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Barriers To Working With Low Income Clients As Experienced By Counsellors

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Education

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Abstract

This study aimed to answer the question “*what are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*”. Participants were recruited via mass email sent to professionals registered with the Canadian Counselling and Psychotherapy Association (CCPA), who then completed a survey via Qualtrics (n = 322). 113 Canadian counsellors from across Canada were interviewed. Data obtained from interviews was analyzed using concept mapping software GroupWisdom. Participants (n = 29) grouped the statements into seven themes including: barriers due to low income and employment, systemic barriers for clients, barriers due to trauma, competing needs and priorities, biased approaches, limits to real world helpfulness of counselling, and negative impacts of systems on and for counsellors. Results of the study highlight the importance of identifying and addressing inequities faced by low income clients to make mental health services accessible and available to all regardless of income.

Keywords: low income, counselling, barriers, challenges, Concept Mapping, Participatory

Action Research

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Summary for Lay Audience

This study aimed to answer the question “*what are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*”. Counsellors from across Canada were invited through email sent to members of the Canadian Counselling and Psychotherapy Association (CCPA), which provides leadership to professionals in the fields of counselling and therapy. 322 counsellors completed a survey and reported whether they were interested in being interviewed. 113 counsellors were interviewed and the statements from these interviews were reviewed and edited, removing any unnecessary details. The counsellors then grouped and labelled these statements based on themes they saw within the statements. These groups were analyzed using the concept mapping software GroupWisdom, which created a visual of the statements most commonly grouped together, how often they were grouped together, and how consistent the statements within each group were. Counsellors grouped the statements into seven themes including: barriers due to low income and employment (i.e. unable to take time off work to come to counselling, etc.), systemic barriers for clients (i.e. limited number of sessions and difficult to access), barriers due to trauma (i.e. client’s experiences of trauma impacting counselling), competing needs and priorities (i.e. being in crisis mode and wondering how to pay rent), biased approaches (i.e. judgements made by counsellors and lack of awareness), limits to real world helpfulness of counselling (i.e. unable to change client’s lives outside of counselling) and negative impacts of systems on and for counsellors (i.e. certain approaches not as helpful with clients and judgement about how they choose to counsel clients). This study highlights the importance of identifying and addressing the challenges and barriers experienced by low income clients so that mental health services are more accessible and available to all.

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Chapter 1: Introduction

While low income is not officially defined by the Government of Canada, it is often evaluated by “measuring the number of Canadians with low incomes” (Government of Canada, 2016). However, this definition and number of low income Canadians varies widely depending on the indicator used to measure this concept (Burkinshaw et al., 2022; Government of Canada, 2016). For instance, using low income cutoffs, which are “income thresholds below which [one] will devote a larger share of ... income on the necessities of food, shelter and clothing,” low income individuals are those who need to spend 20 % or more of their income on those necessities, classifying 3 million Canadians as low income in 2014 (Burkinshaw et al., 2022; Government of Canada, 2016). Conversely, in the same year using the low income measure, which defines a low income household as one whose income is “below 50 [%] of median household incomes,” classifying 4.5 million Canadians as low income (Burkinshaw et al., 2022; Government of Canada, 2016). Although these two measures produce vastly different results while seemingly measuring the same concept, it is agreed upon that low income and poverty is an issue that needs to be addressed (Burkinshaw et al., 2022; Government of Canada, 2016; Government of Canada, 2021). However, according to a survey conducted by the Government of Canada in 2019, 10.1 % of Canadians fall under Canada’s official poverty line, which equates to 3.7 million people who are living with low income in Canada (Government of Canada, 2016; Government of Canada, 2021).

Although those of low income may have similar experiences associated with their socioeconomic and income status, low income is not a uniform and universal experience. The lives of low income families and individuals are complex and nuanced and each person’s experience with low income is unique. Some low income individuals are afforded privileges

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where others are not and some experience oppression and discrimination on the basis of their intersecting identities (i.e. ageism, racism, sexism, homophobia, ableism, transphobia, and sizeism; Government of Canada, 2021). Individuals with certain social locations, such as family composition (i.e. single parent households), Indigenous status, disability, and immigration status, are more likely to live with low income and face economic barriers (Government of Canada, 2021). For example, approximately 23 % of people in sole-caregiver families and 18 % of Indigenous people living off-reservation were below Canada's official poverty line (Government of Canada, 2021). Furthermore, low income LGBTQIA+ individuals experience key challenges such as “identity-based rejection and discrimination,” homelessness, and lack of inclusion and recognition in research, policy, and program design, whereas low income women experience “violence as a cause and result of poverty,” limited access to affordable, quality child care, and low wages and benefits (Government of Canada, 2021).

Universally, low income individuals tend to disproportionately experience adverse health outcomes compared to their higher-income counterparts universally, a side effect or result of income inequality, an “indicator of how material resources are distributed across society” (Burkinshaw et al., 2022; Prosper Canada, 2021; *Society at a Glance 2011 - OECD Social Indicators*, 2011). Furthermore, low income and mental health issues have often been linked, although low income individuals are less likely to receive care or be offered treatment (Ballo & Tribe, 2023; Niemeyer & Knaevelsrud, 2022; Santiago et al., 2013). This disparity in mental health and accessing care may be a result of financial distress contributing to an increase in the frequency of mental health issues among this population (Prosper Canada, 2021; Santiago et al., 2012).

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Research has found that one's income or financial constraints, along with other social determinants of health, "non-medical social needs" such as access and available support, often deter or prevent individuals from accessing mental health or psychological services (i.e. therapy or counselling; Andrade et al., 2013; Baker, 2014; Marmot & Wilkinson, 2005; Santiago et al., 2012). For example, based on data collected from twenty-four countries by the World Health Organization (WHO), Andrade et al. (2013) saw that financial barriers were one of the top structural barriers to treatment mentioned by respondents (Andrade et al., 2013). Similarly, Ollerton (1995) found that clients of a lower income experience more financial barriers, such as travel costs and childcare costs, which inhibit counselling uptake (Ollerton, 1995).

Despite the many barriers that prevent low income populations from accessing mental health services, many mental health practitioners, such as counsellors, work with those of low income in a wide variety of both public and private-sector settings (i.e. private practice, schools, universities, public agencies, health care providers, and so on; Sheppard, 2016). In recent years, there has been a push for more publicly funded institutions and programs dedicated to increasing access for and providing mental health services to low income individuals (Moroz et al., 2020). Additionally, in private practice, counsellors have more widely begun to provide mental health services to low income clients through use of a sliding scale fee, which is adjusted to the financial needs of the client (Inman & Bascue, 1984).

However, these great strides in both the public and private sectors are not without their faults. According to Moroz and colleagues (2020), barriers for mental health services in Canada "pertain mainly to costs, ... insufficient funding [for government and publicly funded mental health services]," and a high demand for private practice counsellors who offer sliding scale fees if clients are paying out of pocket, which hinders client access, retention, engagement, and

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progress in therapy. Therefore, looking at counsellors experiences is the first integral step in determining the barriers preventing low income clients from accessing, continuing, engaging, and progressing in therapy. Clients may not have access to much-needed knowledge and resources, or be aware of these structurally imposed and normalized inequities to advocate for change. This paper aims to discover these barriers to treatment with low income clients as experienced by their counsellors so that they can be addressed and mitigated, with hopes of lessening the mental health inequity experienced by those of low income.

