies and exaggerating client's mental health difficulties to obtain more sessions; e), acknowledging a client's mental health difficulties as the result of both intrapsychic and contextual factors at every stage of therapy (assessment, formulation and intervention) f), Adapting techniques to account for both factors (addressing economic stressors by making calls, writing letters and giving lists of food banks).

This study was informative and exploratory however limitations are highlighted. Qualitative descriptive methodology acquires information via straightforward description. It could be argued that the directionality of this methodology has the potential for being positivistic, thus providing a narrow view of the participants perspective. Furthermore, the sample consisted of psychologists who chose to work in poverty specific settings, which fails to illuminate how psychologists work with those experiencing poverty in general settings. Finally, as all participants were recruited from the US this can only highlight how psychologists work within this context, which is significantly different from the UK. With one key difference being that the UK has a national health service (NHS) which offers free psychological therapy in services such as IAPT (NHS, 2017a).

This study has provided significant information as to how Psychologists in the US work with those experiencing poverty. Specifically, that practice significantly deviated from mainstream therapeutic modalities, diverging from traditional boundaries. These findings raise important questions as to how psychologists manage the process of these boundaries and ethical challenges. As only one counselling psychologist was interviewed, we cannot be sure whether aspects of their Counselling Psychology identity or training helped or hindered their work, especially as this study failed to enquire about the influence of training on practice.

2.8 The present research

This final section of the literature review introduces the present research by providing a rationale for the study, identifying its relevance to Counselling Psychology, and then presenting the research question.

2.9 Conclusions and Counselling Psychology relevance

This literature review aimed to explore how Counselling Psychologists in the UK deliver therapy when working with clients experiencing poverty. Beginning by introducing the concept of poverty and its links to mental health, which find that those experiencing poverty are a unique population who experience an array of mental health problems compared to their wealthier counterparts (Collins et al., 2011).

While there are many mechanisms that may aid our understanding of the relationship between poverty and mental health, the main theoretical understandings of this relationship are positivistic which highlights difficulties around its research. Research suggests that when economic stressors are directly attended to during therapy, it is helpful. CoP's commitment to social justice and multicultural competence therefore warranted discussion, which found MCT can be beneficial in working with those experiencing poverty (Eleftheriadou, 2010). However, MCT is not necessarily delivered in all CoP training institutions. Furthermore, evidence suggests that some CoP's adopt a social justice frame by critiquing the way mainstream therapy is delivered. However, it also found that some Counselling Psychologists experience working within the medical model as conflicting with their CoP identity while some adopt discourses that favour the medical model of distress.

Counselling psychologist's attributes, such as social class background and attitudes were discussed, which shed a light on how Counselling Psychologists may impact working with those experiencing poverty. However, without data this can only be hypothetical. What we do know is that when UK clinical psychologists work with those experiencing poverty, they appear biased in delivering mainstream

therapy, which may derive from the way poverty is conceptualised. Suggesting that the way poverty is framed has implications regarding which interventions are appropriate for those experiencing poverty. However, Sam's (2008) findings neglected to discuss interventions used.

Only one paper looks qualitatively at the experiences of US psychologists work with those experiencing poverty (Borges, 2014). This paper highlighted that when psychologists made significant adaptations to mainstream therapy, it was seemingly more effective, as it met the needs of the client. However, these adaptations diverged from traditional boundaries and thus posed ethical challenges However, these findings cannot be generalised to the UK or to Counselling Psychologists, which highlights a gap. Furthermore, statistics from the Division of Counselling Psychology's (DCoP, 2018) annual review suggests that Counselling Psychologists in the UK may commonly need to work in organisations/ sectors that provide therapy to those experiencing poverty. Thus, highlighting a need for research looking at how Counselling Psychologists work with this population.

The present research aims to explore how Counselling Psychologists deliver therapy to those experiencing poverty. Specifically: 1) if they make adaptations, how is this done and to what extent 2) to identify what assists them in making adaptions 3) to identify what underpins their decision making when making adaptions 4) to use a qualitative approach that allows for a more idiographic and nuanced understanding of these experiences.

This research is well suited to CoP's humanistic values of empathy, unconditional positive regard, and congruence (Rogers, 1957) to explore experiences of deviating from mainstream therapy with marginalised populations. Current positivistic understandings of poverty and mental health have implications for therapeutic practice with those experiencing poverty (Sams, 2008). CoP's underlying phenomenological philosophy, therefore, makes us well placed to adopt a non-pathologising stance when working therapeutically with this population

(Strawbridge & Woolfe, 2010). By exploring perspectives of Counselling Psychologists who provide therapeutic interventions to those experiencing poverty, and how they understand their work, we can hope to improve practice, policy, and training. Furthermore, this work may increase awareness of multicultural competencies and development of poverty-related skills, thus resulting in better therapy outcomes.

Therefore, the proposed research question is:

- How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with clients experiencing poverty?

Part 3: Methodology

3.1 Introduction:

This section begins by discussing the rationale for using a qualitative methodology. Reflections on my personal ontology and epistemology will then be provided, alongside my rationale for using Interpretative Phenomenological Analysis (IPA). Following this, a reflexive section will look at why the above method and methodology was chosen, before providing a description of the participants and recruitment strategy. Finally, data analysis and ethical considerations will be presented.

3.2 Rationale for choosing a qualitative methodology

This research considers a qualitative method best suited to the research aims of understanding how UK Counselling Psychologists experience making therapeutic adaptations to low-income clients. Qualitative methodology is concerned with generating understanding of phenomena by examining a person's subjective experiences and meanings (Willig, 2001). This process cannot be achieved via a quantitative lens which *"requires the reduction of phenomena to numerical values"* (Smith, 2015 p. 2). In addition, quantitative methods have an entirely different epistemology that underpins them. They are underpinned by a logical positivist tradition seeking relationships between variables and prediction of one variable from several others (Sale, Lohfeld & Brazil, 2002). In contrast, this research seeks to understand individual subjective experiences which is more suited to qualitative and phenomenological methods.

Current theoretical understandings of the relationship between poverty and mental health largely derive from a positivistic tradition, looking at relationships between variables causally (Goldberg & Morrison, 1963; Patel & Kleinman, 2003). Furthermore, research suggests that the way psychologists conceptualise this relationship impacts how they deliver therapeutic interventions (Sams, 2008). In

addition, the positivistic research to date is silent regarding the experience of working with poorer clients therapeutically. With Counselling Psychology's underlying phenomenological philosophy (Strawbridge & Woolfe, 2010) it seems sensible to allow for a qualitative method which seeks to explore, describe, and interpret *"the personal and social experiences of participants"* (Smith, 2014, p.2).

3.3 Reflexivity on Epistemology and Ontology:

It is important for researchers to outline their epistemological position, and to conduct research that is consistent with it (Willig, 2013). The rationale underpinning this is because our ontology (the way we view the world) and our epistemology (our view of what knowledge is and how it is acquired), can influence the way we conduct research. (Smith, 2014). Therefore, acknowledging how we can affect our research can increase its validity (Willig, 2013). This has prompted me to reflect on why I consider a qualitative methodology and IPA as the most suitable for this research, and to reflect on its suitability for me as an individual.

Prior to my training as a Counselling Psychologist, I was very attached to my identity as a working-class woman. I viewed my experiences of poverty as mainly responsible for the internalised stigma and shame I felt. This view was coupled with my assumption that those from working class backgrounds felt the same, especially in terms of feeling alienated from others with different social class backgrounds. It was my belief that my internal representation of the world was indistinguishable from reality, thus adopting a 'naïve realist' epistemological position. This was during a time where I was not exposed to those, I deemed as more privileged than myself. This, alongside my age, limited education and self-awareness perpetuated my naïve realist position.

My worldview changed in line with my increased exposure to different worldviews and perspectives within my therapeutic practice (not only as a trainee counselling psychologist but as a counsellor). Increased reflective practice within therapeutic training, acquiring knowledge of differing philosophical stances

alongside the concept of criticality also contributed towards my changing epistemological positioning. Overall, this acquisition of knowledge led me to value alternative subjective realities, while being sensitive to social contexts.

These experiences led me to adopt an epistemological position which draws on phenomenology; In believing that knowledge is dependent on an individual's perspective but is also informed by critical realism in terms of believing *"that reality exists independently of our knowledge of it"* (Danermark, Ekstrom, Jakobsen & Karlsson, 2002, p25). While I have outlined my ontological and epistemological stance and the reasons for it, it is also important to detail the assumptions that are made within the present research as a consequence of my stance (Willig 2012).

My assumption in this research is that poverty is an important phenomenon that influences connections and divisions between individuals. Therefore, my worldview led to me feeling less than others I perceived to be of higher or lower status. This has influenced my interactions in the world and has the potential to influence my stance towards this research. In short poverty divides and not just economically- but also socially. This led me to choose IPA as a method of research as it is interested in the phenomenology of being poor. The danger is that I may assume my stance towards feeling and seeing others as different, as a function of poverty, may be applied universally. However, this may or may not be the case.

The other assumption I need to be aware of, is my prior belief that my worldview, was not a construction but represented an accurate view shared by everyone in similar circumstances. I now realise that while there are features of an objective world out there, my perceptions are subjective interpretations of these features. Therefore, I no longer assume others share my worldview. One feature of this research will be to explore the lived experience of Counselling Psychologists making adaptations for poverty. Allowing different perspectives to emerge, ranging from sociological, psychosocial and positivist perspectives. I learnt that a person's

reality can only be understood through the lens of the person experiencing it, thus phenomenologically (Giorgi, 1994).

3.4 Qualitative trustworthiness and rigour

Qualitative trustworthiness and rigour can be understood as a way of upholding the integrity and credibility of the research process (Ryan et al., 2007). Trustworthiness is generally established within Quantitative research by measuring validity and reliability (Morgan & Drury, 2003). Qualitative approaches, in contrast have different paradigmatic underpinnings which means that rigour and trustworthiness cannot be applied with the same uniform strategies (Rolfe, 2006). Despite this, attempts have been made by authors to outline criteria for qualitative trustworthiness (Elliot et al., 1999; Yardley, 2000; Morrow, 2005). Morrow (2005) describes criteria which can be used regardless of the research paradigm. Most specifically: social validity, subjectivity and reflexivity, adequacy of data and adequacy of interpretation. I will now briefly consider these points and how they have been addressed within the current research.

<u>Social validity/ adequacy of data:</u>

The current research ensures adequacy of the data by exploring perspectives of Counselling Psychologists who provide therapeutic interventions to those experiencing poverty. This focus also ensures social validity because by understand the way in which they work therapeutically, we can hope to improve practice, policy, and training. Furthermore, this research has the potential to increase awareness of multicultural competencies and development of poverty-specific therapeutic skills. Adequacy of data is further highlighted within the analytic process, which has been clearly described (See 3.7.4 Data analysis). Furthermore, the findings are listed alongside supported quotations, to ensure interpretations were reflective of what was specifically expressed (Smith & Eatough, 2006).

Subjectivity and reflexivity:

Understanding the researcher's relationship to the research itself is essential to give the reader the full context to the study (Morrow, 2007). I believe this has been demonstrated within the three reflective accounts I presented within the research (See 1.2 Reflexive statement; 5.7 Post study reflexivity and above 3.3 Reflexivity on Epistemology and Ontology). Within these accounts I have hopefully provided a level of transparency to the reader with regards to my biases, assumptions, and my relationship to the research subject itself. In order to show continued trustworthiness and transparency, I also kept a reflective journal (Kasket, 2013). This was to prompt reflection over the data interpretation process, giving me a space to stay in check of my assumptions and share my experiences (Mills, Bonner & Francis, 2006).

Adequacy of interpretation:

Lincoln and Guba (1985) advise that to show trustworthiness, the findings must be as close to the participants accounts as possible. This is consistent with the intention of IPA which strives to stay as close to the persons account as possible. However, IPA also acknowledges the double hermeneutic, in that a first-person account can never truly be captured due to the researcher's interpretation (Smith, 2008). Therefore, measures were taken to limit the projection of my own material and to strive to achieve this close level of interpretation. Guba and Lincoln (1994) advise that the most effective strategy to use to achieve this closeness of interpretation is member checking. However, other scholars seem to have a different stance on the validity of member checks. For example, Angen (2000) argues that the process of member checking assumes that there is only one fixed reality, which may go against the interpretative stance of IPA. It was important to therefore keep these different perspectives in mind when member checking. The rationale was therefore not asking for confirmation that this *was* their

reality, but that my interpretation fitted as closely to their reality as possible. Another way in which I attempted to demonstrate adequacy of interpretation was through frequent meetings with my supervisor. These meetings were used to consider several aspects of the research such as data analysis, research findings and potential limitations of the research. I experienced my supervision sessions as not only a valuable source of support, but a place to evaluate and critique the research and my relationship to it.

3.5 Rationale for choosing IPA:

IPA has been chosen for this research to investigate how Counselling Psychologists in the UK experience making therapeutic adaptations to low-income clients. This methodological approach is in line with my epistemological stance, in believing that a person's reality can only be understood through the lens of the person experiencing it, thus phenomenologically (Giorgi, 1994). Conducting research in line with your own epistemology is advocated by Willig (2013).

The intention of IPA fits neatly with Counselling Psychology's seeking to understand how individuals ascribe meaning to their subjective experiences. This contrasts with examining whether this fits with their external reality (Smith et al., 2009). Poverty as a phenomenon can be understood in a variety of ways by people with similar characteristics (Smith, 2011). For example, this phenomenon can be understood from varied sociological, psychosocial or positivist perspectives. Therefore, to lessen projections of my ontology onto the participants- I have framed the concept of adaptation in a way that is open to interpretation. This sits well with IPA by respecting each participant's individual experience (Smith et al., 2009)

Current theoretical understandings of the relationship between poverty and mental health largely derive from a positivistic tradition, looking at relationships between variables causally (Goldberg and Morrison, 1963; Patel & Kleinman, 2003). In addition, positivistic research to date is silent regarding the experience of working with poorer clients therapeutically. The qualitative research that is

available suggests that the way psychologists conceptualise this relationship impacts how they deliver therapeutic interventions (Sams, 2008).

In addition, quantitative methods have an entirely different epistemology that underpins them. They are underpinned by a logical positivist tradition seeking relationships between variables and prediction of one variable from several others (Sale, Lohfeld & Brazil, 2002). This contrasts greatly with this this project's research aims- which seeks to understand individual experiences, which is more suited to qualitative and phenomenological methods.

3.6 Characteristics of IPA:

IPA is a relatively new method, developed by Jonathan Smith (2003) approximately 20 years ago, which provides a detailed, contextual insight as to how a person experiences a phenomenon and assigns meaning to it. IPA was used initially as a new methodological enquiry within health psychology. It has since become increasingly popular in other psychology disciplines such as clinical and Counselling Psychology (Larkin, Watts & Clifton, 2006).

IPA is considered to have three theoretical underpinnings: phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009). The phenomenological aspect of IPA seeks to understand the outside world by focusing on the thoughts, feelings and perceptions of a person's experience (Smith, Flowers, & Larkin, 2009). Phenomenology advocates that a person's experience is unique and subjective, therefore rejecting the view that there is an objective explanation of phenomena or reality (Smith, 1996; Smith & Osborn, 2008).

IPA also has an idiographic focus which means that its aim is to investigate the unique subjectivity of a person's experience- In a way that *"does not eschew generalizations, but rather prescribes a different way of establishing those generalizations"* (Smith et al, 2009, p.29). This idiographic focus also allows for a

deeper understanding of the participants internal world by providing them with a voice, as advocated by Yardley (2009).

The hermeneutic aspect of IPA recognises that while the individual attempts to make sense of their own experience, the researcher is attempting to make sense of the individuals meaning making, thus it is impossible to gain a 'true' representation of the participants worldview. This analytic process is often described as double hermeneutic, a key tenet of interpretative phenomenology (Smith, 2008).

3.7 Other qualitative methods considered:

Two other qualitative approaches were considered for this research question. The first, Grounded Theory, is like IPA in that both describe aspects of an individual's experience to ascertain knowledge of a phenomenon. However, Grounded Theory aims to produce a theoretical explanation based on emergent themes in the participants experience and draw conclusions (Starks, Brown & Trinidad, 2007). This differs largely from the intention of this research, which seeks to acquire new insights by exploring the individuals lived experience of the phenomenon under study in their own context, this is most suited to IPA focusing as it does on understanding a phenomenon from the individual's lived perspective.

Another approach considered was Narrative Analysis (Bruner, 1990). Both IPA and Narrative Analysis share the desire to understand life experiences and meaning making (Smith, 2015). However, Narrative Analysis seeks to understand this meaning through the concept of telling a story (Murray, 2015, p.88). IPA does not seek to weave a person's experience into the form of a narrative. Instead, it seeks to approach a person's lived experience as closely as possible, which reflects the aims of this research.

3.8 Design:

3.8.1 Recruitment procedures:

Several strategies were used to recruit participants. Email addresses of potential participants were obtained via the British Psychological Society's (BPS) register. Recruitment materials were then emailed to Counselling Psychologists directly (Appendix H, Appendix F). Participants were also recruited via research posters which were publicised in therapeutic services offering low- cost therapy for those in receipt of benefits (E.g. Wandsworth and Westminster Mind and The Stress Project in Islington.) Social media platforms such as Facebook, Twitter and Linkedin were also used to circulate the research poster online.

On contact with potential participants the research aims were outlined, alongside the inclusion and exclusion criteria (which is evident in the recruitment materials). Participants who met the requirements were then thoroughly briefed on several important aspects of the research process, via an information sheet (Appendix B). When they agreed to participate in the research, interviews were then arranged either via email or telephone.

3.8.2 Participants:

The participants were six UK Chartered Counselling Psychologists, who have completed their BPS/Health Care Professions Council (HCPC) accreditation and have been working as a chartered counselling psychologist for a minimum of a year (see Table 1 for participants' demographic information). All Counselling Psychologists reported making therapeutic adjustments with clients experiencing poverty, as this was a requirement for the research. Six participants were chosen in conjunction with IPA's focus on relatively small sample sizes (Smith & Eathough, 2007). The decision to use chartered Counselling Psychologists was informed by the research question which aims to explore how Counselling Psychologists adapt therapy with clients experiencing poverty (Willig, 2012). Participants were provided with guidelines (Appendix B (i) - Participant Information Sheet 2) as an aid for identifying how a 'low-income' client may be defined, within the UK. This is because participants may not know in detail their client's current poverty status.

Inclusion criteria – All participants had to provide at least 5 hours per week of individual therapy to 'low income' adults and have at least 2 years' experience of conducting individual therapy on a regular basis to low-income adults. These requirements were to ensure that participants had a higher level of experience with clients experiencing poverty and to maintain homogeneity within the sample; Which is one of the key tenets of IPA (Smith et al. 2009). There were no restrictions regarding gender or ethnicity, but participants had to be over 18 years of age. Homogeneity was maintained in the sample as all participants were Counselling Psychologists and therefore adhere to certain key principles of the discipline. Variance in orientation, age and years of experience was deemed acceptable as this is common within the disciple of Counselling Psychology.

Table 2: Summary of participant demographic information

(Pseudonyms have been used to ensure anonymity.)

Participant name	Age	Gender	Length of time practicing as a Counselling Psychologist	Length of time in practice with clients experiencing poverty	Current setting
Elize	34	Female	4	4	Secondary care
Cassie	42	Female	15	13	Secondary care/ Private practice
Natalia	37	Female	7	5	Social enterprise/ Private practice
David	46	Male	21	19	Charitable organisation/ Private practice
Fiona	56	Female	10	7	Charitable organisation/ Primary

					care and Private practice.
Meredith	41	Female	8	6	Primary care

3.8.3 Data collection:

The method of collecting data was via a semi structured interview lasting between 60 and 90 minutes. Willig (2013) recommends semi-structured interviews as a data collection method for IPA, as it offers a loose structure and allows for the development of novel themes that may not be anticipated by the researcher. With the aim of capturing detailed subjective experiences, a semi structured interview allowed the participants space to explore their experiences in depth, which is in line with IPA's phenomenological nature (Smith, 1996). A structured interview was deemed less appropriate, as questions may constrain or restrict a participant's opportunity to explore their experience (Willig, 2013).