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Chapter 2: Literature Review

Low Income and Counselling

Effectiveness Of Mental Health Treatments In Low Income Individuals & Families

Previous research has noted that low income individuals and families often experience inconsistent attendance over the course of counselling (Appio et al., 2013; Ollerton, 1995; Schnitzer, 1996). According to Schnitzer (1996), there have been “clinical stories” passed on throughout generations of counsellors and psychotherapists that are shared anecdotally between clinicians, one of which is “they don’t come in” (Schnitzer, 1996). As described by Schnitzer, “They don’t come in” is a narrative which occurs when clinicians raise issues surrounding low income clients seeming unreliability and irresponsibly surrounding attendance to therapy (Schnitzer, 1996). Although seen as a barrier for low income clients to engage in therapy, this narrative has been found to be somewhat inaccurate, as many other external factors impact a client’s attendance and thus result in inconsistent attendance, such as obtaining transportation to and from session, as well as other competing needs with counselling (McBain, 2018; Ollerton, 1995; Payandeh, 2023; Schnitzer, 1996).

For example, Ollerton (1995) described other competing needs such as having to obtain childcare for sessions which can be costly or unavailable to the client, clients wanting to attend counselling but unable to as it may only be offered during times in which they work, and clients with variable work schedules, such as shift work, or inability to take time off (Ollerton, 1995). Similarly, McBain (2018) reported “[c]ost of services, lack of insurance, childcare, transportation, and location” to be identifiable barriers that low income people face when trying to access therapy (McBain, 2018). Furthermore, Payandeh (2023) described how competing priorities and needs such as housing and food insecurity and the cost of therapy often conflict,

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making it difficult for low income clients to access and engage in counselling. While research supports the complex nuances surrounding the “they don’t come in” narrative, it is still damaging as it pathologizes and stigmatizes the experiences of low income clients and contributes to extant barriers for access and engagement in the mental health system (Appio et al., 2013).

Nonetheless, mental health treatments have proven to be effective for low income clients. According to a review conducted by Santiago et al. (2013), mental health interventions such as CBT and medications for panic disorder or interpersonal therapy (IPT) for post-traumatic stress disorder (PTSD) conducted with low income adults are quite effective. For example, using a randomized controlled trial (RCT) of a cognitive behavioural therapy (CBT) course in 150 low income adults with depression, Muñoz et al. (2011) found that those who received treatment had fewer depressive symptoms than the control group, both post-treatment and at one-year follow-up (Muñoz et al., 2011). Comparably, mental health interventions used in families and children with low income are also beneficial (Santiago et al., 2012). For instance, an intervention called the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), has been shown to improve symptoms of depression and PTSD among low income Latino adolescents and children exposed to violence (Santiago et al., 2012).

These results further reinforce that the decreased access to mental health support experienced by low income individuals is not due to personal factors such as motivation or ability. Rather, for low income clients, there are structural and systemic barriers to accessing and participating in their own mental health care.

Systemic Barriers

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As mentioned, there are many systemic and structural barriers that low income individuals face when they try to access, commit to, and engage with mental health services. According to Andrade et al. (2013), who used data from 63,678 participants' World Health Organization (WHO) World Mental Health (WMH) surveys, finances and lack of availability were mentioned by most respondents to be a barrier to mental health treatment (Andrade et al., 2013). Furthermore, qualitative research conducted by Thompson et al. (2015) with a sample of nine mental health clinicians identified many flaws within the public mental health system, such as stigma faced by low income clients that may be intensified within the context of counselling, session limits, and having to prove client need to insurance companies (Thompson et al., 2015). These systemic barriers are evident in statements made by participants, including “[p]robably the biggest barrier is just the system in general. Too many people get lost in it. Too many people can’t navigate it. I can’t even navigate it” (Thompson et al., 2015)

Similarly, Moroz et al. (2020) identified many systemic barriers to mental health treatment in Canada (Moroz et al., 2020). These systemic barriers include “not knowing where to go for help, long wait times, shortage of accessible mental health professionals, lack of mental health service integration and government oversight, culture and language barriers, concerns about stigma, inequities due to geography or demographics, and cost of services not covered by private insurance plans” (Moroz et al., 2020). Similarly, research conducted by Placzek (2021) on 102 non-profit health organization clients in Northern California suggests that systemic barriers are linked to the “inequitable distribution of and access to resources” (Placzek, 2021). The resources identified to be unequally distributed included availability, accessibility, and additional challenges such as stigma, strict program criteria, and complicated application processes for low income clients (Placzek, 2021).

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These results, obtained globally, exemplify the many additional barriers and challenges that low income clients face when trying to access and engage with mental health services.

These barriers need to be further investigated, addressed, and mitigated by counsellors in order for low income clients to fully commit to and engage in the therapeutic process, as well as foster the client-therapist relationship and provide an environment where the onus for their mental health is not solely on the low income individual.

Class Issues in Counselling and Implications for Therapy and the Therapeutic Alliance

Numerous systems, such as healthcare and legal, are fraught with power imbalances which put those of lower class or socioeconomic status at a disadvantage (Ballo & Tribe, 2023; Delgadillo, 2018; McBain, 2018). This has implications for therapists counselling low income clients as opposed to non low income clients, as explained by McBain (2018), “traditional psychotherapy paradigms are not relevant for [those of low income] because they were created based on experiences of the White middle class and may inadvertently direct clinicians toward culturally specific middle class values and assumptions” (Kim & Cardemil, 2012; McBain, 2018). As a result, psychology and psychotherapy paradigms are riddled with biases that normalize life experiences, worldviews, and value systems based on White, middle-class norms while pathologizing the experiences of those who do not fit that criteria, further communicating that they are of less value and that their way of being is invalid (Appio et al., 2013). Therefore, there are many factors, both individual and systemic, that need to be taken into consideration when working with low income clients in order for their needs to be adequately met and different interventions or modes of therapy may need to be used (McBain, 2018; Appio et al., 2013). For example, low income clients may focus more on the present, such as wondering how they will

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pay their rent or how they will put food on the table for their families, suggesting that the issues in the here-and-now need to be addressed over long-term goals (McBain, 2018).

In addition, interventions such as Solution Focused Brief Therapy (SFBT) may be useful with low income clients, as it is brief yet cost effective and maximizes clients time, while not pathologizing behaviour and is strengths-focused and can be tailored to the needs of the individual (McBain, 2018). Similarly, the I-CARE model by Foss-Kelly et al. (2017) was designed to acknowledge poverty in the therapeutic space at both individual and societal levels and has the potential to be an effective treatment model (Clark et al., 2020; Foss-Kelly et al., 2017; McBain, 2018). This model integrates the nuanced internal reflections of the therapist, cultivation of relationships with clients, acknowledgment of the reality of low income clients, the removal of barriers, and the expansion of the client's personal strengths (Clark et al., 2020; Foss-Kelly et al., 2017; McBain, 2018).

Acknowledgement of Income Differences, Therapeutic Alliance and Effectiveness.

Research suggests that acknowledging a client's income in counselling is essential in treating a client's presenting problems (Balmforth, 2009; Thompson et al., 2012; Kim & Cardemil, 2012). Class differences, whether or not they are directly addressed, are noticeable in the therapeutic relationship, as there are many verbal and non-verbal cues that serve as indicators of class, such as clothing, vocabulary, the required education to become a therapist, employment status, and office decorations (i.e. an array books that may make clients feel inferior in intellect; Appio, 2012; Appio et al., 2013). This acknowledgement is important as the client's perception of their counsellor impacts their willingness to continue therapy, the creation of the therapeutic alliance, and their perception of therapeutic effectiveness, where a negative perception could become a barrier to treatment (Appio et al., 2013; Balmforth, 2009; Thompson et al., 2012;

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Wolgast et al., 2022). According to research conducted on low income Latina clients, Kim & Cardemil (2012) suggest that, for psychotherapy to be effective with low income clients, mental health practitioners must pay “explicit and ongoing attention to social class” by assessing their client’s social class, incorporate structural and delivery considerations, and manage differences (i.e. practicing and openly acknowledging differences; Kim & Cardemil, 2012).

Similarly, based on research conducted by Sharir (2017) in a sample of ten licensed mental health professionals who had worked with low income clients for at least three years, those who work with low income clients in mental healthcare settings often perceive that differences in income negatively impact the therapeutic relationship (Sharir, 2017). These differences in income appear to create distance and a power vacuum between the client and counsellor, which may cause an unhelpful rupture in the therapeutic relationship and impede therapy (Appio et al., 2013; Sharir, 2017; Wolgast et al., 2022).

According to Balmforth (2009), a client’s perceived experience of their counsellor’s income also affects the therapeutic relationship (Balmforth, 2009). Using a qualitative approach with seven white British adults, Balmforth (2009) found that differences in perceived income caused low income clients to feel shame, discomfort, and powerless, and did not feel understood by and had no psychological connection to their counsellor (Balmforth, 2009). Conversely, clients of a similar income to their counsellor felt empowered and like they benefited from the relationship with the counsellor (Balmforth, 2009). Based on Balmforth’s research, one of the Guidelines for Psychological Practice for People With Low-Income and Economic Marginalization proposed by Juntunen et al. (2022) highlights the importance of acknowledging income differences as unspoken differences may leave clients believing that counsellors are not able to “adequately understand and empathize” with them (Juntunen et al., 2022).

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Likewise, in a sample of sixteen individuals who self-identified as low income and had attended a minimum of six psychotherapy sessions within the past six months, Thompson et al. (2012) demonstrated the importance of counsellors recognizing a client's socio-economic class in the therapeutic relationship. Clients whose counsellor acknowledged their privilege, understood their client's income, and integrated it into treatment experienced safety, trust, connection, and positive outcomes overall (Thompson et al., 2012). In contrast, clients who had counsellors that failed to acknowledge their privilege, did not understand the implications of their client's low income, and did not integrate it into treatment felt judged, powerless, and disconnected from their counsellor (Thompson et al., 2012). It is important to note that these aforementioned studies were conducted with adults and primarily White participants, so the results may not be generalizable to low income children or people of colour. Nonetheless, this study showcases the significance of acknowledging a client's low income in developing the therapeutic relationship and therapeutic effectiveness.

Complementary to this, previous research has suggested that interventions "altered to address poverty-related stressors" are more effective in addressing client issues and strengthening the therapeutic alliance (Borges & Goodman, 2020; Miranda et al., 2003; Veal, 2022). In a sample of twelve American psychologists who had worked with low income clients in outpatient settings for at least three years, research conducted by Borges & Goodman (2020) found that practitioners who adapted their interventions to address power dynamics and stressors related to income with their low income clients felt that "recognizing and addressing issues of power in the [therapeutic] relationship" was exceptionally important (Borges & Goodman, 2020). These clinicians noted that, by addressing low income directly, the client could express their feelings and allow it to "become a named and validated part of the [therapy] relationship,"

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benefiting the client's overall therapeutic process (Borges & Goodman, 2020). These studies further emphasize the importance of acknowledging and addressing client income in the therapeutic space, as the development and maintenance of the therapeutic alliance has been shown to be a predictor of treatment outcomes (Appio et al., 2013; Duff & Bedi, 2010).

As best put by Lavell (2014), "a lack of class awareness and lack of counsellor attention to the specific needs of working-class and poor clients can compromise the development of therapeutic trust and negatively impact the counselling alliance" (Lavell, 2014). Although, it is worth noting that the majority of the participants in these studies were straight, White, female, and possessed a graduate degree. Therefore, the acknowledgement of low income and adaptations of treatment for low income individuals may not impact the therapeutic alliance and effectiveness of therapy to the same extent with clients who are people of colour, male, gender diverse, or LGBTQ+.

However, despite the saliency of income and class differences between therapist and client in the therapeutic setting, and the importance of acknowledging these differences, they "often go... unacknowledged" in the therapeutic context, alluding to the normative silence around discussing income and class, such as that similar to politics and religion (Appio, 2012; Appio et al., 2013). According to Appio (2012), based on the work of Chalifoux (1996), therapists who avoid addressing these salient income and class differences may silence further discussions of income and class-related issues and that "a therapeutic relationship that maintains a strict hierarchical structure recreates the oppressive power dynamics of larger society" (Appio, 2012; Appio et al., 2013; Chalifoux, 1996). Therefore, the therapeutic space and relationship is rendered oppressive and hierarchical rather than liberating, empowering, and collaborative, and further stigmatizing the experiences of low income individuals, primarily based on the attitudes

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and assumptions of mental health service providers, which will be discussed in the next section (Appio, 2012; Appio et al., 2013).

Counsellor Attitudes, Assumptions and Biases.

Research indicates that a counsellor's attitudes, assumptions, and biases towards those of low income may impact their treatment, case conceptualization, and the overall therapeutic process, as a person's beliefs can affect the way in which they interact with others (Appio et al., 2013; Dougall & Schwartz, 2011; Millard, 2017; Tagler & Cozzarelli, 2013; Thompson et al., 2014). For instance, Appio et al. (2013) found clinicians may deem their low income clients as irresponsible if they miss or arrive late to appointments, rather than acknowledging the different external factors that create barriers for low income clients to access mental health services (i.e. transportation and travel costs, delays and availability, childcare availability and affordability, varying work schedules, as well as other social inequities experienced by those of low income; Appio et al., 2013). Furthermore, Appio et al. (2013) also found that clinicians reported some low income clients as "disorganized," implying that they are more symptomatic, or deficient in some functional way that may hinder therapy, ignoring the additional chronic stressors and cognitive and emotional strain experienced by those of low income (i.e. insecurity of instability of housing, food, and income; Appio et al., 2013; Baum et al., 2006a). Additionally, mental health service providers may hold the belief that low income people "don't care," implying that people of low income have low motivation to "adequately" participate in therapy or have "less potential to engage in meaningful work" (Appio et al., 2013). Consequently, all of the aforementioned assumptions may contribute to the internalization of these assumptions as truth in the clients, potentially influencing their desire to continue therapy, their perception of the effectiveness of therapy, and their overall wanting to continue therapy with that practitioner or

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their perception of the practitioner's desire to continue working with them (Appio et al., 2013; Schnitzer, 1996).