The interview schedule was developed with open ended questions to prompt a deeper exploration of this subject (See Appendix D). These questions were open-ended and non-directive, with some prompts to aid participants to elaborate on their responses, which is also in line with the phenomenological essence of IPA (Smith, 1996).

3.8.4 Data analysis:

The analysis followed the guidelines suggested by Smith et al. (2009). The first step was transcribing the interviews. The transcripts contained large margins on both the left and right-hand side, allowing sufficient space to be annotated. (Appendix L). The transcript was then re-read several times to gain greater familiarity with the text, while enabling me to become more responsive to what was being said (Eatough & Smith, 2006). Secondly, the text was highlighted, and the left-hand margin annotated with any observations, key words, and contradictions

that upon first impressions, seemed significant. This was done using the participants own words (Breakwell et al., 2006).

The next stage consisted of revisiting the transcripts and using the right-hand margin to annotate any similarities, patterns or emerging themes found in the text. The themes drawn from the data should encapsulate the essence of the experience as specifically documented by the participant. However, this phase also involves a hermeneutic process as it also captures the researchers' interpretation (Rizq & Target, 2008). Thereafter, any emerging themes were listed and examined for similarity. These were then clustered into groups to form larger themes (Appendix M). The transcript was then double checked to ensure that the themes reflected what the participant expressed (Smith & Osborn, 2003). The essence of this process is similarity seeking (gathering themes and ascribing certain themes to higher order themes through relatedness). During this process, one's own assumptions are bracketed, to seek deeper understanding of the meaning inherent in the participants experience.

The third level of analysis consisted of creating a table to organise the emerging themes, alongside examples of quotations from the text. In keeping with the idiographic principle of IPA, this was done for each individual transcript (Mcleod, 2011).

A cross-case comparison then took place to create a final table of themes. Similarities between emergent themes were looked for and any themes not present in other transcripts were disregarded. Through this process several overarching/ master themes were created each containing a group of subthemes. Supported quotations were listed alongside this to ensure the interpretation was reflective of what the participants have specifically expressed. (Smith & Eatough, 2006).

3.8.5 Ethical considerations:

This study adhered to both the BPS's ethical guidelines (2006) and The Code of Good Research Practice (London Met Research Ethics, 2018). Ethical approval was also obtained from London Metropolitan University's Research Ethics

Committee prior to embarking on the research. Participants were thoroughly briefed on several important aspects of the research process, via an information sheet (Appendix B) by email prior to the interview and communicated verbally at the interview stage. Written consent was sought thereafter (Appendix A.)

The consent form detailed the importance of confidentiality in various forms. The limits of confidentiality were described in accordance to the BPS Code of Ethics and Conduct (2009) It was clearly communicated to all participants that they would be given a pseudonym to protect their anonymity. Any potentially identifiable information, (such as place of employment, or identifiable information of their clients) was altered in the transcripts, and throughout the write up (Bond, 2010). Furthermore, participants were advised prior to the interview that confidentiality cannot be guaranteed if they disclose any harm towards themselves or others during the interview. Due to data analysis commencing shortly after the interviews, the participants were given up to two weeks to withdraw from the research project. In accordance with the BPS Code of Ethics and Conduct (2014).

The indication of risk may be expected to be minimal as the participants are Counselling Psychologists. However, Borges (2014) study highlighted that Psychologists made extreme deviations from mainstream therapy, which posed ethical dilemmas (Such as lying or exaggerating a client's difficulties to get more therapy sessions: Borges, 2014). It was, therefore, be possible that participants are concerned about the issues raised and thus may display a range of emotions. The participant's wellbeing was therefore explored prior to the interview taking place. Most specifically, the participants were asked to complete paper versions of the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001; see Appendix H) and Generalized Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006; see Appendix H). The participants scores were checked after completion, all of which scored lower than 8 and 6 respectively. Participants scoring above this range would have been excluded to minimise risk and distress amongst the participants. Particularly as scores above this range can be considered a moderate form of distress (Dum et al., 2008). The participants level of distress was

monitored throughout the interview, and a protocol was put in place to be followed if necessary (Appendix J). Participants also had the potential to be signposted to relevant organisations, were it appropriate (Appendix K.)

Participants were explicitly informed as to how information and data was safeguarded in line with the Data Protection Act (2018). Paper transcripts and consent forms were stored in a locked filing cabinet at home. Additionally, all electronic data and audio files were stored on a password protected laptop. Participants were also informed that upon completion of the research and in line with the Code of Good Research Practice (London Met Research ethics, 2018) the data can be stored securely for no more than 10 years. I made it explicit to the participants that due to publication purposes I would keep all research materials such as transcripts and audio files for 5 years, aiming to destroy all documents after 5 years.

The participants were given a debriefing form (Appendix E) after the interview thanking them for their participation and providing details of who to contact should they wish to make a complaint. They were also be given a list of resources and organisations (Appendix K) providing information of services they could have contacted if the interview evoked any difficult feelings in them.

Part 4: Analysis & Results

4.1 Introduction

In this chapter findings will be presented which have emerged throughout an in-depth analysis of 6 interview transcripts. Firstly, I will present a brief journey of how the findings emerged. Thereafter, a table will be presented which shows the finalised themes. Finally, the full analysis of the themes will be presented.

Prior to presenting my journey of how the findings emerged, it seems important to note that the outcomes of this project reflect my personal interpretation of the participants accounts. It is possible that another researcher would interpret and present the themes differently. The three superordinate themes that emerged were: Awareness of the relationship between poverty and mental health, Resources that are drawn upon, and Adapting practice in the light of economic differentials.

While there are potential relationships between the themes it seems logical to present them in a linear like fashion. This makes sense, particularly as the aims of the research are to understand how therapeutic adaptations are experienced and made, while identifying what assists the participants to make these alterations, in addition to understanding what underpins their decision making.

I will therefore suggest that it is the first two superordinate themes (The participant's awareness of the relationship between poverty and mental health coupled with their personal resources) which creates the space to make an array of therapeutic adaptations (The final superordinate theme).

4.2 Themes

Three superordinate themes and eight subthemes emerged from the analysis (See Table 3.) Key quotes are also presented which illustrate the essence of the themes captured, with the intention of representing the participant's perspectives.

Table 3. Superordinate themes and subthemes with key quotes

Superordinate	Subthemes	Key Quotes

Themes		
Awareness of the relationship between poverty and mental health	**Poverty as a predisposing/ perpetuating factor**	*"You don't often get someone who's incredibly wealthy coming to a day centre or or, you know, going into a forensic mental health hospital, because the very nature of growing up with the socioeconomic status they have leaves them to have life conditions which make them less likely to eventually have problems with mental health and with, you know, offending." (Cassie: 150-160)*
	Society as a maintaining/ exacerbating factor	*"And actually, when you start to get to… when you start to understand some of the factors that might be a contribution to the distress… is the fact that these people have been a victim of actually a fundamentally social system that has failed these people through various means. They may have less opportunities... erm... Occupational opportunities." (Fiona: 310-319)*
	The workplace as a maintaining/ exacerbating factor	*"But in that example, I gave earlier about the adult mental health- I couldn't be as flexible. And at some point, you know, I would be loathed to do it, but at some point, I would need then to discharge the person, whereas. In terms of... The kind of... The guidelines of the service. But actually, when I was working in adult mental health, I would try to be as flexible as possible with engagement." (Elize: 203-216)*
Resources that are drawn upon	**Using personal experiences to inform practice**	*"I think. I think when you have grown up with an experience with your parents if it's mental health or substance misuse or whatever. You're attuned to that way of being, you can sort of understand if you know… you're used to it. And you can have a lot of empathy." (Natalia: 453-461)*
	Using Personal values in the therapeutic relationship	*"I worked as a person-centred counsellor for some years, years and years ago, and. I think one of the most important things I learnt there was what was congruence. And I think being real with people and clients is…. Probably one of the most important things we can do as a therapist. (Meredith: 756-777)*
Adapting practice in the light of economic differentials	**Poverty as part of the formulation**	*"You've got to really bear in mind. How do these factors impact upon their distress? And so sitting and allowing them the space to explore the impact of all these factors." (Fiona: 88-92)*
	Focus on empowering	*"By helping them shift that locus of control so that they find ways they can become more empowered. And that's, you know, that's a big part of therapy. (Meredith: 435-441)*

	Boundary flexibility	*"A little bit of self-disclosure. And I do self-disclose. I self-disclose my history of mental health problems and I self-disclose my history of addiction. And there's a big there's a good reason for that, because I think it's really important that they know that these are the things that can strike at anyone. (Cassie: 1107-1116)*

1 (Boundaries adjusted included: self-disclosure, giving money, breaking rules, location of therapy and time boundaries.)

4.3 Superordinate Theme 1: Awareness of the relationship between poverty and mental health

This superordinate theme was a dominating theme throughout the transcripts. All participants, when discussing their experiences of working therapeutically with clients experiencing poverty reported an awareness of the relationship between poverty and mental health. The different ways their awareness was understood as impacting practice are detailed below in the subthemes.

4.3.1 Subtheme 1.1: Poverty as a predisposing/ perpetuating factor.

This subtheme encapsulates how all participants viewed the relationship between mental health and poverty as inextricably interlinked. In the excerpt below Cassie describes how she interprets this relationship:

(Cassie begins with a high intonation in her voice while laughing) "You don't often get someone who's incredibly wealthy coming to a day centre or, you know, going into a forensic mental health hospital, because the very nature of growing up with the socioeconomic status they have leaves them to have life conditions which make them less likely to eventually have problems with mental health and to have problems with, you know, offending." (Cassie: 150-160)

Cassie seems to express her view of the unlikelihood of seeing wealthy people as offenders and/or in a mental health unit. Cassie's laughter

seems to emphasise her perception of not only how obvious the relationship between economic wealth and mental health is, but perhaps also the issues inherent in the system. With negative financial circumstances potentially viewed as a factor linked with the development of mental health issues, while positive financial circumstances arguably constitute a protective factor for mental health. It is also possible that Cassie's laughter also serves to cover or control any angry feelings she has around her perception of this relationship, akin to sarcastic laughter.

Fiona provides her view on the complex relationship between poverty and mental health:

(Assertively) "And I've kind of experienced the impact it can have because, you know, it can….We know for a fact that research has suggested that people from a low socioeconomic background have a really poor health outcomes anyway in terms of mental health and physical health….there's a high incidence of coronary heart disease. You know, and. Blood pressure, diabetes, you name it, cancer, even. And, you know, the life expectancy for these individuals can also be quite challenged." (Fiona: 492-507)

Fiona describes how poverty impacts both mental health and physical health by referring to research, evidence and very serious physical health difficulties which may be encountered by those experiencing poverty. It is possible that Fiona does this to emphasise the validity of her point and experience but also the overall negative health effects of poverty. By referencing death Fiona may also be emphasising the sheer gravity of the situation. Her overall account and assertiveness in her tone seems to

emphasise not only her belief in the relationship between poverty and health but her engagement with this topic.

Meredith shares her view that there are common factors encountered by those experiencing poverty:

*"I suppose one of the things that I noticed, particularly with the ****** service, is that often.....low income comes hand in hand with certain ethnic backgrounds." (Meredith: 1158-1163).*

Meredith describes her observation that poverty is strongly linked to certain ethnicities, particularly in the service she works in. Prior to making this statement, Meredith acknowledged that she previously didn't realise the strength of the relationship between poverty and ethnicity. Implying perhaps that life is less fair that she previously realised. According to Meredith, ethnicity and its's possible connection with low income might also bring barriers to accessing mental health care which may also perpetuate a person's experience of distress.

Elize shares a similar stance that poverty is linked to other factors:

"I guess I noticed kind of... The intersection between poverty and trauma." (Elize: 672-674)

"So, people who would not only be homeless, but they would also have complex issues, complex needs around erm... Substance misuse around

mental health difficulties or physical health difficulties. And so, yeah, so there's lots of different kind of challenges and needs that people have. So, there's maybe criminal justice background as well." (Elize: 136-145)

Elize suggests that there is a connection between trauma and poverty. Her use of the word intersection seems to imply that for her poverty and trauma are not separate entities but can be perhaps overlapping. Elize, thereafter describes the various factors that may require consideration when working with poverty such as substance misuse or physical health difficulties. In essence, Elize seemingly connects complexity to poverty. Not necessarily in a causal way but suggesting all these factors are related in a complex web of interconnected factors. By referencing complexity and the different factors that require consideration when working with people experiencing poverty, Elize may be communicating how demanding this work can be.

While all participants discuss their perception of the relationship between poverty and mental health; Natalia is the only participant who reflects on the impact that such a perception may have. Prior to this extract Natalia described witnessing substance misuse and mental health problems exclusively in the economically disadvantaged within the homelessness service she works in:

"I don't think it's that helpful always to just look at the mental health and the substance misuse separately and trying to address one.... They both are together." (Natalia: 179-184)

By reflecting that she does not find separating mental health issues helpful, she is perhaps alluding to the notion that seemingly separate issues may be one and the same. Her use of the word ‘always’ suggests this may be very a common experience for her. Highlighting her awareness of societies influence on individual behaviours such as substance abuse.

4.3.2 Subtheme 1.2: Society as a maintaining/ exacerbating factor

Not only do all the participants show an awareness of the complex relationship between poverty and mental health but they also all show an awareness of how bigger societal factors directly impact their practice. This will be discussed in this current subtheme.

David describes his perception of how the larger social system has made his clients’ life more difficult:

“I learned about food banks. I didn’t know anything about them. But they have a policy of families. Its families where its pregnant women- number one, families, women, and then guys at the bottom. But the foods all gone when the guys show up. Because they've given it to the families. Now, you could say, well, that makes sense. But. It makes sense. Yes, I agree that, you know, if you have to have a hierarchy that's a sensible hierarchy. But what do you do with the people at the bottom?” (David: 338-352)

David’s discusses a system which has connotations of care and consideration- a food bank- an organisation which gives food to those experiencing poverty. He highlights that even organisations like this are structured in ways which restrict some- specifically men - in this passage. While David can rationalise that a hierarchy is understandable, he expresses “But the foods all gone when the guys show up.” This suggests that this system doesn’t merely restrict- but can at times exclude some of the people it

serves – in this case men. Thus, potentially maintaining and exacerbating the distress they are likely to already experience.

This sentence could also imply that David feels an undercurrent of anger towards the system for excluding men. David's final sentence "What do you do with the people at the bottom?" seems to indicate for him a sense of frustration, which in turn may echo a similar hopelessness those in poverty might feel. It embodies the truth that there is not enough to go round and that systems must apportion according to need. While recognising the necessity in this logic, David seems to feel a strong sense of unfairness.

Natalia discusses how a service users' earlier experiences of caregiving impacts their perception of care within services:

"And then into the system where, again, you know, typically more medical model of mental health being diagnosed and being medicated and often treated. Maybe it's that.... (emphasis and heightened intonation) they're the problem." (Natalia: 815-820)

Natalia describes how service users are generally placed into a system of being diagnosed, medicated and treated for their mental health difficulties. Natalia describes treatment within the mental health system as a linear process, which could be likened to a conveyor belt of care. It is arguable that Natalia may recognise an issue in the system which seems to reflect a 'doing to' therapeutic stance towards mental healthcare. This contrasts with a more humanistic and relational 'being with' stance which is commonly advocated within the Counselling Psychology discipline. This may suggest an internal tension between the system and the counselling psychologist.

Natalia ends the extract by stating that “maybe it’s that… they’re the problem.” The intonation in her voice heightens as she places emphasis on the words “they’re the problem”. This statement may also allude to her perception that society views those experiencing poverty as being ‘the problem.’ Thus, highlighting her frustration towards a society that perhaps views the relationship between poverty and mental health as the result of an individual’s actions- not the fault of society.

Fiona shares a similar view:

(Expresses this excerpt with clear annunciation and an increasing tone) “And actually, when you start to get to… when you start to understand some of the factors that might be a contribution to the distress… is the fact that these people have been a victim of actually a fundamentally…a social system that has failed these people through various means. They may have less opportunities... erm... Occupational opportunities.” (Fiona: 310-319)

Fiona explains that in order to truly understand the distress experienced by a person who lives in poverty you need to understand the factors which allow it to occur. These factors being: *“that these people have been a victim of….a social system that has failed these people through various means.”*

Embedded in this sentence there seems to be a sense of unfairness, particularly when referring to the word ‘victim’. The use of this word implies perhaps a view of society as perpetrator or instigator- inherently excluding of some. Denying opportunities to those less financially fortunate. Fiona also seems to imply that society has had many chances to help those in poverty but has failed to do so. Thus, not only contributing towards but perpetuating and exacerbating their distress.

Meredith also discusses the importance of being aware of external stressors:

"I think Counselling Psychology has this…. This… in its philosophy that we (with emphasis) have to understand where the client is coming from, that position where they are, what their difficulties are, what the obstacles are for them, whether they're practical obstacles, economic, social, internal, you know, whatever their obstacles are." (Meredith: 189-200)

Meredith's comments suggest that her awareness of the poverty-mental health link, was absorbed, somehow, from the discipline of Counselling Psychology. Meredith seems to normalise the process of considering external factors impacting mental health, including economic ones. By outlining the various obstacles that a person can come up against, while touching on the philosophy of Counselling Psychology; It seems that Meredith is touching on the importance of understanding a person's distress as being subjective and idiosyncratic. Meredith could arguably be suggesting that understanding a client in a comprehensive manner, particularly including an appreciation of environmental and societal factors which can maintain or exacerbate a person's distress, (as opposed to solely in an intrapsychic fashion), is an important part of deepening understanding and therefore being a Counselling Psychologist.

All of the participants so far acknowledged how external societal factors can be detrimental to clients experiencing poverty. Cassie, however, describes how this can take a more implicit and unconscious form, laden with bias:

"And I think a lot of it (bias) comes from…. is to do with… the fact that there's, again, this structural imbalance between the caregivers and the care receivers. And that's I guess that's what it comes to, income. It's… it's not just about the money. It's about the power and the systemic imbalances that come along with being low income." (Cassie: 682-681)

Cassie expresses her view that the bias of society towards people experiencing poverty, derives from larger structural and systemic inequities which appear, in her view strongly linked with low income. Cassie notices that amongst these inequalities is a difference between those who give and receive help. It is interpreted here that possibly such an imbalance, for Cassie, is emphasised when the person receiving care comes from a low income.

Cassie appears frustrated and disarmed by acknowledging the treatment received by people in poverty due to the 'systemic imbalances' that she highlights. Perhaps further underlying that this population may not only be at a disadvantage from a power dynamic perspective due to being at the receiving end of the help, but also struggle with the additional obstacle of being treated unfairly due to their socioeconomic background.

4.3.3 Subtheme 1.2: The workplace as a maintaining/ exacerbating factor

The previous subtheme described the participants' awareness of larger systemic factors. These factors are likely to be felt, perhaps more strongly by Counselling Psychologists in the therapeutic workplace, in terms of aids or barriers to therapeutic effectiveness. This theme therefore relates to factors which maintain and/or exacerbate mental health difficulties as felt by the therapists within the workplace. For example, lack of support, time, energy, money for treatment, or insufficient number of sessions.

Meredith describes the impact of financial input have within her current workplace setting:

> *"I mean, we're very lucky in the way our way we're resourced financially. It's.....it's exceptional…. and…it's not the same within other services. But also, we're really good in that we have a very active signposting…(pause)… well not just signposting. But, you know, it's…it's like we can do more to help clients. It's not just signposting. It's… we can get in touch. You know, there are services associated with ******* that I can refer clients to or talk things through with...Being connected to them really helps with consistency in care. (Meredith: 1112-1126)*

Meredith describes the resourcefulness of her service as not only lucky but exceptional. while comparing this to other services which are not as well resourced. Meredith references luck, a concept usually associated with chance. Use of this word in addition to the word exceptional may highlight Meredith's desire to emphasise this experience as a rarity.