To further reinforce this idea, while examining the influence of client income on psychotherapists' biases in a sample of 141 American counsellors and counsellor trainees, Dougall & Schwartz (2011) found that clients with higher income were assigned milder symptoms than clients with low income (Dougall & Schwartz, 2011). However, there were no statistically significant differences in overall assumptions of client attitudes, behaviours, and therapeutic motives based on income, meaning that participants did not differentially ascribe certain characteristics to low income or high income clients (i.e. problems as a result of internal or external factors such as personality or environmental stressors; Dougall & Schwartz, 2011).

Similarly, while examining experiences of classism as clients in psychotherapy in a sample of 12 mental health clinicians who originally came from low income backgrounds, Millard (2017) found that participants felt clinicians were "imposing implicit biases or middle-to-upper class norms on working class clients" (Millard, 2017). For instance, one participant noted that a therapist from a seemingly income privileged background would "suggest that [she] attend more yoga classes... And attending yoga classes is expensive, and [she] did not feel like that was heard when [she] named that as part of [her] subjectivity. [She felt] like he looked at that as [her] making an excuse to not take care of [her]self, and that [she] was personally doing something wrong because [she was] not taking care of [her] self in the way he suggested" (Millard, 2017). It was also found that classist responses and behaviours experienced by low income participants led to misunderstandings and feelings of invalidation for the client which ruptured the therapeutic alliance (Millard, 2017). For example, a participant noted that, while working with a therapist a few years prior, she felt as though he was not very class-conscious and

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that “he judged [her] family when [she] talked about how [she] grew up, and he even used terms like ‘white trash’ in a way that [she] found so offensive” (Millard, 2017). Overall, these assumptions and biases on the basis of class detrimentally impacted all participants’ relationships with their respective therapists, as many chose not to continue therapy with that practitioner and some even opted out of therapy entirely (Millard, 2017).

Conversely, in a sample of 208 American White, straight, female, mental health practitioners with doctorates and middle to upper-middle class backgrounds, Thompson et al. (2014) found that practitioners did not significantly differ their assumptions even when they detected income differences between the two versions of the vignette (Thompson et al., 2014). Additionally, these perceived differences in income between vignettes did not impact practitioners' willingness to work with the client overall (Thompson et al., 2014). These results were unexpected as previous findings, including those aforementioned, often reveal significant differences in assumptions about differences in therapeutic utilization rates, experiences, referrals, and outcomes of low income versus non low income psychotherapy clients (Thompson et al., 2014).

Overall, existing research emphasizes the importance of a counsellor’s attitudes and assumptions about those of low income, as negative, classist biases may detrimentally impact the client’s treatment and the therapeutic relationship, leading to attrition and creating additional barriers to therapy for low income clients. However, these experiences regarding counsellors' assumptions towards those of low income and the subsequent impact on therapy may not be generalizable. Participants in these studies were primarily straight, white, able-bodied, female, middle to upper income, with the exception of Millard (2017), and have received a graduate

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degree. Hence, the experiences of male, gender-diverse, racialized, or low income mental health practitioners may not coincide with these results.

Counsellor Preparedness.

Research suggests that new counsellors may feel ill-prepared to work with low income clients and their presenting problems, particularly ones related to financial matters (Cook et al., 2021; Smith et al., 2013; Tucker et al., 2021). When examining ten therapist's experiences with training and preparedness for working with low income clients, Smith et al. (2013) found that many participants endorsed that "school had been less valuable than hands-on work experience," and therapists who work with low income clients should receive specific training on the subject, despite what was already included in their curriculum (McBain, 2018; Smith et al., 2013). For instance, one participant noted that school alone didn't adequately prepare them to work with low income populations compared to the real world experience they gained from their internship and their subsequent full-time job (McBain, 2018; Smith et al., 2013). Additionally, another participant expressed the need for a more in-depth knowledge base regarding psychotherapy with low income clients and that "[t]here should be some sort of best practices that we could all put into place," as there are no guidelines on how to best support low income clients (McBain, 2018; Smith et al., 2013).

Likewise, in a sample of nine mental health care providers in the United States, Thompson et al. (2015) found that many had felt that their "training did not adequately prepare them to meet the needs of their clients from low-income backgrounds" and that their preparation for working with low income clients was "inadequate" (McBain, 2018; Thompson et al., 2015). Similarly, while examining perceptions of low income in a sample of seventy-one graduate counselling psychology students, Tucker et al. (2021) found that students in these programs felt

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“significantly less competent and less trained to address clients [living with low income]” and more trained and competent to address “self-growth issues” in therapy (Tucker et al., 2021). In addition, despite 85.9% of respondents reporting having received training in regards to socioeconomic status and low income, 11.4% of students surveyed had only three or less hours of coursework and class time dedicated to these topics (Tucker et al., 2021). Therefore, due to their lack of training, these students supplemented their graduate training to better address the needs of low income clients by attending workshops (33.8%) and self-study (49.3%; Tucker et al., 2021).

Moreover, while examining 157 American counsellors’ social class and socioeconomic status perceptions, Cook et al. (2021) found that, although 93% of participants took a multicultural course during their master’s level training, only 53% responded that income, class, and low income were covered during this time (Cook et al., 2021). Additionally, only 10% of participants felt very prepared to work with clients of different income than their own with 26% feeling prepared, 37% somewhat prepared, 12% somewhat unprepared, 9% unprepared and 6% very unprepared (Cook et al., 2021). Taken together, these findings are worrisome, given that roughly 43 participants providing mental health care to clients felt unprepared one way or another to work with clients of a different income than their own (Cook et al., 2021).

These aforementioned results emphasize the lack of formal training and knowledge about best practices with low income clients which may be creating more barriers for low income clients engaging in therapy. It is worth noting that the majority of participants in these studies were white women with graduate degrees and middle to upper class backgrounds. Therefore, the experience regarding a lack of formal training with low income may not be generalizable to male

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or gender diverse mental health practitioners, therapists of colour or counsellors with low income backgrounds.

Client Choice of Mental Health Practitioner.

Literature has suggested that client choice of mental health practitioner may be significant in determining treatment outcomes. Pre-existing literature has also indicated that the match or connection between the client and counsellor may be significant in determining treatment outcomes. According to Swift et al. (2013), a client's preference of counsellor often influences both treatment outcomes and therapy dropout (Swift et al., 2013). In their meta-regression of thirty-three studies, they found that clients whose preferences were matched (i.e. gender, type of therapy provided) experienced less dropout and better outcomes regardless of gender, age, education level, or ethnicity than those unmatched (Swift et al., 2013). Unlike clients whose preferences were matched, unmatched clients were more likely to terminate early on in shorter-term treatments, accounting for roughly 50% of the difference in dropout between matched and unmatched groups (Swift et al., 2013). Research also suggests that giving clients more options and power regarding their mental health treatment increases client engagement and attendance (Laugharne & Priebe, 2006).

This issue is especially pertinent to low income clients, especially those who seek mental health services from publicly funded agencies, as they may not have the ability to choose whom they seek treatment from and what modality of treatment they receive. According to various organizations, such as Children's Mental Health Ontario (CMHO), due to the growing demand for mental health services many of these publicly funded agencies and programs have extensive waitlists, with some clients waiting two and a half years to see a mental health professional (CMHO, 2020). Therefore, when clients get off the waitlist, they are often assigned to whomever

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is available at that time to provide treatment, regardless of a client's preference. Hence, client-therapist matching or lack thereof for low income clients may be contributing to barriers in treatment, preventing positive outcomes.

Mental Health Trends During The COVID-19 Pandemic

The novel coronavirus disease has had an immense impact on the mental health of people all across the world, with many experiencing increased levels of stress and anxiety (Egede et al., 2020; Kar et al., 2020; Tsamakis et al., 2021). Moreover, researchers have found that the pandemic has also contributed to the development of new mental health problems, such as anxiety disorders, panic disorders, depression, and PTSD, and the worsening of pre-existing mental health conditions (Egede et al., 2020; Kar et al., 2020; Tsamakis et al., 2021). Vulnerable and marginalized populations have experienced adverse mental health outcomes (Egede et al., 2020; Tsamakis et al., 2021; Wathen et al., 2022). For example, elderly individuals and those with chronic health issues were at a higher risk of experiencing deleterious mental health symptoms due to social distancing and isolation during the pandemic (Amerio et al., 2020). Furthermore, in 2019, prior to the COVID-19 pandemic 67 % of Canadians rated their mental health as “very good or excellent,” whereas, in July 2020, only 55 % of Canadians rated their mental health similarly (Government of Canada, 2021).

In response, many mental health and safety providers, such as those who work in violence against women (VAW) shelters, have noted their inability to provide adequate care and support for their clients because they are “so limited with what [they] actually can do if [they] follow all the rules [set in place because of the pandemic]” (Wathen et al., 2022). Due to the pandemic, low income individuals have also been at higher risk for new and worsening mental health issues, as added financial strain and social distancing measures further limited access to

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much-needed social supports and mental health services (Alonzo et al., 2022; Government of Canada, 2021; Moeti et al., 2022; Purtle, 2020).

Challenges With Teletherapy

With social distancing and other restrictions set in place during the COVID-19 Pandemic, counsellors and their clients faced the shift from in-person sessions to online teletherapy; this shift was fraught with unique challenges and adaptations that needed to be made to meet those challenges (Al-Mahrouqi et al., 2022; Gheorghe et al., 2023; Roberts et al., 2021; Spagnolo et al., 2022; Tajan et al., 2023). According to Roberts et al. (2021), who conducted participatory action research (PAR) with eight mental health service providers who delivered service to fly-in and fly-out Inuit regions during the pandemic, general challenges for counsellors delivering teletherapy include difficulty connecting with clients especially with no prior contact, clients not having access to needed technology and not having access to a safe, private space for sessions (Roberts et al., 2021). Moreover, research conducted by Spagnolo et al. (2022) identified that using technological modalities for mental health service delivery posed challenges such as the potential for counsellors to miss non-verbal cues, such as body language and client hygiene, and that clients, especially those of an older age, may not have access to an email address or the web platforms needed to participate in teletherapy sessions (Spagnolo et al., 2022).

Furthermore, after conducting 19 semi-structured interviews with clients and mental health clinicians, Al-Mahrouqi et al. (2022) identified challenges with teletherapy including lack of public teletherapy services and guidelines surrounding conduct, shortage of counsellors trained to use teletherapy, limited access to Internet, devices, and privacy for clients, as well as concerns about the security of systems used for teletherapy (Al-Mahrouqi et al, 2022). However, participants also reported favourable experiences using teletherapy, with clients noting benefits

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such as convenience, easy accessibility, reduced stigma receiving mental health care, and decreased absences from work, along with lower commuting costs; clinicians reported benefits including reduced healthcare costs, and a sense of having achieved work-life balance (Al-Mahrouqi et al, 2022).

Similarly, Tajan et al. (2023) conducted a mini-review of 46 studies globally regarding teletherapy during the COVID-19 pandemic and identified many challenges such as insufficient Internet connection and stability, client's lack of access to technology and privacy to participate in teletherapy sessions, lack of guidelines surrounding teletherapy practice, a shortage of trained therapists, and increased workload for and insufficient support for therapists (Tajan et al., 2023). Additional challenges were identified for certain populations including couples in regards to intimate partner violence, children with ADHD, those with familial conflicts, older adults, and those who experience conditions such as antisocial personality disorder and traumatic brain injuries (Tajan et al., 2023). Most importantly, the review found that clients with low income and socioeconomic conditions had difficulties accessing mental health services (Tajan et al., 2023). Despite this, it was also noted that teletherapy was beneficial for families, increasing access for working parents, and clients living in rural areas, as well as underserved populations, veterans, autistic clients, and clients receiving trauma therapy (Tajan et al., 2023). Additionally, teletherapy was identified to reduce counsellors expenses, and that, in most cases, the shift to teletherapy did not threaten the therapeutic relationship, with 80 percent of participants in a study examined noting that "teletherapy offers good quality of care" (Tajan et al., 2023).

Additionally, Gheorghe et al. (2023) examined the experiences of 196 North American mental health clinicians and found that teletherapy "contested the notion of therapy as a 'safe space'," as clients may not always have access to a safe and private space to engage in

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teletherapy sessions, and allowed for less “immersive clinical interventions” (Gheorghe et al., 2023). It was also identified that teletherapy also increased access to specialized mental health services such as clients with “long commutes, caregiving responsibilities, ... [and] compromised immune systems”, as well as enhanced clinicians’ opportunities for professional development (Gheorghe et al., 2023). All of the aforementioned research emphasizes the importance of considering new research regarding barriers and challenges with teletherapy in addition to that examined in the traditional in-person practice of psychotherapy. These challenges are especially important to consider with the incorporation of teletherapy into everyday counselling practice which are undoubtedly impacting low income clients who are trying to access and engage with the mental health system and, therefore, need to be addressed in order for low income clients to engage with counselling.

Counsellor’s Experiences of Working With Low Income Clients

Prior to the Covid-19 pandemic, the experiences of counsellors working with low income clients were explored. Specifically, Thompson et al. (2015) examined nine mental health practitioners' perspectives on working with low income clients in a clinical setting. Using open-ended questions and probes founded on previous literature, the authors found that the therapists' experiences regarding income (i.e. childhood and current) influenced how they interacted with their clients (Thompson et al., 2015). For example, one respondent with low childhood income noted that her experiences during childhood "open[ed] her eyes to poverty and the inequalities that exist within the world" and that those experiences "informed her decision to choose to work in a non-profit organization to serve underserved populations" (Thompson et al., 2015). In addition, the authors found that practitioners with low income clients viewed the mental health system as flawed and believed the future of mental health depends on whether the increased need

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for counsellors or therapists who will work with low income clients is filled or addressed (Thompson et al., 2015). For instance, one respondent mentioned that "I think the commitment [to serving low income clients] is ever more increasingly difficult because we can't find money like we used to... It doesn't [go] as far as it used to..." (Thompson et al., 2015). Moreover, Thompson et al. (2015) also determined that, due to the personal nature of the work, counsellors experienced challenges such as countertransference because "of their own personal economic contexts and emotional reactions experienced within and outside the therapy room" (Thompson et al., 2015).