Meredith thereafter explains that it is not just financial resourcing which helps clients but having good relationships with other services. She initially describes this process as signposting. However, she questions her use of this word on two occasions. Signposting suggests a process of directing a service user towards another service. Perhaps due to not being able to meet certain specific needs. It is possible that her questioning of this word is highlighting her perception of care as attending to a variety of stressors. Stressors that may go outside of the capabilities of the therapeutic relationship. This might be what she means when she refers to consistency of care.

Natalia also describes how the work environment impacts her practice. Throughout the interview Natalia advocates the essentiality of flexibility with homeless service users.

> *"I can basically be much more flexible than I would be if I was working in an NHS service where I'm much more governed by their sort of blanket policies and rules." (Natalia: 90-95)*

Natalia touches on her experience of therapeutic flexibility in her current work within a homelessness setting. She compares this to work within the NHS which has felt more restricting; the result of being governed by "blanket policies and rules". Her words may suggest a perception of inflexibility and lack of control for Natalia. She seems frustrated by the idea of being led by blanket policies utilising a one-size-fits-all approach, irrespective of individuality.

It would seem that Natalia perceives that working with a homeless population, while under an NHS umbrella, might reduce her ability to provide a care that is appropriate to that person's idiosyncratic experience. Providing generalised therapy which is what Natalia seems to believe would happen in an NHS setting, may not allow her to practice effectively as a Counselling Psychologist. Rigid practice with people experiencing homelessness may evoke conflict with Counselling Psychology values. Resulting in cognitive dissonance and an obstacle to her therapeutic effectiveness.

Elize is another participant who discusses flexibility in practice as influenced by the setting:

"But in that example, I gave earlier about the adult mental health- I couldn't be as flexible. And at some point, you know, I would be loathed to do it, but at some point, I would need then to discharge the person, whereas. In terms of... The kind of... The guidelines of the service. But actually, when I was working in adult mental health, I would try to be as flexible as possible with engagement." (Elize: 203-216)

Elize discusses the process of engagement extensively throughout the transcript. To her this is an essential part of the therapeutic process. Elize describes her previous experience in adult mental health and vocalises her disappointment towards having to discharge clients and relates it to being inflexible possibly even rejecting. She acknowledges that this is part of the role and follows the guidelines of the service, but it conflicts with her internal sense of what is best for the client. Therefore, she maintains efforts to preserve as much flexibility as possible in the face of restrictions. She complies with the guidelines but does so uneasily and is emotionally challenged by her own actions, possibly relying on reducing distress by stating it's not her actions but merely following guidelines. Thus, highlighting how important this part of therapy is - in her view.

Cassie reflects on the impact of being bound by service policies:

*"and that's what I'm finding when I'm working at ********, is that it's not like an NHS service where you're very sort of bound between what your service can offer and all of that.... In the ******* and in private mental health care- it's very... Whatever the client needs the client gets." (Cassie: 346-354)*

Cassie compares her experience of working in a rather prestigious setting which offers private therapy to her experience of working with those experiencing poverty within the NHS. Whatever the paying client needs- the client gets. Highlighting Cassie's awareness of the certain features in mental health provision, such as: the richer can pay for their mental health needs to be met, whereas for those experiencing poverty, mental health needs are limited to what services can offer. The services offered are in essence dependant on funding that is received. Highlighting the way in which societal obstacles can be felt first-hand within the workplace.

Cassie uses the word 'bound' when describing the obstacles and thus the limits of what she can offer in the NHS. This possibly implies that Cassie feels restricted and frustrated in her practice, wishing to give more, but not being able to.

David expresses his view in relation to his experience of alcohol services:

> *"But all of the alcohol services say if they continue to drink, they're not gonna be seen. The NHS says that." (David: 465-467)*

David describes his perception of the rules within NHS alcohol services around eligibility in receiving mental health treatment. David explains that a person is excluded depending on whether they still drink alcohol or not. David alludes to the relationship between addiction and mental health, portraying the NHS as viewing these factors separately. David's explanation emphasises a sense of inflexibility and rigidity towards clients which seems shared by the other participants thus far. David's use of personification alludes to his view of the NHS as a rigid gatekeeper in mental healthcare.

This statement seems to encapsulate the frustration David feels with the NHS for not understanding that the relationship between poverty and substance abuse is

complex and multifaceted. To exclude those who continue to drink from accessing services is in some respects excluding those in most need. David is a man who works extensively with economically disadvantaged men in private practice. It is therefore possible that his frustration stems from feeling obligated to provide a service that is unavailable on the NHS.

Fiona shares a more optimistic experience of a setting which takes various factors into account when understanding a person's difficulties:

(Places emphasis on first two words) "Even when we are doing those cognitive neuropsychology assessments in the past. We did…(pauses) We do… (with emphasis) …. bear in mind people's…. social and psychosocial environments... their occupational functioning." (Fiona: 629-640)

Fiona reflects on her experience in a brain injury setting which draws mainly on the medical model. Explaining which factors are considered when doing cognitive neuropsychology assessments. Fiona's explanation begins by placing emphasis on the first two words 'even when.' The emphasis on the words may suggest that she is providing an example of something which may be, in her experience, a rarity. Fiona's switch from past tense to present tense appears significant due to increased prominence of words in the present tense. Perhaps indicating Fiona's viewpoint regarding the essentiality of considering different perspectives when undertaking assessments.

4.4 Superordinate Theme 2: Resources that are drawn upon.

All participants referred to drawing on personal resources when delivering therapy to clients experiencing poverty. For example, their own encounters with significant life difficulties. These resources are potentially unlocked by a heightened

awareness of their own values as a result of being Counselling Psychologists. Furthermore, their personal values in the therapeutic relationship appear to serve as a channel to level out inequalities between themselves and their clients.

4.4.1 Subtheme 2.1: Using personal experiences to inform practice

All the participants, except one, spoke of experiences in their private lives which guided their practice. The Counselling Psychologists reflections on their personal experiences and values which informed and guided their practice will now be detailed.

Cassie, quite simply states that:

"My own experience as a service user and my own experience as a recovering addict. Which which... guides me." (Cassie: 866-869)

Cassie elaborates further:

"Because there are certain human emotions and human cognitive processes that transcend income, feelings of being stigmatized and discriminated against. Feelings of being rejected. Feelings of being unloved. Even if I come from a nice family background, it doesn't mean that I didn't have family trauma. There is a history of.... you know, a lot of childhood stuff. There's a history of abuse, there's a history of neglect. There's a history of addiction. And that is something that also a lot of my clients have as well. And there is there is a shared experience that helps. That really helped me in my work. And if I didn't have that, I don't think I would be a very good psychologist." (Cassie: 905-924)

Cassie engages in significant self-disclosure in this excerpt, discussing her own experience of childhood trauma, abuse, neglect, addiction and how these have informed her practice. Sharing of these experiences appears significant because not only are they incredibly personal and sensitive, but they resulted in her feeling unloved and rejected. The sharing of traumatic experiences like this requires allowing oneself to be vulnerable.

It seems that Cassie has, throughout her life reframed these adverse experiences in a way which makes her feel she can use them in a more meaningful and connected way, potentially making her a more effective practitioner. This seems likely considering that she claims these experiences have helped her in her work. Most specifically because they are shared experiences with her clients. Cassie even goes as far as stating that without these experiences, she doesn't think she would be a good psychologist. Therefore, highlighting her belief that shared experiences, even highly traumatic ones are something which aids the therapeutic relationship and can be used to enhance practice. This is important as it suggests trauma may in some instances provide connection and enhance therapeutic interactions.

Natalia shares a similar stance:

"I think. I think when you have grown up with an experience with your parents, if it's mental health or substance misuse or whatever. You're attuned to a certain way of being, you can sort of understand…if- you know… you're used to it. And you can have a lot of empathy. (Natalia: 453-461)

Like Cassie, Natalia shares her perspective that adverse childhood experiences can not only aid the therapist in their therapeutic work but can

increase understanding of the client's difficulties. Even to sit with people that have experienced trauma and severe difficulties may be enhanced by the therapist having had similar experiences, enabling a better quality of being with or alongside the client. For Natalia these were the experiences of growing up around parents with mental health or substance misuse difficulties.

Natalia expresses that such experiences facilitate tuning in to 'a certain way of being'. It feels as though, almost like how a mother does not have the words to describe how they are attuned to their baby, yet understands their baby's experience in a deep, nonverbal, and unique manner, so does Natalia with her clients. It seems her experiences equipped her with a greater ability to empathise and understand people in distress.

Elize discusses her own experience of hardship:

"My family was kind of, you know, working class background, but wouldn't have experienced poverty. So, I was never hungry. I was never... you know, but I guess my parents would have… Yeah, kind of ensured that. But there would have been times where there would have been, you know, financial hardship. But I guess as a child, I was never- I never felt that- you know? They kind of-would have- gone above and beyond type thing to make sure that I didn't feel that. But I guess I would have sensed it." (Elize: 700-716)

Elize seems to rationalise that identifying as working-class does not mean she has necessarily experienced poverty. It seems that Elize's understanding of poverty means that her basic needs such as hunger were met. Her parents strove for her to not feel these effects. To do more than what is required to avoid an experience suggests that the experience itself

might be feared. It might also suggest that the experience of deprivation/ poverty was at times felt to be close by. Therefore, efforts were made to ensure this did not catch up with them. This sense of feared events being close by is a common encounter therapeutically.

David describes a traumatic experience which he believes he has in common with his clients. The result of which has made him *"See it more in the world." (David: 585)*

"I guess I have to come clean. I guess I you know, I've also been in the same position. So, you know, like when I divorced, I was thrown out of my house. I was told by the police I could not return home under any circumstances. I had nowhere else to go. I was told I couldn't take my car. I was escorted by two police officers and given 10 minutes to collect whatever I could carry and then told I wasn't allowed home. Now, I had a job, but just. And I remember walking around thinking, OK, where do I go? I didn't have enough money to go to friends or family. I knew I couldn't get my car. You know, we're talking 15 miles away. And I remember at that moment realising shit, you know?" (David: 543-563)

David begins by confessing "I guess I have to come clean" before disclosing his experience of divorce which led to not only homelessness but a series of losses. 'Coming clean' perhaps implies that this was a difficult, perhaps even shameful experience that David tried to keep to himself.

There is a sense of helplessness in David's narrative particularly as he refers to being escorted out of his own home by police officers. David attempts to rationalise that although he had a job, he was left with questioning "okay, where do I go?" which implies a sense of feeling lost and

perhaps alone. Particularly as he references being so far away from friends and family. David using the exclamation word “shit” when recalling his thought process at that time. It is likely that this word represented shock, strong emotions and pain. His previous experiences with sudden helplessness and loss can be used in the therapeutic relationship to suspend judgment and deepen the encounter with clients.

Fiona describes what influences her practice:

“I think one's own background is a key influence because I identify- I- I’m, I'm happy to share this. I'm a British Pakistani Muslim. And personally, I don't come from an underprivileged or low socio- economic background, however, I've lived abroad in Pakistan for many years and I have had face to face exposure to what social economic deprivation can be. And I have seen. I've had. Not first-hand experience, because that would be a total deceptive kind of statement. But I have experienced seeing people in extreme poverty.” (Fiona: 436-452)

Fiona shares her view that a person’s background is a key influential factor within their therapeutic practice. This perspective has seemingly arisen from her own identification with being a British Pakistani Muslim. Fiona expresses happiness to share how she conceptualises her identity, and a sense of pride. Fiona is also clearly able to identify what she is not- that she does not come from an underprivileged or low socio-economic background. While she doesn’t have first-hand experience of poverty, face to face exposure sounds like a known presence. Something useful in working with underprivileged clients. Furthermore, the use of the word ‘but’ at the start of her last sentence perhaps alludes to this idea- that she believes seeing people

in extreme poverty has had a similar, perhaps long-lasting effect on her practice.

While all the participants above provided examples of personal experiences which influence practice; Cassie is the only participant who reflects on a work-related experience:

"And that's where it became much more aware to me because (begins to laugh) I really hadn't had much- cause to go into, you know, a council flat where a large family was stuffed into a two-bedroom flat before- in my life, often." (Cassie: 425-431)

Cassie identifies the moment in which her awareness of poverty related difficulties really increased. Perhaps even a moment of realisation- in which she witnessed overcrowded living conditions during home visits. Cassie laughs when describing her experience. She states "hadn't had much-cause to go into, you know, a council flat where a large family was stuffed into a two-bedroom flat before." Cassie, through the channel of humour highlights the stark reality- that her previous awareness was blind to certain realisations. Particularly as she describes this encounter as a rarity. Not only are people hastily forced into a space, but they are also treated like objects. Furthermore, her laughter may also serve as a tool to emphasise the shocking conditions of poverty and perhaps even her uncomfortable feelings around this. Despite this her changed awareness arguably serves as an aid to understanding her clients in poverty to a deeper degree.

4.4.2 Subtheme 2.2: Using Personal values in the therapeutic relationship.

Every participant commented on their principles and values which guided their therapeutic practice While their values varied, they all appeared humanistic in nature.

Meredith discusses her values:

"I worked as a person-centred counsellor for some years, years and years ago, and. I think one of the most important things I learnt there was what was congruence. And I think being real with people and clients is…. Probably one of the most important things we can do as a therapist. That it gives the message that I am being myself and I'm not putting on anything. You know, there's no need to be anything different. And therefore, it encourages the client to do the same thing."(Meredith: 756-777)

Previous experience of working as a person-centred counsellor seems to hold significant meaning in Meredith's development as a therapist, especially the concept of congruence. Meredith alludes that we- as humans show different selves, perhaps even false selves and expresses the importance of showing only our authentic self. Her reasoning being that this encourages the client to do the same, a seemingly similar process to how we learn from our caregivers.

Natalia describes her view:

"I mean, just… trying to build rapport at the beginning. And that's particularly…..particularly important with all... all... Clients. In every kind of service. But where I work… I think with clients with complex PTSD and trauma, past trauma. It's potentially huge." (Natalia: 319-326)

Natalia acknowledges the importance of building rapport in all therapeutic relationships. While seemingly a universal therapeutic value it is clear that some therapists prioritise this value more personally. However, it

seems important for her to emphasise that this may be more important in the service she works at. Natalia makes no reference towards this being a homelessness setting. She instead describes the client group as people who suffer with complex PTSD and past trauma albeit connected to poverty and homelessness. This perspective is likely to reflect the care, respect and understanding she has towards her clients.

Elize describes what she thinks is important within the therapeutic relationship:

"I think that's where most… maybe even all of…the healing comes from, repairing- within the relationship." (Elize: 1166-1167)

Elize views the therapeutic relationship as not just important- but the main vehicle for healing and change. From her words she views the therapeutic relationship as the opportunity for a corrective experience. Seemingly, to repair the hurt causes by historically difficult relationships, through experiencing a caring therapeutic and present relationship

It seems that Fiona also views the therapeutic relationship as a vehicle for change:

"Fundamentally one of the aspects of good therapy is to keep in mind… and to keep holding in mind- the therapeutic frame... maintaining the therapeutic relationship." (Fiona: 774-778)

However, it seems that she perceives the relationship as serving a different function. Fiona refers to the concept of the therapeutic frame as a fundamental part of therapy. It may be that she perceives the therapeutic

relationship as providing a safe, boundaried and consistent space within which a person can increase their self- and other awareness.

The following excerpt increases our understanding regarding Cassie's values:

"I think the important things are... The ability to build a relationship and to find the relatability and the similarities. Despite the fact that you might be completely different to the person in the room with you. And in that there's a warm, fuzzy humanness. There's a genuine ness that you need for that. It's... It's being aware and calling out.... I often sort of say, you know, obviously there's something that I can't understand about your life because, you know, (laughs) hello, white middle class. But tell me about it. I'd like to learn about it. And I think respect. Is very important." (Cassie: 996-1011)

Earlier in the interview Cassie admits to feeling *"a sense of shame in being a clinician that comes from a privileged background." (486-489)* Particularly when working with those from poorer backgrounds. From Cassie's words, relationship building is essential. It could also be argued that for Cassie looking for similarities and calling out difference could be even more important when working with those from poorer backgrounds. Finding common ground could therefore be used as a vehicle to reduce power differentials within the relationship. This would make sense considering Cassie uses humour when touching on her own difference, a reaction she seems to express when she is experiencing uncomfortable emotions. Despite this, being more authentic in the therapeutic relationship gives her meaning and appears to be an important value she uses to drive practice.

David reflects on the meaning of values:

"There are different methods of valuing that aren't to do with what you have. They're to do with who you are and what you think, what you believe, how you treat people. And I think you can be rich in all that." (David: 1443-1452)

David seems to not define values based on what a person does or owns. This suggests his criticism and potential frustration towards a society placing value on people based on their economic status. He, in contrast seems to take a more humanistic stance in defining values based on more internal processes such as your attitude towards others, perhaps hinting at respect and acceptance. His values regarding respect and unconditional positive regard allow him to encounter more genuinely his less fortunate clients. Using internal values to navigate his work.

4.5 Superordinate Theme 3: Adapting practice in the light of power differentials.

This theme seems to capture the explicit adaptations that took place as a result of the experiences and processes involved in the above two superordinate themes. Most specifically, participants described their unique practice of adapting therapy specifically for this low-income population.

4.5.1 Subtheme 3.1: Poverty as part of the formulation

Most participants incorporated poverty as a factor which contributes towards their distress within the formulation. This was done collaboratively and was made explicit with clients. Fiona shares her perspective by discussing the various factors which contribute towards distress with clients:

"Yeah, well, I think it's (with emphasis) fundamentally having a conversation about all these factors... Tending to it, because I think we can get drawn into normalizing and validating but that on its own....It's not enough, is it?" (Fiona: 380-385)

Fiona attempts to normalise how easy it can be to get drawn into a pattern of validating and normalising- yet asserts this requires tending to. Suggesting merely considering economic difficulties is insufficient. Therefore, the formulaic focus might be on working towards attempting to change external stressors. Getting drawn into something suggests embarking on a process without much questioning and/or awareness. Fiona's emphasis on discussing factors which contribute towards distress could therefore suggest the importance of increasing awareness. Therefore, highlighting the importance of openly conceptualising and formulating a person's difficulties.

Meredith discusses goal setting within therapy:

"Say, you know, we would have a discussion about that, about what they can and they can't do and so on." (Meredith: 133-136)

Meredith seems to take a direct approach with regards to what is realistic for her clients to engage in and aspire to. Recognising that for low-income clients' certain goals may be less attainable. This would inform the formulation as a potential limitation not necessarily the fault of the individual, but a limit partially given by society.

Cassie discusses how they formulate in her service:

"And there would always be someone that's been to their home and seen what their living conditions is because they work very much with families as well. And I think that- that's a very important resource in learning what interventions are realistic when working with them." (Cassie: 614-619)

For Cassie, attending a person's home and working alongside the family seems to allow for a wider perspective, and perhaps an increased understanding when conceptualising a person's difficulties and what's attainable in working with them.

For Cassie this seems like an invaluable tool during the formulation process in identifying what interventions are realistic. This also implies that without this experience- therapeutic recommendations may be made which are inappropriate for clients. The result of which could harm the therapeutic relationship- by lacking a true understanding of the client's world. Not intervening could be equally problematic.

Natalia shares her perspective:

"So, it's kind of helping the client make sense of. What was in the past, how the past impacts on the present. But the sort of changes or control you can have over your present and your future..." (Natalia: 1147-1152)

For Natalia, a large part of the therapeutic work is differentiating between past and present. Perhaps this is because she sees that her clients relate to the world based on their histories and not the present. Helping the client see that there are possibilities for change and control on their condition seems important to Natalia. There is a sense in her words that she holds hope

for her clients, perhaps by showing them that they have more power and influence than they think they do. Therefore, bringing the concept of empowerment to the formulation.