Likewise, Smith et al. (2013) also examined therapists' work in the context of low income, although in regard to the personal challenges experienced by therapists (Smith et al., 2013). They found that many participants felt overwhelmed, that the work with low income clients was "emotionally difficult" to engage in, and that they felt they were not helping those low income clients "enough" (Smith et al., 2013). For instance, one participant noted that "[they] sit with clients and it breaks [their] heart sometimes... [they] will have to, like, choke back tears, and think of, you know, How can [they] best help this person who's sitting in front of me?" (Smith et al., 2013). Additionally, participants lamented that barriers to treatment with low income clients also included ones created by "government and social systems," agency or individual practice requirements, and a difficulty fostering the therapeutic relationship due to income differences (Smith et al., 2013). To illustrate this, one participant indicated that "[p]eople living [with low income] do not see themselves as capable of making change, and that self-concept presents a barrier to [their] work with them" (Smith et al., 2013).

Complementary to this, Sharir (2017) examined how ten licensed mental health professionals and therapists describe their experiences and work with low income clients (Sharir,

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2017). Through a qualitative analysis, they found that four participants felt the impact of financial related stress and income on the therapeutic relationship, particularly regarding systemic and structural inequities and basic needs not being met (Sharir, 2017). For example, one participant stated that “any of the systems that help [low income individuals] are just fraught with bureaucracy that... puts them at even more of a disadvantage... it’s just an ongoing trauma and stressor... they’re in survival mode, so who I am is not as important” (Sharir, 2017). Another participant noted that “[b]efore [they] could work on starting therapy in terms of their mental health, would be to try to help them get access to these basic needs, because without basic needs you’re not getting them further” (Sharir, 2017).

Although the authors of the aforementioned studies were diverse in age, race, and ethnicity, and clinicians varied by gender, age, and childhood income, respondents were primarily white, female, heterosexual, mid-range or higher income practitioners (annual household income of more than \$50,000; Thompson et al., 2015). Therefore, these key themes may not be described similarly by clinicians who differ in race, sexuality, gender, and income to those previously mentioned, as their identities affect how they interpret their practice and what their clients need. Nevertheless, these studies emphasize the importance of qualitative inquiry as, unlike quantitative research, it allows researchers to examine the nuanced lived experiences of clinicians and counsellors who work with low income clients.

Much of the existing literature on low income clients and counselling focuses on the barriers to obtaining such counselling or other mental health services for low income clients rather than the challenges counsellors face when treating these clients before the pandemic. With the exception of Ballo & Tribe (2023), there is little research focusing on experiences of counsellors who have worked with low income-clients during the COVID-19 pandemic,

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particularly in regard to barriers in treatment. According Ballo & Tribe (2023), in a sample of eight psychologists and psychotherapists located in the UK, the main struggles of counsellors who work with low income clients are the limited resources available for those are “less fortunate and need help from the government” and difficulty navigating multiple barriers and challenges to care (i.e. the lack of support experienced by those who provide care to low income clients and lengthy waitlists clients are placed on to receive care; Ballo & Tribe, 2023). For instance, one participant noted that “ [they have] met a lot of clients who are on very long waiting lists and they just need help now. . . our waiting list is not that long, about three months maximum . . . the government helps but this support is very limited’ (Ballo & Tribe, 2023). Like many of the studies examined in this paper, participants were primarily White and above 40 years old and cannot be generalized to younger, racialized clinicians’ experiences.

However, examining the barriers to treatment with low income clients experienced by counsellors further is crucial because the pandemic has contributed to a significant increase in mental health issues among vulnerable populations (Vadivel et al., 2020). For example, McQuaid et al. (2021) found that, in a sample of six-hundred-and-sixty-one adults ranging from eighteen to sixty-five years of age or older, feelings of loneliness were higher among participants with low income when compared to their middle to upper-class counterparts. In addition, the landscape of therapy has drastically changed as a result, with some practitioners switching to online or telephone appointments (Vadivel et al., 2020). Yet, it is still being determined how it has affected the overall therapeutic process, particularly concerning low income clients who may have experienced increased financial hardships during this time. A better understanding of how counsellors with diverse backgrounds view the challenges or barriers while working with low

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income individuals during COVID-19 could lead to insight into how they can better serve their low income clients.

The Present Study

This study aimed to answer the research question: “*what are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*” The goal was to identify key themes in counsellors’ current perceptions of barriers or challenges in working with low income clients following COVID-19 using concept mapping, a form of participatory action research (PAR). This line of questioning is essential as it is unknown whether additional barriers exist for clients with low income in the therapeutic setting or alliance that may hinder their ability to progress in or benefit from counselling.

This project examined work with low income clients by exploring counsellors’ experiences through an anti-oppressive practice (AOP) framework, which is vital for working with marginalized populations. Based on previous research, using traditional research practices with vulnerable populations has often led to ethical dilemmas and the exploitation of participants’ experiences for personal and professional gain (Pittaway et al., 2010). An AOP framework attempts to mitigate the effects of ongoing and historical inequities through various practices that give power to the vulnerable and marginalized to equalize power imbalances, such as knowledge mobilization tactics (i.e. disseminating results in accessible language for lay audiences and events which bring policymakers and other changemakers together to discuss results and potential next steps; Reed & Smith, 2014).

The knowledge obtained as a result of this AOP framework has many direct implications for education, advocacy efforts, and, in particular, counsellors’ practice with low income clients. This study contributes to the literature base of counselling regarding diversity, and counsellor

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self-reflection, competency, and practice while working with low income clients. Additionally, the results of this study will impact counsellors' practice with low income clients, as it will enhance their social and personal awareness and inform them how to best respond to and support their clients with low income. Finally, this study provides information for potential advocacy efforts. Community or professional organizations can use this knowledge to advocate for public policies or services to decrease the barriers within the therapeutic setting for low income clients and to better meet their needs.

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Chapter 3: Methods

Concept mapping was used to answer the research question of *what are the perceived barriers or challenges counsellors experience when working with low income clients in their practice?* Created in the early 1980s by William Trochim at Cornell University, concept mapping was initially used in program planning and evaluation (Kane & Trochim, 2007) but was later adopted by social sciences researchers (Rosas, 2017; Trochim, 1989). Concept mapping is considered a mixed-methods research approach as it quantitatively analyzes qualitative data (Dare & Nowicki, 2019; Rosas, 2017). This analysis is achieved by statistically analyzing the participant's groupings of statements (Dare & Nowicki, 2019; Rosas, 2017).

As previously mentioned, concept mapping is a type of participatory action research (PAR), conducive with an AOP framework as it is a collaborative process which considers participants to be the experts of their own experiences in contrast to traditional research practices. Specifically, participants are enlisted to obtain knowledge with the researchers collaboratively and are involved with all steps of the research process, including the generation of data (i.e. the statements in response to the research question) and data analysis (i.e. providing labels for the statements and sorting said statements into those categories; Baum et al., 2006b; Dare & Nowicki, 2019; Rosas, 2017). Concept mapping has also been effectively used with diverse samples of participants, including newcomer (Burgos et al., 2019) and resident youth (Dare & Nowicki, 2019), as well as young adults (Cook & Bergeron, 2019), which further lends to its credibility as a research and data analysis method.