David takes a critical stance on how to formulate a person's difficulties:

"I think it helps them therapeutically to identify some of their anger issues. And I guess what I've seen is…I don't think, you know, like they're told a lot- they're angry and they need anger management. To be honest I think the anger is actually an appropriate response to a society that doesn't care." (David: 605-616)

For David, it seems important for him to share his perspective with his male clients. With regards to how he perceives their anger difficulties. David seems to do this with the intention of helping his clients therapeutically. By helping them reframe their difficulties to see that their anger can be one of many potentially appropriate responses to living in a society that cares very little for their wellbeing. This will be enhanced when working with lower income clients as they are potentially lower on the societal continuum of care. David's stance suggests that society views client's anger as a maladaptive response that requires intrapsychic altering by the individual which he does not seem to agree with.

4.5.2 Subtheme 3.2: Focus on empowering.

Most participants discussed empowerment as an important therapeutic adaptation to be used with clients experiencing poverty.

Natalia describes what her meaning of empowerment is:

"But particularly with him to really try and empower him to lead... You know...to lead the therapy or to talk about what he wants to talk about." (Natalia: 1111-1113)

For Natalia, empowerment means allowing her client to feel power directly in the therapeutic space. Natalia's client is someone who has experienced a lack of power through economic deprivation but also adverse childhood experiences. She therefore adapts therapy to allow him a sense of control and autonomy. Perhaps this is a significant adjustment- as it is likely her client has not experienced this level of power or control before.

Meredith describes what empowerment is to her:

"By helping them shift that locus of control so that they find ways they can become more empowered. And that's, you know, that's a big part of therapy. And that can be, you know, we can you can do that- using the housing transfer….. (5 second pause) But then you know as I am saying this we try and help them to feel empowered and to see that they have power and things aren't just happening to them. But then there is. I can see some conflict in what I am saying. It's difficult to know how to work with it. But I take the stance of working in a way that makes them feel like they do have power. No matter how small. (Meredith: 435-453)

Meredith begins by outlining what empowerment looks like to her during therapy. She expresses that empowerment involves helping clients shift their locus of control. Therapy therefore involves helping clients to see that they have control over their circumstances in contrast to letting things just happen 'to them.' This statement highlights Meredith's belief that her clients have the potential to acquire more power than they think. Her view

may also imply that her client's circumstances are partially the result of disordered perspectives as opposed to structural inequalities existing outside of the individual.

Meredith then provides an example of how she helps her clients gain power- through the housing transfer form. Meredith then pauses- seemingly a moment of reflection and admits there is conflict in what she is saying. She then admits a difficulty in knowing how to 'work with it.' This statement alludes to the difficulties when working with factors largely outside of a person's control. There is a sense of confusion in Meredith's voice. This pause and reflection might represent the confusion she feels in not knowing what interventions are appropriate for this unique population. Her voice then shifts to a more direct tone. This directiveness might reflect the sense of certainty she wishes to feel with regards to delivering interventions with this population.

Interestingly, both Cassie and Meredith share similar processes around identifying what empowerment is:

"But they are one of the ways that I work. It is empowerment. You know, there are things that I have power over, and things that they can control. But sometimes I feel like I'm telling the clients that. And in my head, I'm actually thinking, you know, if I was in their shoes, I'd feel exactly the same way. And sometimes it's acknowledging this is a crap situation. And if I was in your situation, I wouldn't be coping. And there's something very powerful about an always not trying to put a positive spin on things, because sometimes that's really patronizing, because sometimes there is no positives that you can get from it (Cassie: 1338-1355.)

Cassie begins by assertively explaining that empowerment is a key approach she uses therapeutically. Almost like it is a recognised intervention. Empowerment- to Cassie consists of helping clients look for ways to acquire power or control over their circumstances. She too, like Meredith then appears to retract on this position, appearing to then express her true reflections on the matter. That, she would be inclined to hide how she truly feels with her clients in these hopeless moments. Her reflections on withholding perhaps symbolise the real difficulty she has working with this therapeutically.

Cassie then seems to adjust her stance on how to work with this therapeutically. From helping clients find ways to acquire control over their circumstances, to having a more accepting acknowledgement that their circumstances are difficult. Acknowledging that it might not be possible to have a positive view on a person's situation might reflect that their circumstances are difficult to change. Thus, showing a shift in her perception during this exert.

Fiona shares her view on empowerment:

"I want to empower these clients to think about. You know what would need to change? And sometimes, yes, we can help. For instance, with some clients who were unfortunately very economically hard up, we can provide them access to food vouchers. I mean, it doesn't take away the problem, does it? It's, I suppose. It communicates that you care, communicate that you're held in mind. It's a gesture of goodwill. And it's not a long-term solution. And I think with such clients, some clients actually, all they need is someone to listen to their story and they may not be coming for a Problem-Solving based approach." (Fiona: 388-408)

Fiona explains her perception of empowerment in therapy: Helping clients think about what requires change in their lives. This stance seems similar to Meredith and Cassie's. The difference, however, appears that Fiona shows little confusion around what can be changed within therapy. This clarity may be part of acknowledging that larger systemic factors impacting her clients' distress cannot be changed in therapy. Her offer of practical help is not a long-term solution- more a symbolic token of care she has towards her clients. Fiona reflects that client's may not need a problem-solving approach in therapy, but someone who can listen.

It is difficult to interpret the meaning behind Fiona's last reflection. Perhaps it is her awareness that a problem-solving perspective dominates UK mainstream therapeutic approaches; Or recognition that a problem-solving approach is something evoked in clinicians working with this population.

4.5.3 Subtheme 3.3: Boundary flexibility: (Includes: self-disclosure, giving money, breaking rules, client's taking a shower, location of therapy and time boundaries.)

Every participant described an adjustment of the therapeutic boundaries. These ranged from moderate to somewhat extreme adjustments. We begin by looking at Meredith's stance on adjusting boundaries-which appear to be the mildest of all the participants:

"While there are many different ways you can adjust your practice, but I mean, it depends. I mean, obviously, as a therapist, boundaries are hugely important- and part of the therapy and part of the therapeutic process. But sometimes low income can make certain boundaries difficult to adhere to. So, for instance, time keeping might be one of those things that is difficult. In which case, we would certainly talk about it. I would certainly talk about, you know, if I noticed that there was a there was a difficulty with

timekeeping and look at ways that we could work with that (Meredith: 799-816)

Meredith begins by expressing her belief in the importance of therapeutic boundaries. She states that this is 'obvious' indicating the strength in her belief. Meredith asserts that an array of changes can be made during therapy and acknowledges that some boundaries may be particularly difficult to adhere to- for those experiencing poverty.

Timekeeping is renowned for being an important boundary within therapy. With importance given to understanding timekeeping violations, which usually signify a client's readiness to engage in therapy. Meredith reflects that timekeeping may be practically difficult for poorer clients. Meredith's stance is that an open discussion around this is important, as a very different meaning can be assigned to poor timekeeping. The strength in her belief around the importance of boundaries- coupled with her acknowledgement that several changes can be made during therapy is likely to highlight Meredith's confidence in this therapeutic adjustment.

Cassie discusses her reasoning behind her boundary adaptations:

(Full excerpt with clear diction) "Yes, a little bit of self-disclosure. And I do self-disclose. I self-disclose my history of mental health problems and I self-disclose my history of addiction. And there's a big there's a good reason for that, because I think it's really important that they know that these are the things that can strike at anyone. (Heightened tone) It's not because they are not good enough, it's because anyone can struggle with mental problems. Anyone can struggle with addiction and that it's okay to do that. And that recovery is possible. So, I do I do disclose." (Cassie: 1007- 1023)

Cassie's rationale for self-disclosure seems clearly articulated in this extract. Not only does she disclose her history of mental health in the substance misuse service she works in, but also her history of addiction. Cassie asserts that there is not only a good but big reason as to why she chooses to self-disclose with her clients. Her heightened tone of her voice and clear diction within this sentence indicates the strength in her conviction. Her rationale is to show her clients that these difficulties can strike at anybody and are not because they *"are not good enough."* By saying this Cassie alludes to the idea that people experiencing poverty and mental health difficulties may internalise the view that these difficulties arise due to an endogenous deficiency rather than external limitations.

Throughout the interview Cassie shows a heightened sense of awareness of her many privileges and power that this holds. It therefore seems that the function of this self-disclosure is to level out the power dynamics within the relationship.

Elize outlines her boundary adaptation:

"I'm thinking of a session I had with somebody where they had missed the food bank. And for the session we actually went for not just coffee, but we got some food." (Elize: 312-313)

She explains the impact of this:

"It felt odd for me, because I was aware that it was breaking a traditional boundary. So, I felt uncomfortable around it. And then I was thinking about what can this symbolize? What can food symbolize in there in the relationship? And you're giving nourishment by giving food. And what's

that all about? And how does this relate to previous experiences and how does it relate to her attachment kind of organization?" (Elize: 377-399)

For Elize, breaking a traditional boundary led her to feeling uncomfortable. It seems that Elize coped with this by reframing the boundary violation's meaning by giving it a clear psychological rationale. Giving nourishment and a positive experience of care seemed to outweigh the traditional boundary breakage.

Natalia seems to undertake a similar decision-making process:

"As long as that client is, you know, isn't completely out of it in the session that they can listen and engage, then I'll do that." (Natalia: 186-189.)

Natalia embodies a caring and understanding attitude and does not appear to take a rigid stance when contemplating working therapeutically with someone who has taken drugs before a session. She is comfortable with this boundary flexibility which seems based on whether her clients can listen and engage with her.

In a similar vein to Elize, David describes assigning a different meaning to giving clients food during the session:

"And I think it culminated in about maybe the second session. He came and he collapsed because he hadn't eaten. So, I literally had to cook the guy a meal. So, I abandoned the session. You know, I made some pasta and stuff and got him to eat. And that's kind of…. It really shocked me that

in modern society, that was allowed to happen. So, I guess. You know, is that therapy? Is making someone a meal when they collapse on your floor from starvation therapy? Well I'd say, yeah, it is." (David: 58-75)

David provides an illuminating account of his experience with a client who collapsed on the floor due to not eating. David explains that he "had to" cook his client a meal. His use of definitive language implies there was no other choice. It is likely that this parallel's the strength of his stance on these matters. David interestingly uses the word abandoned when describing his session. This indicates that he does not conceptualise giving food as a therapeutic intervention. He thereafter asks himself whether giving food is part of therapy to which he answers that it is. David's use of two rhetorical questions in addition to the answer appears to serve as certainty on his perception of therapy. However, I wonder if the use of the word abandoned signifies that the function of his rhetorical questions aided him in making sense of this confusing phenomena.

David continues to describe his experience of the boundary adjustments he made with the same abovementioned person:

"It was also the futility of it, like there was nothing I could do that would really help. There was stupid stuff like, I remember, I gave him 20 quid, I gave him some food. Every time he came, I gave him a bag of food. But then I realised it wasn't really healthy. So maybe the bag of food I gave him would last two days. What did you do then...right? Maybe the 20 quid would get him a couple of days food. But again, what's he going to do then, you know, there was no…. I wasn't really helping him, I was just enabling him to survive one, two days longer..." (David: 160:175)

The excerpt begins with David describing the futility of the adaptations he made with his client who experiences poverty. David expands on his belief that his adaptations were pointless, that no matter what he did, this would not help his client. Despite this absolute and hopeless statement, David provides examples of ways in which he still attempted to intervene- to help his client.

Beginning with an example of giving his client money, which he regards as "stupid." Use of the word stupid might reflect his experience of engaging in an act without much thought. This lack of thought could either arise from a mere not knowing or a suppression/ denial of difficult feelings. Whatever the reason, David was soon led to a realisation that this boundary adjustment was not healthy. For David, he realised that giving his client food and money was not a long-term solution. Almost like a short-term 'plaster-like' fix. David then offers a question, a real conundrum: "What did you do then?" Interestingly, David shifts from referring to himself to referring to "you." The function of this question may serve to increase the listeners empathy but may also reflect his desire to have a more concrete answer to this dilemma.

David thereafter reiterates his previous point, that giving to his client was only a short-term solution. David's reiteration of this point may serve to emphasise that this situation requires a larger societal and/or systemic intervention. The excerpt finishes by David explaining that he was not helping him at all, he was merely enabling his client to survive. "Enabling him to survive" does not seem to encapsulate the experience of someone truly living life. In fact, it feels synonymous with the experience of prolonging another person's suffering. It is likely that this illustrates David's feelings of responsibility and care for his client. In addition, his belief that a life of extreme poverty has the potential to be not worth living.

David provides another example of a boundary adjustment that was made with a different client who experiences poverty:

(Serious expression and demeanour) "There are funny moments, like I had one guy who came round said, can I can I use the toilet? And I said, Sure. All right. He goes to the toilet and he takes a shower. And, you know, you can- what the hell? You know, is that therapy? But he said, Sorry, mate, I haven't had a shower for two weeks and I said I'd say, all right, let's get back to therapy. And I said, you know, what made you take a shower? He said I needed a shower! And I was like, well, that's kind of not what we're here for! But, you know, I wasn't pissed with him. But I it made me think a lot about these issues. You know, it made me think shit, you know. I never thought of that. You never expected clients to come round and have a shower! They never trained you for that! So that was shocking. But it was- it opened my eyes to a whole other thing, right?" David (816:916)

David begins by outlining a moment where his client came to his home (for a therapy session), asked to go to the toilet, but instead took a shower. The word David uses to describe this extreme boundary pushing was "funny." There was nothing at this moment within David's expression, body language or tone of voice which suggested that he found it comical. It is therefore possible that David reframed this experience in a way to diffuse any difficult emotions which may have arisen. This may be likely as he questions "What the hell?" David comes back to the same question he asked himself before (David: 58-75) when another boundary violation occurred: "You know, is that therapy?" The asking again of this question is likely to emphasise that he is still making sense of this experience.

David explains that his client thereafter apologised and explained that he had not had a shower for two weeks. Despite David's repeated questioning of whether meeting basic needs constitutes as therapy, he seems clear in his communication to his client: "all right, let's get back to therapy."

David details the conversation he had with his client about this, asking why he had done it, his client responding that he needed a shower. David seems to revisit his display of certainty around what therapy is by stating “well that’s kind of not what we are here for!” It seems that maintaining a boundaried frame took precedence over showing confusion around whether taking a shower constituted as a therapeutic intervention.

Despite David’s acknowledgement that his client had overstepped a boundary, David expressed that he was not angry with him. On the contrary, this experience seemed to be a moment of real learning- nothing he had ever expected or had been trained for. Whilst it was a shocking experience it was one that had opened his eyes. David was no longer in the dark about these issues, he had been offered a completely new perspective.

Part 5: Discussion

5.1 Introduction

In this chapter findings emerging from the IPA analysis will be reviewed and compared with existing theories and literature, while keeping in mind the research aims. Specific aims centre around, understanding the experience of how therapeutic adaptations are made, while identifying what assists Counselling Psychologists to make these alterations, in addition to understanding what underpins their decision making.

Findings will be presented in a sequential fashion, as per the analysis section which can be likened to a process-based experiences of how these adaptations are generated and applied. Thereafter, the implications of these research findings in the context of practice, supervision and training will be discussed. Possible future research and the limitations of the current research will also be considered. The following section will explore the main themes to emerge from the IPA conducted in the results section and discuss key implications. Finally, post study reflections on my personal involvement in this subject area will be discussed with the intention of maintaining an awareness of how I may have influenced the process.

5.2 Awareness of the relationship between poverty and mental health

The first superordinate theme describes the ways in which UK Counselling Psychologists show an awareness of the relationship between mental health and poverty; In general, in society and within the workplace.

5.2.1 Poverty as a predisposing/ perpetuating factor

While all participants understood the relationship between poverty and mental health as complex, they seemed to imply that the relationship was somewhat causal. Fiona's statement seems to echo this: *"... research has suggested that people from a low socioeconomic background have a really poor health outcomes.*" (Fiona: 495). This relationship was not understood as occurring in the opposite direction.

For example, the participants did not describe ill health as causing poverty. These findings appear consistent with the social causation theory which argues that it is the impact of poverty which increases the development of mental health problems (Patel & Kleinman, 2003; Lund et al., 2010).

This could arguably be an important finding if considering Sams (2008) research. Sams (2008) looked qualitatively at psychologists' understanding of the relationship between poverty and mental health. The study highlighted that psychologists' conceptualisation of poverty had implications for the types of interventions used. Sam's (2008) participants gravitated towards understanding the relationship between poverty and mental health as due largely to individual ineffectiveness so that they could work with it therapeutically. This created conflict and confusion because they wanted to understand the relationship as being due to structural inequalities as opposed to individual ineffectiveness. This parallels with the experiences of half the participants (explored further in the 'empowerment' subtheme) where they described how confusion in understanding the relationship between poverty and mental health can lead to confusion in delivering therapeutic interventions.

5.2.2 Society as a maintaining/ exacerbating factor

All the participants expressed a sense that society maintains and exacerbates mental health difficulties by allowing and not adjusting for poverty. Fiona seems to conveyed her perception that issues associated with poverty represent a kind of societal failure: *"these people have been a victim of….a social system that has failed these people through various means."* (Fiona: 312). This stance seems consistent with findings from the social mobility commission (UK Government, 2020). which show that social mobility in the UK has in fact worsened and the opportunity to move up the social hierarchy is slim. These findings also appear consistent with literature specific to therapists working with poverty, in that all participants viewed society as a factor which can maintain and exacerbate poverty. For example, both sets of therapists in Smith et al (2013) and Borges' (2014) studies described the

therapist's awareness of larger institutional barriers (in the broad sense- such as lack of funding, resources, and restrictive policies) which impacted their work, resulting in frustration and burnout. Borges (2014) and Smith's (2013) participants were able to specify the main obstacle in their work as struggling to meet their clients' basic needs (such as shelter and food) which seems consistent with the current study.

This, however, contradicts findings from Ballo (2020) whose participants, were described as having more resilience when impacted by institutional barriers within their therapeutic work. Ballo (2020) concluded that this resilience was due to the participants own self-care. However, Ballo's (2020) participants were also explicit in highlighting that their clients' basic needs were met. For example, having easy access to food vouchers within the NHS.

This may be an important finding as it highlights Counselling psychologists find working therapeutically with unmet basic needs as not only difficult but potentially very stressful. This makes sense if considering Maslow's hierarchy of needs (Maslow, 1943) as it is, of course, unrealistic to expect therapists to be able to work with their clients' internal processes when their clients are hungry. Particularly as it can be assumed that Counselling Psychologists would know the impact hunger would have on the person engaging in therapy. This may highlight the potential appropriateness of therapeutic adaptations with absolute poverty as opposed to relative poverty. For example, it may be necessary to help a client with having their basic needs met so they are able to engage in therapy.

5.2.3 The workplace as a maintaining/ exacerbating factor

This subtheme focused on obstacles within the counselling psychologist's workplace that hindered or prevented them from working effectively with poorer clients, such as strict boundaries. This seems to parallel with a society where resources are unequally distributed, in which the workplaces described have very different levels of resourcing. All of the participants made reference to having poor

resourcing except for Meredith who described her service as having *"exceptional"* (Meredith: 1113) resourcing.

Ballo (2020), Borges (2014) and Smith (2013) share similar findings in that access to resources was seen to directly impact the therapist's therapeutic work. While the participants in the current study also seem to make this general point, both Natalia and Elize appear to frame it somewhat differently. Both participants who work in homelessness settings advocated throughout the interview that flexibility with appointment times/ location was the most valuable resource within their work. If dealing with social stressors under the extremity of homelessness flexibility in terms of therapeutic time, frequency and setting might be warranted. Furthermore, it might emphasise that traditional therapeutic approaches and/ or the therapeutic setting may not be appropriate with those encountering absolute poverty due to implementation of some unhelpful boundaries.