Concept mapping was chosen as the method for this research question as it has enough quantitative properties for its results to be considered valuable in academia and formal structures (Trochim & McLinden, 2017). In structures such as academia, there is a heavy emphasis on

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reliability and the supposed truth that is revealed through quantitative analysis and conversely, qualitative research is often condemned or dismissed in these circles for being too subjective or biased and informal or lacking structure (Mays & Pope, 1995; Trochim & McLinden, 2017).

However, according to Rosas (2017), concept mapping has become “widely recognized as a means for capturing the complexity found in social phenomena,” signifying a compromise in academic circles regarding whether quantitative or qualitative research yields more valuable results. Furthermore, using PAR research methods, such as concept mapping, is essential when working with underserved or marginalized populations, such as those with low income, as it values their lived experiences, which are often neglected, and reduces the power imbalance between the researcher and participants (Wilson, 2019).

Participants

For this study, participants were primarily professionals registered with the Canadian Counselling and Psychotherapy Association (CCPA) who have formal counselling training and provide counselling services across Canada. A total of 322 counsellors participated in the initial survey, 113 counsellors participated in the interview portion, and 29 counsellors participated in the sorting activity for the current study. Participants ranged in age from 24 to 67 years old, with the average age of participants being 40.08 years. Participants identified as female, male, non-binary or genderqueer, and femme nonbinary. In regards to race, participants were primarily white, followed by Mixed race, South Asian, Asian, Middle Eastern, East Asian, Southeast Asian, Black, East Indian, and Indigenous; for classification purposes, if participants noted more than one racial identity they were categorized as mixed race.

With reference to location, the majority of participants were located in Ontario, followed by Alberta, British Columbia, Nova Scotia, Manitoba, Newfoundland and Labrador, New

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Brunswick, Quebec, Prince Edward Island, Northwest Territories, and Switzerland. Majority of participants had obtained a Masters degree, followed by a Bachelors, Doctorate, and Diploma. In regards to session type, the majority of participants conducted sessions both virtual and in person, followed by Virtual only and in person only. Majority of participants have spent 0-5 years in the counselling profession, followed by 6-10 years, 10-15 years, 21+ years, and 16-20 years, ranging from 0 to 34 years. In terms of language, the majority of participants spoke English only, followed by English and French, English and another language, and English, French, and other language(s). Refer to Table 1 below for specifics of demographic information for participants.

Table 1: Demographic Characteristics of the Sample

Characteristics	Total Interview Sample (N = 113)
	<i>M</i> (Range)
Age (in years)	40.08 (43)
	N (%)
Gender	
Male	12 (10.62)
Female	94 (83.19)
Non-binary or Genderqueer	5 (4.42)
Femme Non-binary	2 (1.77)
Race	
Black	2 (1.77)
East Asian	2 (1.77)
Asian	3 (2.65)
Middle Eastern	3 (2.65)

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South Asian	5 (4.42)
Southeast Asian	2 (1.77)
East Indian	1 (0.885)
White	84 (74.34)
Indigenous	1 (0.885)
Mixed	10 (8.85)
Location	
Ontario	48 (42.48)
Alberta	18 (15.93)
British Columbia	18 (15.93)
Nova Scotia	9 (7.96)
Manitoba	7 (6.19)
Newfoundland and Labrador	4 (3.54)
New Brunswick	3 (2.65)
Quebec	2 (1.77)
Prince Edward Island	2 (1.77)
Northwest Territories	1 (0.885)
Switzerland	1 (0.885)
Highest Degree Obtained	
Masters	105 (92.92)
Bachelors	6 (5.31)
Doctorate	1 (0.885)
Diploma	1 (0.885)
Session Type	
Virtual	19 (16.815)
In-person	9 (7.965)
Both	85 (75.22)

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Years in Counselling Profession

0 - 5	62 (54.87)
6 - 10	26 (23)
10 - 15	11 (9.73)
16 - 20	6 (5.31)
21+	8 (7.08)

Language(s) Spoken

English only	76 (67.26)
English and French	20 (17.7)
English and another language	13 (11.5)
English, French, and other language(s)	4 (3.54)

Procedure

Participants were recruited using a mass email advertisement sent to all registered members of the CCPA. Initially, participants were given a survey link via Qualtrics (see Appendix A), which contains the letter of information (LOI). The survey was provided in both English and French. At the end of the survey, participants had the option to be entered into a raffle for one of two iPads, to be contacted for a follow-up interview, or both entered into the raffle and contacted for a follow-up. Participants who opted to be interviewed were contacted and scheduled for a Zoom interview lasting roughly 30-60 minutes and asked closed-ended demographic questions and open-ended questions, such as the one that this study's research question is founded on (“*what have you found to be the least helpful aspects of counselling with clients facing low income?*”). Interviews were then transcribed by research assistants.

Concept Mapping

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There are five steps to follow when using concept mapping with groups (Rosas, 2017; Trochim & McLinden, 2017). First, in their individual interviews, participants generated responses to the specific research question (Dare & Nowicki, 2019; Rosas, 2017; Trochim & McLinden, 2017). In this study, participants responded to the question “*what have you found to be the least helpful aspects of counselling with clients facing low income?*” Secondly, researchers independently reviewed and edited all statements generated by participants for clarity by removing redundant items (Finnigan, 2019; Rosas, 2017; Trochim & McLinden, 2017).

Next, in step three, participants were invited by researchers to provide labels for all statements and sort them into groups (Dare & Nowicki, 2019; Rosas, 2017; Trochim & McLinden, 2017). In this study, researchers reached out to everyone who had participated in the individual interview in step one and asked if they would be willing to participate in the grouping task. Each willing participant was sent all of the responses collected from the research question via either email or mail and given detailed instructions on how to proceed. Researchers called participants and provided an explanation of the task remotely over the phone. Following this, researchers and participants collectively decided on a date and time to collect the groupings via telephone.

Then, in step four, all groupings were analyzed using multidimensional scaling and cluster analysis (Dare & Nowicki, 2019; Rosas, 2017; Trochim & McLinden, 2017). Next, in step five, researchers used the results from data analysis to narrow down the groupings to an appropriate, manageable number that they felt represents all responses (Dare & Nowicki, 2019; Finnigan, 2019; Trochim & McLinden, 2017). Researchers also provided each of the groupings with a label that adequately captured all labels generated by participants and themselves (Dare & Nowicki, 2019; Finnigan, 2019; Trochim & McLinden, 2017).

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Analysis

GroupWisdom (groupwisdom.tech) was used to perform multi-dimensional scaling analysis and cluster analysis on data collected from the open ended questions and construct the concept map, which is a graphic representation of the responses collected and the clusters of groupings that have been made (Finnigan, 2019). Both statistical analyses combined together produced the concept map (Trochim, 1989).

During the multi-dimensional scaling analysis, the GroupWisdom program placed each statement on an x-y axis that corresponded to the frequency in which the statements were grouped together by the participants (Finnigan, 2019; Trochim & McLinden, 2017). This analysis produced a point map where each statement is given a point (Rosas & Kane, 2011; Trochim & McLinden, 2017) and unique meanings were given to two visual representations in particular: the distance in between responses, and the dimension of the concept, both a result of the multi-dimensional scaling analysis. The distance in between responses, represented as points within the map that denote the frequency of how often responses were grouped together, with closer responses having been grouped together more frequently (Rosas & Kane, 2011; Trochim & McLinden, 2017). The dimension of the concept, as in whether it has single or multiple layers, signified how cohesive each statement within that concept is, meaning that concept groupings with fewer layers have more similar statements (Rosas & Kane, 2011; Trochim & McLinden, 2017).