Literature from the field of community psychology suggests that traditional psychology approaches are based on an individualistic perspective and are therefore inappropriate interventions for those experiencing poverty (Jason et al., 2019; Chavis & Wandersman, 2002). A person's environment is considered a crucial factor in the development of distress, which is understood as being due largely to an incongruence between a person and their environment (Kreutz, 2014).

A community psychology perspective promotes connection with other services and the redistribution of resources as being a key factor in alleviating distress. This seems reflective of the views of all participants in the current study who acknowledge the impact resources have on their therapeutic work. Meredith expressed that *"being connected to them* [other services] *really helps with consistency in care."* (Meredith:1126) This seems to suggest that her service users 'case management' tasks were addressed outside of her role as therapist. These findings seem to highlight the importance of good communication/ connections with services and perhaps even the importance of more transformational systemic based interventions when working therapeutically with poverty.

5.3 The second Superordinate Theme: Resources that are drawn upon.

5.3.1 Using personal experiences to inform practice.

Nearly all the participants (minus one) drew on their personal experiences to aid therapeutic practice. It wasn't just any experiences that they drew upon. It seemed that the participants drew on significant, traumatic, and adverse experiences. For example, Cassie shares that she has a *"...history of abuse, there's a history of neglect. There's a history of addiction"* (Cassie: 905).

It appears from the current findings that the participants were motivated to alleviate the suffering of others due to their own experience of suffering. This seems closely aligned to the concept of the 'wounded healer.' It has been observed in the literature that mental health professionals, such as psychologists are drawn to their professions to facilitate their own growth (Zerubavel & Wright, 2012). Jung (1951) explained that to be a wounded healer, the person would need to go through a process of enlightenment or transformation with regards to their own adversity or trauma.

We cannot conclude that therapists who have had adverse experiences are by default better positioned to work with poverty- someone may have had similar experiences but have not had the opportunity to use them as a resource. However, they were used as a resource by the participants in the current study. For example, Cassie reflects on her traumatic experiences: *"that really helped me in my work. And if I didn't have that, I don't think I would be a very good psychologist."* (Cassie: 907). Cassie therefore alludes to this experience as being transformative, in line with the above-described wounded healer concept.

In relation to the wounded healer concept, Guggenbuhl-Craig (1971) asserts that personal adversities can lead to an increased sensitivity to power imbalances. Thus, resulting in a desire to 'balance' power differentials. This appears consistent with the participants experiences particularly as power has been an identified theme

in the participants narratives. The participants 'woundedness' not only seemed to increase their attentiveness to power dynamics, but also appeared to permeate their willingness to be more empathetic. As observed in Natalia's account: *"I think. I think when you have grown up with an experience with your parents, if it's mental health or substance misuse or whatever. You're attuned to a certain way of being, you can sort of understand…if- you know… you're used to it. And you can have a lot of empathy."* (Natalia: 453-461). Regarding the client seen as 'similar' to them, seemingly prompted a desire to help and thus make adaptations.

It is suggested that 'woundedness' is key in facilitating professional integrity (Sedgwick, 1994) and has the potential to increase empathy (Adler, 1985; Martin, 2011). Being a wounded healer could therefore be seen as a desirable feature for therapists working with underprivileged clients who are made more vulnerable by the weight of inequalities.

Overall, research highlights that there are benefits and risks to being a 'wounded healer' (Costin, & Johnson, 2002; Gelso, & Hayes, 2007). A study by Newcomb et al. (2015) stated that there are three considerations to be made if applying 'the wounded healer' concept to practice. 1) That countertransference may prompt inappropriate, self-disclosure 2) vicarious trauma and burnout can potentially occur and 3) wounded healers may display enhanced resilience. The current research has highlighted a unique finding: that Counselling Psychologists draw on adverse and traumatising experiences when working with those experiencing poverty. However, the absence of literature around how Counselling Psychologists use adverse or traumatising experiences within their practice is concerning. Particularly as we are unaware of the impact this may have on practice.

5.3.2 Using Personal values in the therapeutic relationship

Counselling Psychology as a discipline is renowned for its humanistic values, emphasising the importance of the therapeutic relationship, paying attention to the client's subjective experience (Cooper, 2009; Hemsley, 2013). Gale & Austin,

(2003) argue that there are overlaps between personal and professional values. While Alves and Gazzola (2011) argue that these values are clearly distinguishable from one another. Regardless of where the participants values originated from, it is clear all the participants held strong humanistic values. Meredith shows this via her statement: *"I think one of the most important things I learnt there was what was congruence."* (Meredith: 758)

This seems consistent with Verling's (2014) research which found that when Counselling Psychologists made sense of their CoP identity, they identified with various values all of which were humanistic in nature. The most common value referred to in this research was the therapeutic relationship. This parallels the current research, as half of the participants (Elize, Fiona and Cassie) described placing considerable value on the therapeutic relationship.

There is clearly an interplay between ethics and values, as a person's ethical reasoning process is based upon their values (Bergin et al., 1996). This is consistent with the current findings, as values were highly influential in the Counselling Psychologists adaptation-based decision making. The extreme adaptations made to therapeutic boundaries raise important questions around how Counselling Psychologists might experience clinical decision making when faced with a client deprived of basic needs. Particularly as a situation as such poses a unique ethical dilemma. Giving food during therapy is likely to be regarded as taboo, especially as training advocates the importance of adhering to traditional therapeutic boundaries. Counselling Psychologists may therefore feel reluctant to seek advice on boundary violations such as this.

Despite the same resource sharing dilemmas being highlighted previously by Borges (2014), research in this area has been completely silent since then. The current study's strikingly similar findings, and lack of discussion in this area may indicate that conversations around these extreme boundary violations may be difficult to have.

The role of ethics within therapy is not clear cut (Shillito-Clarke, 2003). While Counselling Psychology has a clear humanistic value base, and considers ethics during training, the way Counselling Psychologists think about ethics is absent from the literature (Parker, 2002). Apart from one study which looked at how final year Counselling Psychology trainees discussed values and ethics (Graham, 2013). Findings revealed that two discourses accounted for the way in which values and ethics were constructed, either via an institutional or humanistic discourse. The institutional discourse advocated that Counselling Psychologists should adhere to the values and ethics specified by theoretical models and professional bodies. Whereas the humanistic discourse advocated that Counselling Psychologists should put the clients subjective experience before any predetermined values or ethics. This created tension as it positioned the Counselling Psychologists as social control agents, attempting to direct their clients to adhere to Counselling Psychology's theories, rules and guidelines.

The BPS Practice Guidelines (2017) advise that *"When working towards social inclusion psychologists are encouraged to….make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions."*(BPS Practice guidelines, p.38). Basic needs resource sharing may therefore be an important consideration to enable people to participate in therapy. The BPS Code of Ethics and conduct (2018) advise that when applying the value of 'Integrity' Psychologists should consider: *"(v) Maintaining personal and professional boundaries"* (BPS Code of Ethics and conduct, 2018, p.7). If Counselling Psychologists are recommended to apply both these guidelines together, this has the potential to create the tension observed within Graham's (2013) research.

The present study provides a novel and unique finding, that Counselling Psychologists' values (For example, valuing the importance of the therapeutic relationship) may play a key role in underpinning their decision making around

therapeutic adaptations. This may create tension which has the potential to impact therapeutic practice. An example of this tension may be demonstrated through Elize's experience of confusion when buying her hungry client food: *"It felt odd for me, because I was aware that it was breaking a traditional boundary. So, I felt uncomfortable around it."* (Elize: 337).

5.4 Adapting practice in the light of economic differentials.

5.4.1 Poverty as part of the formulation.

Four of the participants in the study were explicit when communicating with their clients that poverty was a factor that contributed towards their distress: *"Say, you know, we would have a discussion about that, about what they can and they can't do and so on."* (Meredith: 133-136). The definition of a psychological formulation is: "a hypothesis about a person's difficulties which draws from psychological theory" (Johnstone & Dallos, 2006, p. 4). There are different types of formulaic frameworks. Some of which are associated with a medical model epistemology (e.g., NICE, 2011a, 2011b; Smallwood, 2002).

Counselling Psychologists are trained to adopt a pluralistic stance when formulating a person's difficulties (Strawbridge & Woolfe, 2010). This is primarily due to the discipline's phenomenological and humanistic underpinnings (Frankland & Walsh, 2005) and the inherent tolerance of uncertainty, complexity and theoretical pluralism and diversity (Risq, 2006).

A formulation is understood as a crucial factor in therapy as it drives therapeutic interventions and treatment (Johnstone, 2008). Inaccurate formulations therefore have the potential to lead to unhelpful and inappropriate interventions. A series of studies have found that therapists unintentionally influence the formulations they devise (Hamilton & Kivlighan, 2009; Antaki, Barnes, & Leudar, 2005; Bromley, 1991). The participants counselling psychologists influence on the adaptations that are made are seemingly observed within the first two superordinate

themes. It therefore makes sense that the current participants worldviews, values and personal experiences affect the way in which they devise their client's formulation and communicate it back to the client.

All of the participants conceptualised (formulated) their client's distress as a complex interaction of various factors. This aligns with Counselling Psychology's identification with pluralistic practice (Strawbridge & Woolfe, 2010). While some argue that Counselling Psychology's pluralistic stance has the potential to generate confusion (Clarkson, 1996; Draghi-Lorenz, 2010) or ambiguity (Cross & Watts, 2002). The current findings suggest that that this may be our forte. A pluralistic style of formulating allowed the participants to gain a wider perspective regarding their client's difficulties. This can be observed via Cassie's experience of attending a person's home: *"And I think that…*(going to their home)*… that's a very important resource in learning what interventions are realistic when working with them."* (Cassie: 619)

The current research suggests that Counselling Psychologists may be well placed to formulate and make sense of a client experiencing distress as a result of poverty. Not only due to the way they conceptualise their distress but also because research highlights the importance and benefits of openly sharing and devising formulations collaboratively with clients (Antaki, Barnes, & Leudar, 2005; DCP, 2011; Redhead, Johnstone, & Nightingale, 2015).

5.4.2 Focus on empowering.

Four of the participants in the study referred to empowerment as an important consideration when working with clients experiencing poverty. In keeping with existing literature, they all seemed to experience and understand the concept very differently (Alsop, et, al, 2006; Fraser, 2010; Cyril, Smith, & Renzaho, 2015). For example, Natalia seemed to understand empowerment as allowing her client to lead the session.

Interestingly, both Meredith and Cassie shared similar processes in identifying what empowerment means to them. Meredith begins by describing empowerment as "helping them shift that locus of control so that they find ways they can become more empowered." (Meredith: 435). Meredith then retracts on this statement by saying *"I can see some conflict in what I am saying. It's difficult to know how to work with it."* (Meredith: 450). Meredith initially alludes to the notion that her clients' circumstances are partially the result of disordered perspectives as opposed to structural inequalities. This confusion seems relevant to discuss, not only because empowerment was observed as an important therapeutic adaptation, but also because these different conceptualisations have the potential to drive different therapeutic interventions.

Cassie, like Meredith begins by explaining what empowerment means to her therapeutically. By helping clients look for ways to acquire control over their circumstances. She too, like Meredith retracts on this position before alluding to the idea that circumstances may be difficult to change for someone experiencing poverty: *"Because sometimes there is no positives that you can get from it"* (Cassie: 1355). Both participants share the experience of confusion regarding understanding what the concept of empowerment looks like therapeutically. This seems to act as a roadblock preventing them from helping the client gain a greater sense of agency.

Overall, the desire to aid the client gain a sense of agency appears present within all the participant's understanding of empowerment. In fact, Meredith explicitly references Rotters' (1966) theory on locus of control. This concept refers to the way in which people perceive the level of control that they have over their future and circumstances, as opposed to believing that these factors are outside of their control. Some authors have hypothesised that those experiencing poverty are likely to have an internal locus of control (Lachman & Weaver, 1998; Goldsmith, Veum & Darity, 1995; Shifrer, 2018). Therefore, viewing their economic difficulties they have agency over and are thus responsible for. Those with an external locus of control may view their economic situation due to factors outside of their control.

Locus of control has been regarded to be an important mediator not only within a person's mental health but physical health also (Stephenson-Hunter, 2018). It therefore makes sense that part of the therapeutic task when working in the context of poverty is to help the person acquire realistic internal/ external control expectancies given the potential consequences noted above.

Research on terminal illness is a field which may be assimilated to that of poverty. Particularly with regards to factors which may be outside of a person's control. Research on long term illness suggests that control over one's illness may be key in a person's understanding of empowerment (EU Health Programme, 2014; Barr., et al, 2019; Hibbard, 2014). However, a systematic review on the meaning of patient empowerment for those with terminal illness had contrasting findings (Wakefield et al.,2018). Control over a person's health state or illness was not considered the most important factor for helping sufferers understand empowerment. The review found that those with a terminal illness considered the quality of their relationships with caregivers as the most important factor in their understanding of empowerment. This highlights that clarity around what empowerment means therapeutically when working with those in poverty may be necessary.

The current research highlights that the desire to empower those experiencing poverty is potentially a key mechanism underpinning therapeutic adjustments. However, the adjustments described in the current study should not necessarily be advocated (discussed further below). Arguably, as Counselling Psychologists with our commitment to social justice, it is essential that we deliver appropriate interventions, particularly to vulnerable populations. It is therefore important that discussions take place around the extent to which the acquisition of personal control is deemed important to those encountering poverty. In keeping with Counselling Psychology's bottom-up approach to equalising power (Strawbridge, 2017) it makes sense to have open conversations with clients around the extent to which they desire to have power and/ or control in their lives. This of course

reiterates the importance of the findings discussed in the previous section- the importance of open and collaborative formulations.

5.4.3 Boundary flexibility.

The need to adjust therapeutic boundaries to accommodate for the needs of their clients arose for every participant in the study. These ranged from moderate to somewhat extreme adjustments, including self-disclosure, giving food, giving money, the location of therapy and time keeping. Perhaps the most controversial of the research findings was the extremity of some of these adjustments (expanded on later). Different theoretical orientations hold different perspectives on therapeutic boundary adjustments. Regardless of the orientation there seems to be a consensus that therapists need to set specific therapeutic limits.

5.4.4 Time.

Meredith engaged in perhaps the least extreme boundary adjustment by making timekeeping allowances within the sessions due to acknowledging this as a practical difficulty for poorer clients. Lazarus and Zur (2002) argue that a humanistic, person-based stance is crucial when considering therapeutic boundary adjustments. Adding that this facilitates critical thinking and is likely to strengthen the therapeutic alliance. This is, of course in line with the values of Counselling Psychology. An adaptation such as Meredith's may therefore be considered normal practice for some Counselling Psychologists

Zur (2005) argues that to gauge the appropriateness of boundary adjustments, cultural norms should be considered. Lui (2004) argues that those from lower social classes should be considered as a culture in their own right, due to their shared norms and values. It is therefore arguable that sensitivity to time-based adaptations for those experiencing poverty is culturally sensitive and thus a useful adaptation. This is in keeping with existing literature from the perspectives of those

experiencing poverty themselves which acknowledges time-based adaptation as not only useful, but essential (Pugach & Goodman, 2015; Nitzarim, 2012).

This time-based adjustment was the only boundary adjustment Meredith made. This is a divergence in the findings as the other participants presented as making an array of adaptations which were in comparison more extreme. Meeting the needs of her clients seemed influenced by her views regarding the importance of therapeutic boundaries: *"I mean, obviously, as a therapist, boundaries are hugely important" (*Meredith: 799). In line with the research aims, to understand what underpinned the decision making to make adaptations, it feels important to try and understand why Meredith's experience was so different to that of the other participants.

There were several notable differences. Meredith's client group appeared to be experiencing relative poverty. Furthermore, her service had *"exceptional"* resourcing (Meredith:1112) as well as strong links to other services. This makes sense considering that the most severe adjustments made were based on basic needs being unmet, which will now be explored.

5.4.5 Basic needs.

Of all the participants, both Elize and David seem to have made the most extreme therapeutic adaptations, as both gave their clients food during a session. David explains his reasoning: *"He came, and he collapsed because he hadn't eaten"* (David: 58-59). The context of both situations require contemplation in an attempt to understand their experiences. This parallels with Cowles, and Griggs, (2019) assertions that boundary adjustments are dependent on contextual factors. These include *"the therapeutic model, the needs of the client, the training of the therapist, the nature of the therapeutic relationship, and the treatment setting."* (p.2).

One could argue that it is the responsibility of the social system to provide help with a person's basic needs. Moreover, if applying Cowles, and Griggs, (2019)

assertions it seems that David was prioritising his clients need for food at that moment. However, the significant blurring of the boundaries means that this adaptation may not fall within the parameters of the BPS's code of ethics (2019). Most specifically in terms of *"(v) Maintaining personal and professional boundaries"* (p.7). Cowles, & Griggs (2019) argues that the most unethical boundary violations occur when risk management principles hold more importance than human interaction.

It could be argued that this adaptation was necessary in the context of this situation, as David seemingly took both these principles into account. While David's account of adaptations falls under the extremity of boundary blurring, it highlights that there may be difficulties applying ethical principles to practice with those experiencing poverty-based stressors. These are views shared by scholars in the field of social justice (Prilleltensky, 1997; Goodman et.al, 2004). This seems evident when David tries to make sense of whether satisfying a person's most basic needs represents therapy itself: *"You know, is that therapy? Is making someone a meal when they collapse on your floor from starvation therapy? Well, I'd say, yeah, it is."* (David: 58-75)

Elize in comparison works in a homelessness setting which should be arguably more prepared to expect service users experiencing hunger. Despite this, Elize reflects on feeling uncomfortable when buying her client food after the food bank closed: *"It felt odd for me, because I was aware that it was breaking a traditional boundary. So, I felt uncomfortable around it."* (Elize: 377-399)

While both experiences are in seemingly different contexts, Elize's uncomfortableness adjusting food-based boundaries with extreme poverty may highlight a lack of courage in making these adaptations. This lack of confidence is paralleled in a study by Griggs & Cowles (2019) who explored the experiences of therapists adjusting boundaries with asylum seekers. Most specifically, the therapists discomfort arose when attending to social stressors, due to the potential impact on

the therapeutic work. (For example, helping their clients obtain support such as benefits and secure housing due to an insecure immigration status). It is therefore arguable that a lack of confidence can be experienced by therapists when dealing with the possibility (or fact) of crossing boundaries if working in particular settings.

5.5 Experience of confusion when making adaptations

This experience of confusion appears further evident in a recent qualitative study of clinical psychologists working in the context of homelessness (Xenophontos, 2020). The study sought to examine the clinical psychologists' perspectives on homelessness, in addition to what influences their practice (Xenophontos, 2020). The study highlighted a consistent theme of conflict and confusion expressed by the psychologists, identified via the two contrasting themes of 'Homelessness is not for psychology' and 'Our role as Clinical Psychologists.' The author hypothesised that the Psychologists initially responded to therapeutic work with homelessness under the narrative of 'we do not work with it.' They thereafter reflected that they do work with it, yet not in a traditional sense. It sounds like the participants were engaged in a sense making process similar to what Meredith and Cassie described in the empowerment section. Xenophontos (2020) hypothesised that the experience of confusion arose *"due to CPs (Clinical Psychologists) conceptualising homelessness as a social issue rather than a psychological issue."* (Xenophontos, 2020 pg. 76).

The participants' experience of confusion with attending to social stressors could be understood in terms of literature on role confusion. Multicultural authors argue that social justice work is synonymous with attending to social stressors (Goodman, 2004; Prillettensky & Nelson, 1997). Thus, the need to take on different roles which veer away from the traditional therapist role is likely to be inevitable, especially when working with those experiencing poverty. The experience of confusion could be explained by the limitations of social justice training: *"training programmes have provided narrow guidance for Counselling Psychologists*

regarding their role with clients with little attention to roles such as advocate, social activist, consultant and others." (Toporek & Williams, 2006, p.25). The experiences of confusion and the lack of confidence with making adaptations (seen via Elize's account above) may be accounted for with difficulties in putting social justice values into practice, which Cutts (2013) suggests is due to a lack of consistency within UK training programmes.

5.6 Final considerations with regards to boundary adaptations:

Before concluding the discussion of the research findings, it feels important to highlight a common factor which emerged within the findings. Most specifically, four of the participants worked in the context of extreme poverty. David worked in a charitable organisation/ private practice providing therapy to men with complex needs such as substance misuse or homelessness. Elize and Natalia worked in homelessness settings and Cassie in a substance misuse setting. Cassie explains the boundary adjustment she uses within her practice: *"I self-disclose my history of mental health problems and I self-disclose my history of addiction."* (Cassie: 1007).

It seems important to consider that these settings share similarities due to the associations between substance misuse, complex trauma and extreme poverty (Fitzpatrick et al., 2013). While there are arguably strong intersections between the abovementioned factors, the literature suggests that the mental health settings which support those experiencing the above-mentioned difficulties may hold different theoretical perspectives on boundary flexibility. For example, self-disclosure in terms of recovery from alcohol/ drug use is often advocated within alcohol and substance misuse treatment (Forrest, 2010; Mallow, 1998). They are also likely to be considered as less taboo that the food-based adjustments Elize and David experienced. Overall, it seemed that the more extreme the experience of poverty was for the client, the more extreme the adaptation. This highlights a novel finding in the current research in that boundary adjustments may be more appropriate with those encountering extreme poverty. This may be particularly important, because as

indicated above, some mental health settings may be more receptive to boundary flexibility than others.

As discussed in the literature review, Intersectionality theory (Schulz & Mullings, 2007) proposes that social identities overlap. Smith (2005) explicitly references the experience of poverty when discussing the concept of intersectionality. Smith (2005) elaborates that this phenomenon can only truly be understood in the context of other social identities, due to its complexity.

Intersectionality was a concept acknowledged by Elize: *"I guess I noticed kind of... The intersection between poverty and trauma."* (Elize: 672-674) We can assume that the participants in the study were aware of this concept, particularly as most (4) incorporated poverty within the formulation. Furthermore, all showed an awareness of the complex relationship between poverty and mental health. While all the participants made boundary adjustments, they all seemed to experience them differently. This is interesting considering their clients shared intersecting characteristics associated with extreme poverty.

Bryant-Davis, (2019) argues that the lack of consideration of intersectionality is what makes the treatment of PTSD ineffective. They propose that this is because those who have experienced trauma will have different perspective of what therapy, trauma and recovery looks like. It is therefore likely that the framework of intersectionality could be an effective tool to use when considering the appropriateness of boundary adjustments with those experiencing poverty. Particularly, extreme poverty as the literature suggests there may be strong intersecting factors associated with complex needs (Fitzpatrick et al., 2013).

The proposition that boundary adjustments may be more acceptable for those experiencing absolute poverty further highlights that they are a unique population with specific needs. It is therefore arguable that working therapeutically with those experiencing extreme poverty is a specialisation that would thus require a separate strand of training.

5.7 Post study reflexivity.

Coming towards the end of the current research has led me to reflect on its teachings, but also the potential impact I may have had upon it. Firstly, it is important to acknowledge the impact this research has had not only on my development as a professional but as a person. My reflective statement prior to the research commencing outlined my reasoning regarding choosing to focus on a psychologists' perspective as opposed to clients experiencing poverty. This was to limit emotional entanglement in the research topic. However, my sense of identity has shifted considerably during the research process. While I identify, in some ways as a 'working class' woman, I now also identify in many ways as a psychologist. Several factors can account for this shift. Most notably, my therapeutic experience which has allowed me to witness different worldviews of people from various socio political and cultural contexts. These experiences have cemented my belief in pluralistic practice. Particularly due to my ontological positioning which draws on phenomenology.

This shift in my identity has not been an easy process. My earlier experiences led me to experiencing 'class' in a dichotomous manner. While I am aware of this and can reflect on it, I also recognise that I am susceptible to thinking dichotomously when I am highly stressed or attempting to make sense of complexity. This, to me emphasised the appropriateness of using IPA as a methodology. This is because it acknowledges that I will inevitably influence the research (Kasket & Gil-Rodrigues, 2011).

I now recognise that this binary lens played a part in my earlier analytical reflections. For example, the assumption I initially held that adaptations should 'always' be made with those experiencing poverty. Reflexivity was therefore vital, and journaling became an essential part of the research processes. Taking notice of my emotional responses and any dichotomous thinking styles during the interviews

and analysis. I am grateful to my supervisor who always challenged my reflections and prompted consideration of other perspectives.

Having an 'insider' perspective of someone who has experienced absolute poverty may have aided the research process. My experiences influenced me during the interview process as I approached it with gentleness and compassion, enabling the development of trust. I recognise this stance may have also led to my reluctance to prompt the participants to elaborate on their difficult experiences.

Kasket & Gil-Rodrigues (2011) propose that research will also influence the researcher. Both the experiences of reading extensively in this subject area and hearing the participants perspectives has been enlightening for me. It has taught me that learning is constant and to expect the unexpected. My earlier assumptions as to the essentiality of adaptations were challenged. I considered the extremity of adaptations that were made in the study which highlighted that while adaptations can be helpful, therapeutic boundaries are also essential.

It feels fitting to end with a participant's statement which symbolises much of my learning. Cassie refers to her clients stating: *"I feel like they're my people"* (Cassie: 957-958). While Cassie was economically privileged, as identified in the interview she also experienced childhood trauma. Her perspective reminded me that we hold multiple and intersecting identities. While I identify as working class, I am also someone who has experienced trauma, I am also privileged because I am afforded status in my role as a trainee psychologist.

Part 6: Conclusion

6.1 Introduction

In this section the research aims will be briefly revisited. Thereafter, knowledge generated from the current research will be outlined, while expanding on how the present work contributes towards the existing literature. Implications for Counselling Psychology training, practice and the greater community will be interwoven within this discussion. Several unique findings were identified in the current study and will be further examined. Finally, potential limitations will be included, in addition to suggesting potential future research.

6.1.2 Brief summary of research aims

To my knowledge, the current work is the first study which explores the experiences of UK Counselling Psychologists adapting therapy with clients experiencing poverty. The study sought to explore the ways in which Counselling Psychologists experience making therapeutic adaptations. In addition to understanding the nature of these adaptations, the extent to which they occur and identifying barriers and benefits to making adaptions. The study also aimed to identify what underpinned the participants decision making when making adaptions. Throughout, the use of IPA allowed for an idiographic and nuanced understanding of how these adaptations were experienced.

6.2 Implications for Counselling Psychology Training, Practice and the Wider Community.

A strong finding to emerge from the current research was participants awareness of the relationship between mental health and poverty, in general, in society and within their workplace. Understanding this relationship was identified as a major factor underpinning the participants decisions to make therapeutic adaptations. A consistent dilemma for the participants throughout the study appeared to present as an issue working out the best way to intervene or adapt therapy in terms

of social interventions versus psychological ones. For example, in line with Sams (2009) research, it became apparent that the participants understanding of this relationship was often a source of confusion.

Emerging from the study it appears that conceptualisation and understanding of the relationship between poverty and mental health is itself a vital stage of the decision-making process when considering making adaptations. This has important implications for practice, as it reiterates the essentiality of formulation. Particularly as formulation is regarded as the starting point for identifying appropriate interventions (Johnstone, 2006).

The study highlighted possible conflict and confusion when conceptualising, and 'formulating' a person's difficulties. The Division of Clinical Psychology (DCP, 2011) produced guidelines for Clinical Psychologists when devising formulations to promote best practice. These guidelines explicitly expressed that Clinical Psychologists regularly exclude social factors from their formulations. The way in which Counselling Psychologists view and incorporate formulation into their practice is absent in the literature (Challoner & Papayianni, 2018). It is therefore possible that Counselling Psychologists also neglect social factors within their formulations. The HCPC (2015) standards state that practitioners must *"be able to formulate service users concerns" (p.24).*

While the small sample size of the current research means the findings cannot be generalised to all Counselling Psychologists, the identification of confusion regarding formulation suggests that we as Counselling Psychologists may not be fully adhering to HCPC standards if we are unable to adequately formulate a service user concerns. This is potentially problematic as those experiencing absolute poverty are more likely to be vulnerable in addition to experiencing complex comorbid difficulties. The small sample size did, however, show how effective it is to incorporate other factors into the formulation. This was done by all the participants which is hopeful. The current research therefore highlights a unique and

novel finding, which has the potential to increase therapeutic effectiveness for those encountering poverty.

Concerns regarding the place of social factors in formulations could potentially be rectified via the creation of guidelines which reiterate the importance of incorporating external stressors within formulations. The Division of Counselling Psychology would be well placed to do this. Particularly as our engagement in pluralistic practice (and thus accepting complexity within our conceptualisations) has been highlighted as a potential unique asset within the current study.

The current study also lends support to existing literature from the field of community psychology as it highlighted the importance of good communication/ connections with services when working therapeutically with poverty. The practical implications suggest that it may be important for psychologists to be knowledgeable of services which may offer help with social stressors in their workplace area. Whilst this may seem like common practice, we cannot be sure that all Counselling Psychologists do this. Whilst there is evidence to suggest that some Counselling psychologists engage in social justice work (Cutts, 2013; Lewis et al., 2003) we cannot be certain that all engage in advocacy. Particularly as Constantine and colleagues (2007) suggested that advocacy was not the most cited social justice practice in the field of counselling psychology. Many of the participants in the current study did not have access to good resources. It might therefore be advisable for psychologists working in poverty settings to engage in advocacy on the client's behalf, such as via signposting or ensuring that their client is able to access important resources. If psychologists are required to take responsibility beyond the therapy room, although not unthinkable, it should be something the professional signs up for from the outset. It would therefore be advisable for services to have this provision and thus support psychologists who are willing to do this.

The current study highlighted that there may be potential role confusion when working with those experiencing poverty. This parallels previous research

suggesting that there are difficulties incorporating social justice into practice (Cutts, 2013; Lewis et al.,2003). Guidelines could therefore seek to reduce ambiguity around this. It therefore makes sense that we follow our US colleagues by devising guidelines for putting social justice work into practice (as described in the literature review) (Goodman, 2015). We could also examine ideas currently used by social work colleagues due to our shared interest in social justice. For example, The British Association of Social Workers (BASW; 2018) devised a Capabilities Framework for their trainees and qualified practitioners. The guide advocates that practitioners should engage in reflective practices, similar to Counselling Psychology training. However, these guidelines also provide practical suggestions regarding how to attend to external stressors. For example, knowing what benefits and support the person is legally entitled to. Counselling Psychologists will often work in environments that require knowledge of legislation (Rethink Mental Illness, 2020). According to Rethink Mental Illness, (2020) those: *"who are vulnerable – for example, because of financial difficulties"* and/or *"have misused drugs or alcohol"* are entitled to a care package named The Care Programme Approach (CPA; NHS, 2021). This is basically an assessment which considers a person's mental health difficulties while considering their external needs, such as housing. It makes sense that we should be knowledgeable of these kind of approaches considering their prevalence in NHS settings, which Counselling Psychologists commonly work within (DCoP, 2018).

Another finding in the study was the psychologist's awareness of larger systemic barriers to practice. Therefore, another reason that guidelines might be useful is to differentiate between macro-based transformational interventions and interventions that can be used within the therapeutic space. A macro-based approach to transforming social, economic, and political systems would of course decrease therapeutic barriers, allowing service users to access important resources and enable the development of policies. While psychologists do hold a degree of power, it will nonetheless be very challenging to address these larger systemic difficulties.

Furthermore, it is the personal choice of the psychologist. Guidelines could advise that if psychologists are interested in transforming social, government or economic establishments they can join/ create forums which are specific to this. The current study highlighted that there may be potential role confusion when working with those experiencing poverty. Guidelines would therefore seek to reduce inherent ambiguity. Guidelines do not solely need to come from top-down institutions such as the BPS or the HCPC. It makes sense for guidelines to also be enshrined into local services (e.g., NHS trusts), who wished to commit to such special needs of this unique population more holistically and comprehensively. Ultimately, so that the burden doesn't simply fall on the psychologist who chooses to break a therapeutic boundary and thus feels potentially left out, at times potentially embarrassed and arguably lacking confidence in doing what they do.

Another emergent finding from the current study was that nearly all the participants (minus 1) drew on their own historical and/or traumatic experiences to inform their practice. While the literature suggests practitioners may commonly draw on their own adversities to help others, there is no research which has described the impact of this on practice. As described in the discussion section there may be varying consequences on this for the psychologist and the client. Counselling Psychology training encourages self-reflective practices such as reflective journaling, peer supervision and focus groups. Furthermore, it is currently the only applied psychology training which has personal therapy as a core requirement (Rizq, 2006). The implication of the current study's findings highlights the importance of these practices, which have been argued to facilitate safer therapeutic practice (Strawbridge & Woolfe, 2010). The current study's findings also highlighted that the participants were able to use their own negative experiences to connect with this unique population. This suggests that this subgroup of practitioners may be better positioned to work with this group due to an increased self-awareness, arguably mediating greater empathy and thus potentially leading to a

more effective therapeutic relationship, which is widely recognised as one of the most powerful platform and engine for therapeutic change (Luborsky, 1994).

Overall, the current study highlighted that traditional and/or manualised ways of delivering therapy to those experiencing poverty may not be helpful or appropriate for this unique population. In fact, the findings of the current study highlight the importance of flexibility within the therapeutic work. The current study's findings lend support to the findings of Borges (2014) which suggest that that the extremity of the adjustments may be related to the extremity of the poverty experienced. In keeping with other literature, the study has highlighted that some flexibility, for example, with time boundaries may be a useful adaptation (Brown, 2009; Borges, 2014; Smith, 2000).

The current study was also able to provide a nuanced understanding of the decision making underpinning these adaptations. Most specifically, the current study's unique findings suggest that ethical dilemmas occur due to the psychologist's conflict between personal values, the notion of ethics and therapeutic boundaries.

The proposition that boundary adjustments may be more acceptable for those experiencing absolute poverty highlights that they are a unique population with specific needs. Especially given that comorbidities and complexity are associated with extreme poverty. It is therefore arguable that working therapeutically with those experiencing extreme poverty is a specialisation that requires a separate strand of training. Not all Counselling Psychologists will work in the context of extreme poverty. Therefore, training could be catered specifically for those working with extreme poverty. This would allow for discussions around comorbidity, intersectionality, and ethical dilemmas, therefore aiming for best practice with this unique population.

6.3 Limitations and Suggestions for Further Research

Limitations of the current study in addition to potential future research will now be discussed. Hore (2014) and Cutts (2013) suggest that Counselling Psychologists generally engage with social justice work due to personal choice as opposed to training. The participants in the current study seemingly have a commitment towards working with this population. Thus, the six psychologists cannot be representative of Psychologists or Counselling Psychologists in general.

The inclusion criteria stated that the participants have at least 2 years' experience providing therapy on a regular basis to 'low-income' adults. Whilst all the participants adhered to the inclusion criteria, it was not documented how long they had practiced for. It therefore difficult to gauge whether their level of experience influenced their decision making with regards to making therapeutic adjustments. Not having this information also leaves questions unanswered as to whether the Counselling Psychologists level of experience relates to them being more susceptible to resilience or 'burnt out' by the work.

A lot could be learned from Counselling Psychologists who have chosen to stop working with this population to work with another population. Particularly given the difficulties experienced by the participants in the current study. This could therefore be a suggestion for potential future research. To examine the extent to which Counselling Psychologists incorporate external stressors within their formulations may also be a potential research avenue. This could potentially highlight methods of formulation which drive the therapeutic interventions in a way which helps the client's needs to get met. Particularly if these needs are generally considered to be outside of the psychologist's role. The concept of empowerment was evident in the current study alongside the experience of confusion in knowing what this might look like therapeutically. Therefore, a very valuable research avenue might be to look at what empowerment means therapeutically from the perspectives of the clients experiencing poverty. Thus, providing us with valuable information around the appropriateness of interventions.

Zerubavel and O'Dougherty-Wright (2012) argue that there may be elements of secrecy in therapists displaying their wounds, particularly in the context of seeking support. It is therefore essential that the Counselling Psychology syllabus continues to promote critical reflection on how adverse experiences can impact practice. This is so that these experiences can be harnessed into resources which have the potential to facilitate good practice. Thus, highlighting another potential research avenue looking at how adverse experiences impact Counselling psychologist's practice.

While the inclusion criteria specified how a 'low-income client' could be identified, the criteria were perhaps too broad. This could have been narrowed down by specifying that the participants' clients were either experiencing relative poverty or absolute poverty. It transpired that most of the participants worked in the context of extreme poverty, thus by the marker of absolute poverty. Further specificity may have provided more homogeneity within the sample. However, such differences allowed for the finding to emerge that extreme adaptations may be linked to extreme poverty. Research within the context of either of these domains (extreme vs relative poverty) may build on the current research by emphasising key differences in interventions. Furthermore, a focus specifically on extreme poverty may pinpoint traditional boundary violations that are considered acceptable and helpful to the client.

Another limitation may also be represented by my relationship with poverty. Not only have I experienced extreme poverty, but I also work therapeutically with those experiencing poverty. I therefore have my own belief system around the way in which one should receive and deliver therapy with those experiencing poverty. For example, I believe it is sometimes appropriate for boundary adjustments to be made. However, I continuously made attempts to question my own biases. This was done through engaging in journaling, cross checking my analysis and themes. In addition to discussions with colleagues and my research supervisor. I also asked two

of the participants to clarify whether they thought my analysis represented their experience, which they both expressed as being consistent with their experiences.

Despite these limitations, this is, to my knowledge, the first qualitative study which has looked at how Counselling Psychologists experience making therapeutic adaptations in the context of poverty. It is my view that the current findings highlight important considerations and challenges that Counselling Psychologists face when working with this unique population.

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Part 8: Appendices

Appendix A - Informed Consent Form

Consent to participate in a research Study

How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with low-income clients?

Name of researcher: Donna Veal

Researcher email: DOV0029@my.londonmet.ac.uk

Research supervisor: Dr Raffaello Antonino

Research supervisor email: r.antonino1@londonmet.ac.uk

Please indicate if you agree with the following statements by signing at the bottom.

I have read the information sheet and have been given a copy to keep

I understand the purpose of this study

I agree to this interview being audio recorded

I agree to and understand the limits to confidentiality

I understand that I am able to withdraw up until two weeks post interview

I understand that if I chose to withdraw up until two weeks post interview the audio recordings and interview transcripts will be destroyed

I understand that the data collected for this study is strictly confidential and I will not be identifiable in any reporting of this study including any publication in academic journals.

I understand that brief quotes from interviews will be used and they will be fully anonymised

I understand if the analysis has already started my anonymised data will be used in the research write up and may be used for further analysis.

I have been given the opportunity to discuss and ask questions about this research and my involvement in it.

I understand there will be a debriefing in which I will have the opportunity to ask any further questions about the study

I understand that due to possible publication all data will be kept for up to five years and thereafter will be securely destroyed.

I hereby freely and fully consent in this study which has been fully explained to me.

Participant's Name (BLOCK CAPITALS) Participant's Signature Date

Researcher's Name (BLOCK CAPITALS) Researcher's Signature Date

Appendix B (II) - Participant Information Sheet 1

London Metropolitan University,

166-220 Holloway Road,

London N7 8D

Title of study:

How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with low-income clients?

I am a Trainee Counselling Psychologist at London Metropolitan University and am currently carrying out research to discover how Counselling Psychologists in the UK experience delivering therapy to clients experiencing poverty, and to what extent they make adaptions.

Statistics reveal that 14 million people in the UK currently live in poverty, which is 1 in 5 people. (JRF, 2017). Furthermore, those who live in poverty experience a variety of psychological difficulties as well as a multitude of stressors that contributes towards their psychological distress[3]

It seems inevitable that Counselling Psychologists in the UK will come face to face with those experiencing poverty. Especially in services such as IAPT which offer therapy to this population.

Researchers have found that when therapy is tailored to remove barriers, focus on economic stressors or when therapists are considerate of these difficulties, it is effective[4]. However, it is unclear to what extent Counselling Psychologists make these adaptions and how they feel about doing so due to lack of research in this area.

In order to develop poverty-related sensitive skills, it seems importance to understand how Counselling Psychologists experience deviating from mainstream therapy with this client group.

I will be looking specifically at how Counselling Psychologists experience delivering therapy to low- income clients and to what extent they make adaptions.

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[3]Butterworth, Rodgers, & Windsor, 2009, DeParle, 2009, Narayan, Chambers, Shah, & Petesch, 2010, Weich & Lewis, 1998a; Santiago, Wadsworth, & Stump, 2011

[4] Ammerman et al.2005, Azocar, Miranda and Dwyer,1996, Falconnier and Elkin,2008, Goodman, 2015

As part of the screening process potential participants will be provided with guidelines to specify how a 'low-income' client is defined in the UK. (For example, clients who are in receipt of benefits such as JSA (Job seekers allowance), carer's allowance or income support, are considered to be experiencing poverty, as these are means tested benefits and are regarded as markers of poverty or deprivation within the UK.) This is to ensure that our definitions of what constitutes as a low-income client match and also to ensure that participants have worked with this population.

Additionally, Counselling Psychologists will be required to:

- Have at least 2 years' experience of providing therapy on a regular basis to 'low-income' adults and have made some therapeutic adjustments when working with this particular group. An adjustment can mean any change that you instigate based on the fact that it's a low-income client relative to non-low-income client. (Please refer to guidelines on Participant Information Sheet 2, if necessary.)
- Be currently providing at least 5 hours per week of individual therapy to 'low income' adults
- Are able to define a low-income client in line with the low-income client guidelines provided.

I am writing with the hope that you will be interested in helping me explore this topic by sharing your experience of working low- income clients by participating in this interview.

The interview would last between 60 – 90 minutes and will be voice recorded. Data from your interview will be used for my Doctoral level Counselling Psychology project.

Participation is completely voluntary. If you choose to participate you are free to withdraw at any point (up until … [specific date]) without question. Interviews will be voice recorded and strictly confidential. All recordings will be kept securely and destroyed once the project is completed.

Thank you so much for your time, if you have any further queries please do not hesitate to ask either by phone: 07951253321 or email: DOV0029@my.londonmet.ac.uk

I look forward to hopefully hearing from you soon.

Yours Sincerely,

Donna Veal

Appendix B (ii) - Participant Information Sheet 2

This participant Information Sheet will be used as part of the screening process but also to reiterate how a low-income client is defined within this study- in line with the UK Government's definition.

'Low income clients' will be identified as individuals in receipt at least one of the following government benefits, or as those who fulfill the criteria outlined in points 2 or 3 below (even if not in receipt of any benefits outlined under point 1).

1) Those in receipt of:
- income support,
- Jobseekers allowance,
- income-based jobseekers' allowance and/or
- housing benefit or in receipt of
- Healthy start vouchers (If they have a child under four.) This is because these categories are recognized as indicators of relative poverty in line with the government threshold (UK Government, 2017). (**Error! Hyperlink reference not valid.**)
- Child Tax Credit (With a family income of 16,190 or less per year)
- Universal Credit (With a family take home pay of £408 or less per month
- Working Tax Credits

This is because these categories are recognized as indicators of relative poverty in line with the government threshold (UK Government, 2017). (www.towerhamlets.gov.uk,www.gov.uk/income-support)

2) Clients who have a weekly income (or less than) of £144 for single individuals, £248 for couples without children, £297 for single parents with children, and £401 for couples with children.

According to Joseph Rowntree Foundation, (2017) these incomes are determinants of relative living in poverty in the UK.

3) Client who are currently experiencing difficulties in meeting their basic survival needs.

Appendix C - Participant Demographic Information Sheet

Please can you answer the following questions. The answers to these questions will be used for no other purpose other than informing the research data. This information will be will be disposed of and stored in the same way as all other data which is outlined in your information sheet.

What is your gender? Male □ Female □

What is your age?: 20-30 □ 31-40 □ 41-50 □ 51-60 □ 60+ □

How many years has it been since you qualified as Counselling Psychologist?

.....

Please list the types of settings you have worked in e.g. NHS, charity, or university counselling service and the client groups worked with in each setting e.g. adult, child and adolescent etc: **Particularly please emphasize what settings you have worked with those in receipt of means tested benefits as explained in the Information sheet.**

Appendix D- Interview Schedule

Asking the listed prompts will depend on the answers given; these are potential prompters and may be altered or not asked if already answered elsewhere.

1. **Can you tell me about your experience of working therapeutically with low-income clients?**

- Prompts: What have you noticed within the therapeutic relationship when working with poorer clients (if not at all) as opposed to clients not experiencing poverty?
- Have you experienced any differences providing therapy for clients experiencing poverty and those who are not?
- What feelings come up for you when working with clients in poverty?
- How did you cope with/ handle these feelings?
- Have you come across difficulties? How have you adapted the therapy to overcome these difficulties?

2. **What is your experience of making therapeutic adaptations with low-income clients?**

- Prompts: What has helped you to make these adaptations? What could have made you feel more prepared?
- When you have made adaptations what helped in your decision-making process? (Was there anything in particular that you drew from at that time- experience, training, literature, theory or research?)
- What adaptations to therapy have you found most helpful so far? How confident did you feel in making these adaptations?
- Can you tell me a bit about whether you experienced any service or professional difficulties when making adaptations?

3. **I'd like to know a bit more about your experience of adapting practice with low- income clients: Can you tell me about the extent to which you felt you had the resources to work with these clients?**

- Did you find that there were any obstacles? Can you provide an example?

- Were there any aspects of your identity that you found were helpful during therapy?
- Were there any aspects of your identity which may have had a detrimental impacted on the therapeutic relationship?
- If so, how did you work with that?
- Was there anything in particular that led you to working with those from disadvantaged backgrounds?
- Are there any other resources (outside of interventions) that you think you have used when working with low-income clients?
- Would you consider yourself as having the skills to make these adaptations? What skills are they? How did you learn or develop these skills?
- When making adaptations on what basis do you make these? (Experience, training, literature, theory or research?)
-

4. **Can you tell me a bit about your experience of training in relation to working with low-income clients**?

- Was poverty a topic of discussion during your Counselling Psychology training?
- If yes what did you find helpful in working with these clients?
- Did you find anything hindering?
- Was there any other kind of training / support that was particularly helpful in your Counselling Psychology training in working with these clients?
- Has there been any other kind of training relating to issues of poverty that has been helpful? Can you give me an example?
- To what extent do you feel supported in your workplace when working with low-income clients? Can you tell me more?

5. **I wonder as part of your work with low-income clients if you could tell me a little bit about your experience of when there were circumstances in the life of a client that was out of their control?**

- Can you tell me a little bit about when there were circumstances outside of the control of the client that was affecting their wellbeing?
- What was it like to experience this in the process of therapy?
- How do you work therapeutically with clients when circumstances outside their control affect their wellbeing?
- Is there anything specific you did when you worked with this?
- Were there any therapeutic interventions/ modalities that you felt were unhelpful when circumstances were outside of your client's control?
- Did you work with internal processes when it seemed that little or no external change was possible for your client/s?
- What was that like for you?

Is there anything further you would like to add which you think is relevant to the things we've been exploring?

Closing of Interview:

- Ask if they have any questions
- Give participants debrief sheet
- Thank them for participation

Appendix E - Debriefing Form

Research project title: *How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with low-income clients?*

Thank you for participating in this research project. If you have any questions regarding any stage of the research process, are interested in the results of the study, or you wish to withdraw, then feel free to get in touch with me via the following email address:

DOV0029@my.londonmet.ac.uk

Emails will be checked regularly.

Please be reminded that if you wish to withdraw your date from this study it should be done by ******** as this may not be possible two weeks post interview.

Equally, if you have any questions or concerns you are more than welcome to address them now.

If you have any questions, concerns or complaints about this research, please feel free to contact my research supervisor:

Research supervisor name: Dr Raffaello Antonino

Email: r.antonino1@londonmet.ac.uk

Appendix F- Recruitment Poster

Counselling Psychologists needed for research study

The title of the research project is: *"How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with low-income clients?"*

I am a Trainee Counselling Psychologist studying at London Metropolitan University (LMU) I am currently recruiting Counselling Psychologists to participate in my research project.

This research aims to explore how Counselling Psychologists experience delivering therapy to clients experiencing poverty and to what extent they make adaptions.

Participation will involve taking part in a semi structured audio recorded interview which will be held at a location and a time convenient to participants will take place via Skype. (This will depend on the guidelines implement by the UK Government (2020) on social distancing at the time of interviewing. and will last approximately one hour. This study has been approved by London Metropolitan University's Research Ethics Committee.

I am looking to recruit Counselling Psychologists who:

- Have at least 2 years' experience of providing therapy on a regular basis to 'low-income' adults and have made some therapeutic adjustments when working with this particular group. An adjustment can mean any change that you instigate based on the fact that it's a low-income client relative to non-low-income client.
- at present providing a minimum of 5 hours per week of individual therapy to 'low income' adults.
- Are able to define a low-income client in line with the low-income client guidelines provided.

Low income clients' will be identified as clients who are in receipt of specific benefits. This is because benefits such as JSA (Job seekers allowance), carers allowance or income support, are means tested benefits that are regarded as markers of poverty or deprivation within the UK. (Additional guidelines will be provided.)

This research is being Supervised by Dr Raffaello Antonino, Lecturer in Counselling Psychology at LMU (Email: r.antonino1@londonmet.ac.uk Tel: 0207 133 2448)

I would sincerely appreciate your participation in this research. If you would like to take part and would like an information sheet, please contact me on the details below.

Telephone: 07951253321 or email: DOV0029@my.londonmet.ac.uk

I look forward to hearing from you.

Many thanks,

Donna Veal

Appendix G - Recruitment Advert

Dear All,

I am a Trainee Counselling Psychologist at London Metropolitan University (LMU.) I am currently recruiting qualified Counselling Psychologists as participants in my research project.
The title of the research project is: *"How do Counselling Psychologists in the UK experience making therapeutic adjustments when working with low-income clients?"*
This research aims to explore how Counselling Psychologists experience delivering therapy to clients experiencing poverty and to what extent they make adaptions.
Participation will involve taking part in a semi-structured audio-recorded interview. Interviews will either be held at a location and time convenient to participants or will take place via Skype. (This will depend on the guidelines implement by the UK Government (2020) on social distancing at the time of interviewing. Interview's will last approximately one hour. research has gained ethical approval from the ethics committee at LMU. I am looking to recruit Counselling Psychologists in the UK who have direct experience of clients in therapy who were in receipt of means tested benefits such as Jobseekers allowance (JSA) and Income support.
This research is being Supervised by Dr Raffaello Antonino, Lecturer in Counselling Psychology at LMU (Email: r.antonino1@londonmet.ac.uk Tel: 0207 133 2448)
I would sincerely appreciate your participation in this research project. If you would like to take part in this research and would like an information sheet, please contact me by email or telephone:
Telephone: 07951253321 or email: DOV0029@my.londonmet.ac.uk

I look forward to hearing from you.

Many thanks.

Donna Veal

Appendix H- Patient Health Questionnaire-9 & Generalized Anxiety Disorder-7

Patients name: …… Date: ……

PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1.Little interest or pleasure in doing things	0	1	2	3
2.Feeling down, depressed, or hopeless	0	1	2	3
3.Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.Feeling tired or having little energy	0	1	2	3
5.Poor appetite or overeating	0	1	2	3
6.Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	PHQ9 total score:			

Q6 Core 10	I made plans to end my life in the last 2 weeks	No	Yes

GAD-7

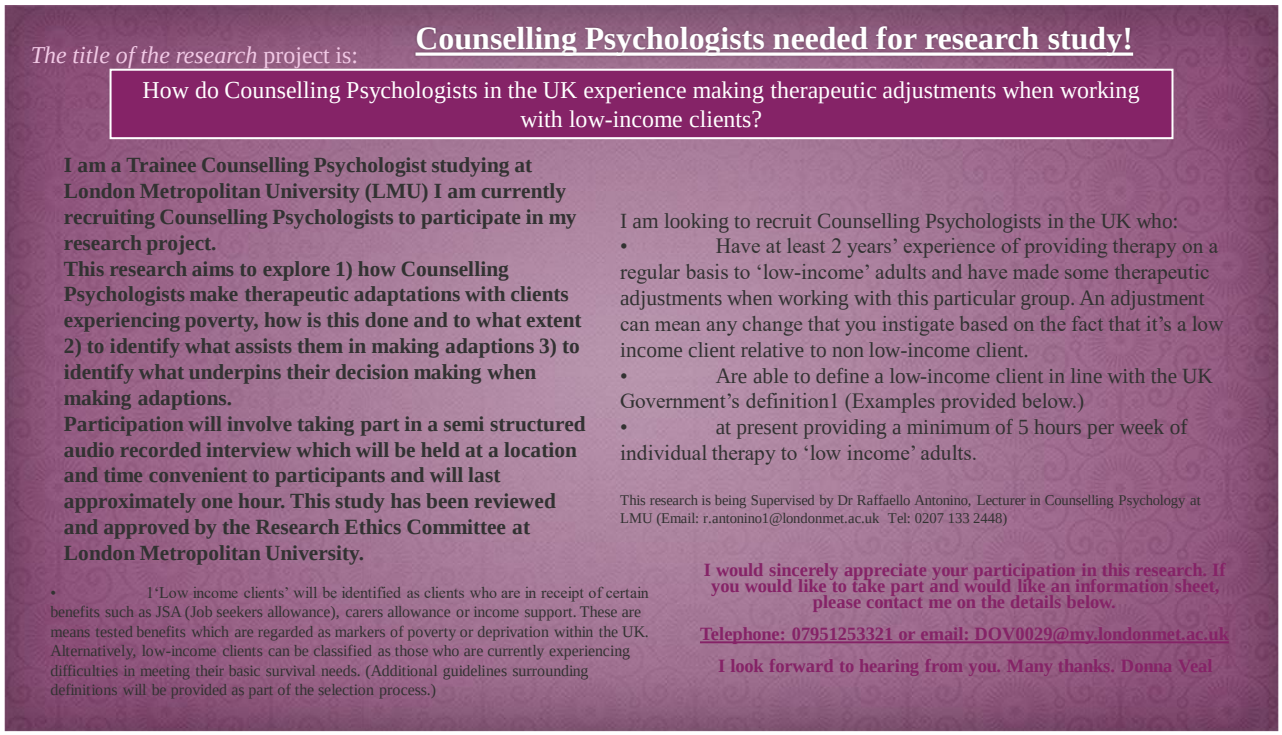
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half days	Nearly every day
1.Feeling nervous, anxious or on edge	0	1	2	3
2.Not being able to stop or control worrying	0	1	2	3
3.Worrying too much about different things	0	1	2	3
4.Trouble relaxing	0	1	2	3
5.Being so restless that it is hard to sit still	0	1	2	3
6.Becoming easily annoyed or irritable	0	1	2	3
7.Feeling afraid as if something awful might happen	0	1	2	3
	0	1	2	3
	GAD-7 total score:			

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Appendix I- Research Poster



Appendix J- Distress Protocol[5]

This procedure will be used if participants feel distressed amidst the interviewing process.

This Distress Protocol is designed to deal with the possibility that some participants may become distressed during the interviews while discussing their experiences of therapy. As a Trainee Counselling Psychologist, the researcher has developed a set of skills for working with people with psychological difficulties, and this allows the researcher to ensure the safety of the participants and to manage situations where distress occurs. It is not expected that severe or extreme distress will occur during this research study, because every attempt will be made to ensure that potential participants such as psychotic, unstable and suicidal participants will be excluded from the study. In the situation where participants do become unduly distressed, the following action will be taken to ensure the wellbeing of the participants.

Mild distress: When mild distress occurs, it tends to be evidenced by signs such as tearfulness (watering and redness of the eyes), crying, difficulty in speaking, and the voice tends to become choked with emotion and the participant become distracted/restless.

In such cases appropriate action will be taken. The researcher will ask participants whether they are experiencing distress, and if they are, then the researcher will offer them time to pause and compose themselves and ask whether they would like to continue with the interview.

Severe distress: Severe distress can be identified by signs such as uncontrolled crying, uncontrollable tremors, inability to talk coherently, panic attacks, and hyperventilation.

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[5] London Metropolitan University

In such cases appropriate action will be taken. The researcher will stop the interview, debrief the participant immediately and employ relaxation techniques to regulate breathing and reduce agitation. The researcher will recognise the participants' distress and will reassure the participants that their experiences are normal reactions to abnormal events and that most people recover gradually from such experiences. If any unresolved issues arise during the interview, the researcher will accept and validate the participants' distress, and suggest that they might want to discuss the experience with a mental health professional. Participants will be reminded that this research study is not designed as a therapeutic interaction and details of counselling/therapeutic services will be offered to the participants.

Extreme distress: Extreme distress is manifested by signs such as severe agitation and possibly verbal or physical aggression. In extreme cases psychotic breakdown can take place where the participant relives traumatic incidents and begins to lose touch with reality.

In such cases appropriate action will be taken to maintain the safety of the participants and of the researcher, and if the researcher has concerns about the safety of the participants' or of others, then he will inform the participants that he has a duty to notify mental health services such as a Community Psychiatric Nurse or the participant's General Practitioner. However, if the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask to be seen by the on-call Psychiatric liaison team. If the participant is unwilling to seek immediate help and becomes violent, then the Police may have to be called and asked to use their powers under the Mental Health Act to detain the person and take him to a place of safety pending psychiatric assessment. (This last option would be used only in an extreme emergency.)

Appendix K- List of mental health organisations

Here is a list of organisations that may provide you with support should you need it after the interview process.

Highbury Counselling Centre

http://www.wlm.org.uk/what-we-do/hcc

020 7354 4791

Email: highburycounselling@wlm.org.uk

Highgate Counselling Centre

http://highgatecounselling.org.uk/counselling/fees-and-registration

020 8883 5427

Individual, group, couple and family counselling, 21 years old +.

Area: Based in Muswell Hill, N. London

Mind

http://www.mind.org.uk

Email: contact@mind.org.uk

Mind is a mental health charity that offers a range of support, advocacy and therapy.

Spiral Centre

http://www.spiralcentre.org/

020 7607 4403

info@spiralcentre.org

Short- and longer-term counselling and psychotherapy, self-referral.

Area: based in N London

The Stress Project

http://www.stressproject.org.uk

020 7700 3938

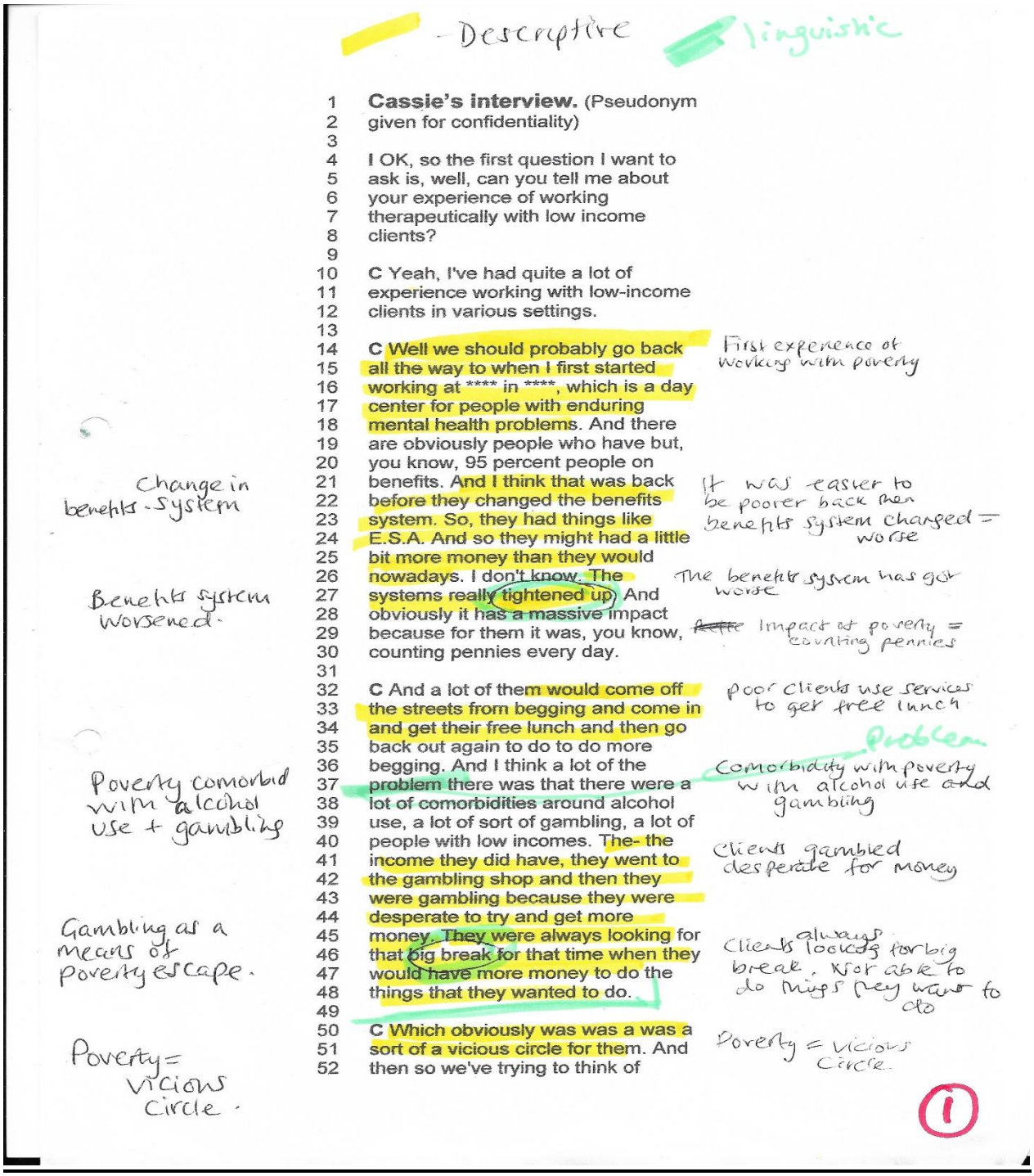
Counselling and complementary therapies for people experiencing mental health problems and living in Islington. Referral is via a Health Professional

Samaritans

This helpline is open 24 hours a day 7 days a week

Tel: 08457 90 90 90

Appendix L- Section of one transcript with notes: Cassie



- Descriptive
- linguistic

Cassie's interview. (Pseudonym given for confidentiality)

I OK, so the first question I want to ask is, well, can you tell me about your experience of working therapeutically with low income clients?

C Yeah, I've had quite a lot of experience working with low-income clients in various settings.

C Well we should probably go back all the way to when I first started working at **** in ****, which is a day center for people with enduring mental health problems. And there are obviously people who have but, you know, 95 percent people on benefits. And I think that was back before they changed the benefits system. So, they had things like E.S.A. And so they might had a little bit more money than they would nowadays. I don't know. The systems really tightened up. And obviously it has a massive impact because for them it was, you know, counting pennies every day.

C And a lot of them would come off the streets from begging and come in and get their free lunch and then go back out again to do to do more begging. And I think a lot of the problem there was that there were a lot of comorbidities around alcohol use, a lot of sort of gambling, a lot of people with low incomes. The- the income they did have, they went to the gambling shop and then they were gambling because they were desperate to try and get more money. They were always looking for that big break for that time when they would have more money to do the things that they wanted to do.

C Which obviously was was a was a sort of a vicious circle for them. And then so we've trying to think of

First experience of working with poverty

Change in benefits system

It was easier to be poorer back then benefits system changed = worse

Benefits system worsened.

The benefits system has got worse

Impact of poverty = counting pennies

poor clients use services to get free lunch

Problem

Poverty comorbid with alcohol use + gambling

Comorbidity with poverty with alcohol use and gambling

Clients gambled desperate for money

Gambling as a means of poverty escape.

Clients always looking for big break. Not able to do things they want to do

Poverty = vicious circle.

Poverty = vicious circle

(1)

activities that we could do with them at the day center. And so we would do things like walking groups, which was nice. I did a cooking group, which was was also very popular. And the walking groups, they like to come because, of course, we would pay for coffee. And and it was it was nice to be able to pay for for, you know, for a coffee for them, some sustenance for some of them, when sometimes I only have one meal a day, you know.

Did activities that were cheap or free

clients came because they got free coffee

feels good to help

C I think then after that, I started. Let me think when I started working. I was doing my second Masters at that time, and then I started working in a forensic mental health hostel, a private forensic mental health hostel out in ******, which is sort of ******** area around there.

Experience in forensic mental health hostel

C And again, it was people who had been released from hospital, from being under a section, and they were working. They were living in the hostel, supported housing as part of the sort of the conditions of their release because they didn't have homes to go to. They didn't have family that would take them, or at least it was dangerous for them to go back. And again, there was similar problems with sort of alcohol, drugs, addictive behaviors.

living in hostel after being sectioned.

They live in hostel because they have no home.

Family does not want them or home is dangerous

Poverty linked to alcohol and drugs

Housing conditions perpetuate mental health difficulties

C You know. There was also- sort of- people not eating very healthily, people not really taking much care of themselves because it costs a lot of money to eat healthily. They didn't really have kitchen equipment. So, it's not like they could cook themselves, you know, a healthy vegetable laden meal. It was chips and burgers because that was much cheaper. And then obviously, they had a lot of health problems. And then the health problems compounded into psychological problems because of- you know, I'm

Can't look after themselves = costs money.

Healthy eating costs money

kitchen equipment costs money

unhealthy food cheaper

unhealthy eating impacts health.

health problems make psychological problems worse

"obviously"

impact directly

Poverty impacts physical health.

Physical Poor health impacts mental health.

2

Junk food worsens mental health

a big believer in that food and mood are really linked. And that, you know, actually it can really impact on your mental state if all you're eating is junk food. And we can really have a massive knock on impact on conditions like psychosis and things like that.

Really believe food and mood is linked.

Poor diet: big impact on mental health

Poor diet can make psychosis worse

C And then I started working at a forensic mental health hospital. And again, those are people- those are people who at this point were in hospital. They didn't- they weren't on benefits anymore, I don't think, because, of course, the hospital was taking care of all of their needs and they were there under a section and they were they under a legal section, which was basically meant that they had committed a criminal act and instead of going to prison. They came to hospital. So, there were conditions of their release and things like that. Not like go on inpatient hospital where they can just get released much easier. They were given some money per week. So, it was sort of spending money. But a lot of people that would run out, by the end- before the end of the week, they would spend it on things like cigarettes, junk food. They would have their food delivered to them. And they didn't really have many other expenditures apart from buying their own clothes, that sort of thing. And a lot of them would have families that would come and visit the families who bring food and they would sit together any two meal. And I think one of the-a lot of I mean, a lot of these people that I work with, they they...

Experience of working at forensic mental health hospital.

People not in reciept of benefits.

Hospital takes care of needs

Clients go to hospital instead of prison.

clients given Spending money

Spending money runs out before end of week

Use of language

Probe point

Wealthy people don't attend daycentres = forensic units

Relationship between class and mental health.

C You don't often get someone who's incredibly wealthy coming to a day center or or, you know, going into a forensic mental health hospital, because the very nature of growing up with the socioeconomic status they have leaves them to have life

3

conditions which make them more likely to eventually have problems with mental health and to have problems with, you know, offending.

C So it was it's difficult because a lot of them would have families. A lot of them had family- complex family histories where they don't really have the input, the proper schooling or the additional things that they've done, you know, outside of... their parents work all the time. So, a lot of them sort of put themselves up... From teenagers... I mean, I don't know if it actually impacted on them mentally when they were in there, but it certainly impacted on them when they were trying to get released because it's not like they didn't have homes to go to. And that stability that that money brings in- was not part of the picture for them or for their families.

C And a lot of them, it was very difficult because their families all lived in smaller homes and they can't be released from hospital and into a situation where there are other large families, people who are undoubtedly under age living there, and you can't release someone back into conditions like that.

C So after the mental health of the forensic mental health hospital, I started working for another *****, this time done in ******. And again, it was people who thought it was technically an IAPT service, or at least they got referrals from an IAPT service and they were contracted to do sort of counselling.

C And, you know, it's part and parcel of the picture of working, especially in sort of **** *******, where there's a lot of cultural diversity and a lot of socio economic poverty that it's just. Comes with the territory that it's not like you can say to these people:

Offending linked to class and poorer earlier life conditions.

Complex family histories perpetuate poverty related mental health difficulties.

Childhood instability perpetuates

Instability in childhood and adulthood.

Poverty conditions perpetuate mental health difficulties.

Cultural diversity + poverty strongly linked.

Wealthy people don't go to these places because they don't grow up with same life conditions.

Poverty impacts mental health. This leads to offending

poverty complex families

Parents work all time need to raise themselves.

Family impacts might mental health in hospital

Family impacts definately mental health out of hospital.

They did not have stability of money nor did their family.

Can't be released into smaller home

Can't be released into home with children

Next experience

Part and parcel of working in poorer places. Cultural diversity and poverty comes with the territory

(4)

"here, I recommend this book or I recommend that you go and do yoga," because yoga classes cost money, books cost money. I recommend that you eat healthier because, you know, eating healthier. Costs money. A lot of them, if they're in work, they have they working jobs with with small wages.

C And it's pretty hard for them to reduce stress levels if they can't, you know, if they have to work lots of hours and often a lot of them will be working jobs where they have employers who don't really like it if they need to take time off, sick- say, for mental health recovery. So a lot of them have to try and recover from the mental health problems while still working full time. And that's really, really difficult for a lot of people.

C Well, I am at the moment at ******* that has been quite an eye opener for me, because there I'm working with people who do have a lot of resources, although some of them would disagree with that obviously! A lot of them are health insurance through their work and some of them are private funding. And so, there are certainly a much higher socio economic status than some of the other people I work with. And there it really is quite. Obvious how their socioeconomic status helps them because they can take time off work. They can go on holiday. They can do more self-care things for themselves. Get the haircut, buy some clothes, make themselves feel better. Oh, and I have a couple more experiences. Of the last two years I have been working with people with lower incomes is in ****** in the early intervention for Psychosis Unit, and the ****** substance misuse service. And obviously a lot of the people, they're all, you know, primarily on benefits(can't work.

Poverty impacts usefulness of certain therapeutic interventions.

Therapeutic recommendations inappropriate with poor.

Poor have more life stressors.

working with economically privilged - eye opening!

Recurring word "obvious"

Economically privilged Can alter their emotions

Exp of Link between poverty and mental health in setting

language → emphasis on control!

can't recommend books. Books cost money

Can't recommend Yoga.

Healthy eating costs money.

Those who work have small wages

Difficult work conditions

Lack of support

opened eyes....

Experience of working with wealthier people 'eye opening'

Some do not 'obviously' see their resources

why is it obvious??

Very obvious how SES helps them.

Why??

They can change their emotions?

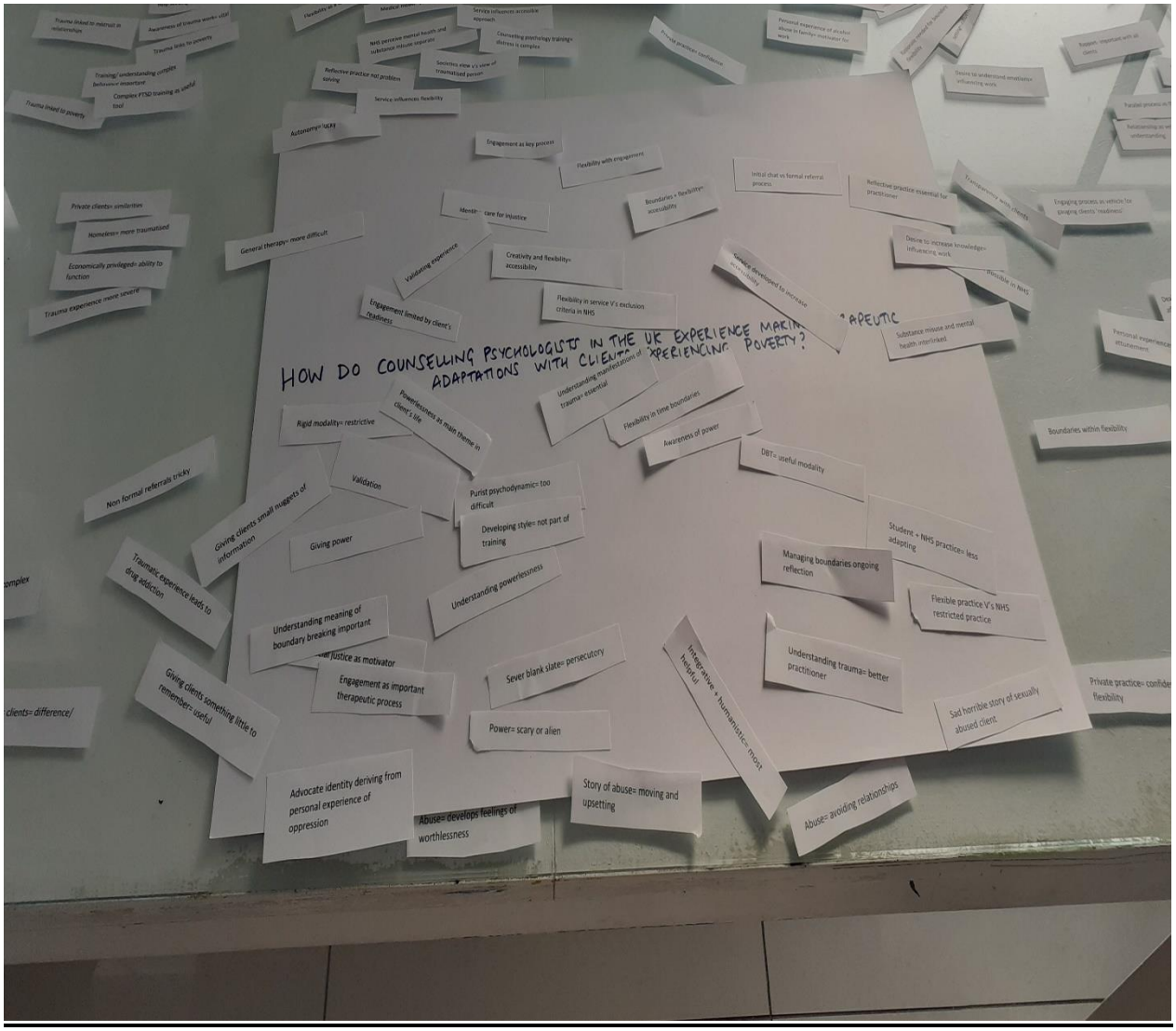
money makes you feel better

People in Psychosis service and Substance misuse service mainly on benefits.

can't as opposed to 'don't'

5

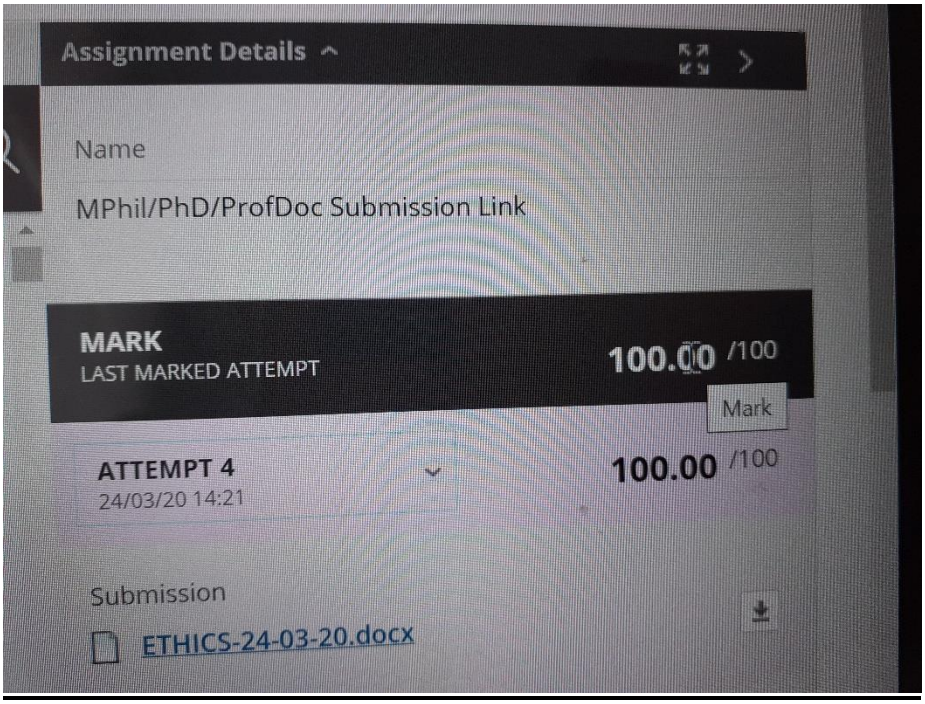
Appendix M- Clustering process

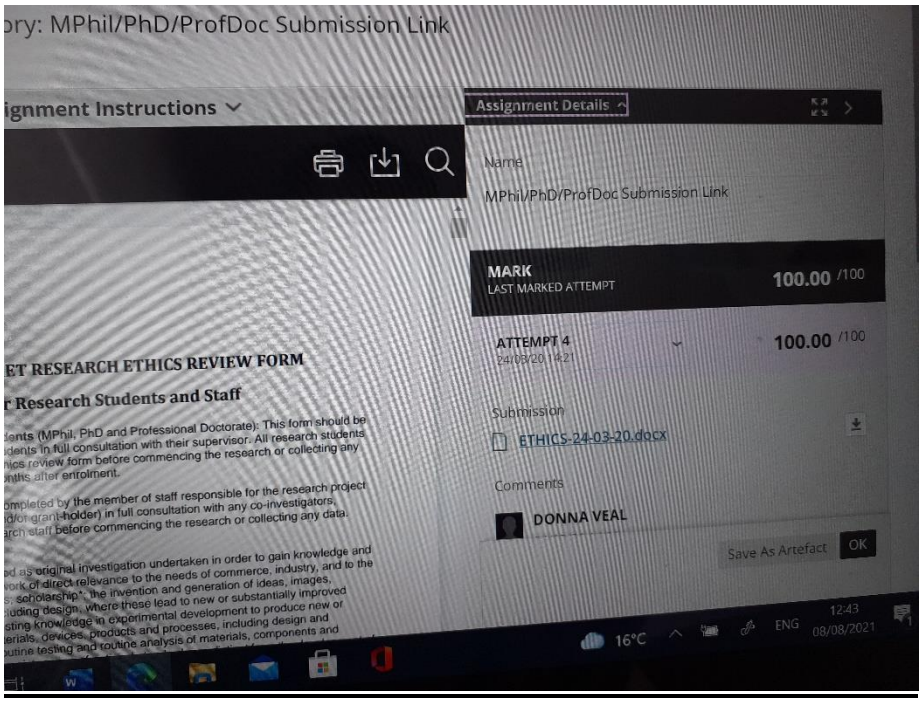


Appendix N- Preliminary superordinate themes and subthemes: Natalia

Superordinate Theme	Subtheme
Mental Health and Poverty:	Poverty linked to trauma
	Substance misuse and mental health interlinked
	Trauma linked to attachment
Influences on Practice:	Theoretical orientation
	Societal influence:
	Personal experiences
Types of Practice:	The therapeutic relationship
	Useful techniques/ modalities

Appendix O- London Metropolitan University Ethical Approval

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