The results obtained by multi-dimensional scaling analysis was then used in cluster analysis (Rosas & Kane, 2011; Trochim, 1989). Initially, each response or point started out as its own cluster but, over time, individual clusters were merged together until all similar statements were grouped into a number of concepts, semi-determined by each statement's bridging indices

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(Rosas & Kane, 2011; Trochim, 1989). A bridging index number indicates how often these statements had been grouped together. Bridging indices numbers range from 0 to 1 (Rosas & Kane, 2011; Finnigan, 2019). Numbers closer to 0 reflect that statements were only grouped with statements located in close proximity on the map and numbers closer to 1 reflect that statements were often grouped with distal statements on the map (Dare & Nowicki, 2019; Trochim, 1989). These bridging indices were used to review the clusters to find an optimal and manageable amount of concepts to adequately describe participant's statements, with lower bridging indices, such as 0.35 and below (Dare & Nowicki, 2019), accepted and indicate the most essential concepts in response to the research question.

Seven concepts for the research question ("What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?") appeared to provide the "best interpretability" (Finnigan, 2019; Trochim, 1989). The labels for the seven concepts were generated based on the themes found within statements in each concept (Trochim, 1989). The statements with the lowest bridging indexes in each cluster were instrumental in the generation of labels as they indicated the salient themes of that concept (Trochim, 1989).

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Chapter 4: Results

In this chapter, results of the concept mapping analysis are presented. The map for the question “What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?” was based on interviews with 113 Canadian counsellors and statements sorted by 29 of them. The stress value of each statement illustrates the goodness of fit between the final representation of 7 clusters with the original similarity matrix, with lower values representing greater consistency between raw and processed data (Finnigan, 2019; Rosas & Kane, 2011). The stress value for the map was within acceptable range (0.17 - 0.34).

As previously mentioned, the concept map for the question “What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?” (Figure 1) was constructed based on statements that were both generated and sorted by participants. A total of 66 unique statements were used in the sorting (Table 2). These statements were sorted by 29 of the counsellors who participated in the individual interviews. Seven concepts were identified, including: barriers due to low income and employment, systemic barriers for clients, barriers due to trauma, competing priorities and needs, biased approaches, limits to real world helpfulness of counselling, and negative impacts of systems on and for counsellors. The stress value for the concept map was 0.26. Based on a pooled study analysis of the rigour and quality of concept mapping methodology by Rosas & Kane (2011), the map’s stress value of 0.26 is within acceptable range (Finnigan, 2019; Rosas & Kane, 2011).

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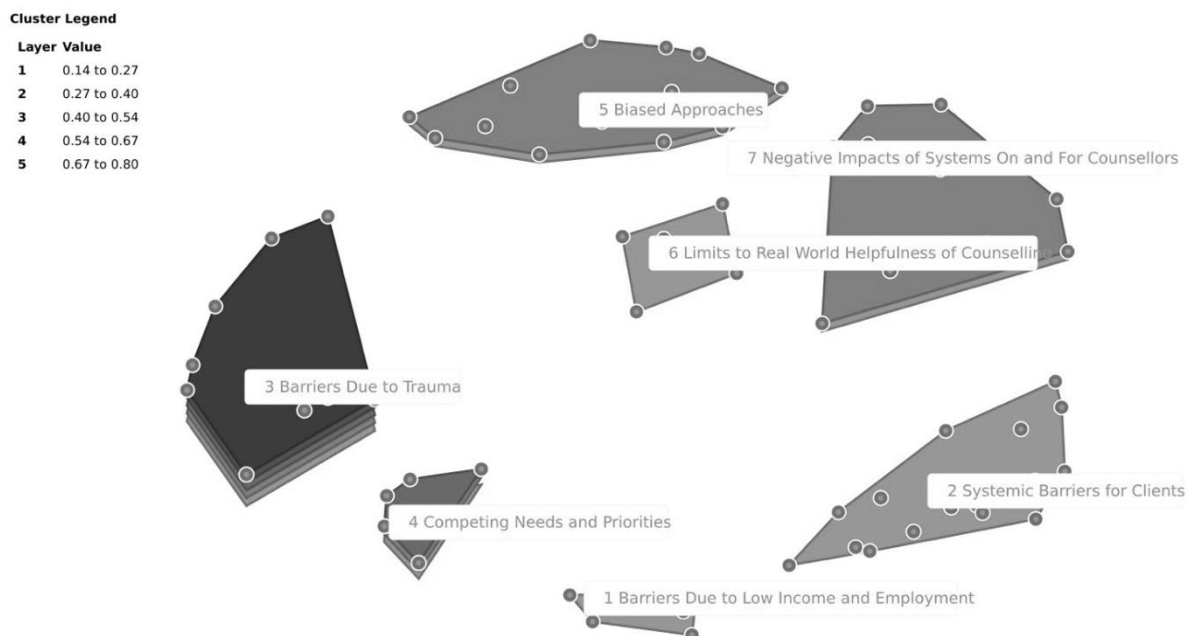


Figure 1: Concept Map for statements for “What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?”

Table 2: Statements and Concepts for “What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?”

Concepts	Statements	Bridging Index
Barriers Due To Low Income And Employment		Concept Mean = 0.14
	25. Don't have access to technology or aren't as tech-savvy.	0.08
	10. Client(s) are working 8, 9, 10 hours a day, and sometimes they're getting called into work and have to cancel sessions because as much as they need the sessions, they need the income more.	0.09
	5. Client(s) are working and they can't take time off.	0.1
	35. Clients facing low income if they are doing a virtual counseling session they may not have the space, the privacy, or feel the comfort.	0.11

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6. Client(s) need child care, low income social determinants of health, you're probably going to have more issues.	0.21
1. The inconsistency of client(s) attending, client(s) may not receive the full benefit of counseling.	0.25

Systemic Barriers For Clients

Concept Mean = 0.24

29. Tight restrictive rules around late arrivals and late cancellations and cancellation fees.	0.04
45. The limited number of sessions that client(s) get for very large issues.	0.06
46. Constraints put on by extended health benefit providers.	0.07
49. Time constraints.	0.07
31. Used to be that have to sit in the waiting room and fill out the form, and half the time they couldn't read the form.	0.11
22. Encouraging low-income clients to lean on social support knowing that access to these supports is still underfunded.	0.15
13. The difficulty in accessing any other resources.	0.16
44. There is so much systemic injustice and people really don't have access to the services they need.	0.18
24. People who are accessing help from people who aren't actually certified.	0.21
3. We are in the structured, therapeutic, mental health agency where we can only talk or provide counseling using a structured format.	0.22
15. All the hoops you have to jump through, even if you are successful you have to be very good at navigating systems.	0.29
40. Mandated services.	0.41
36. I think one is overly rigid about the location where a client is when they're meeting or the type of session access.	0.42
7. If you keep giving client(s) a new counselor every 5 or 10 sessions, you're going to get nowhere.	0.43

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	51. There aren't a whole lot of racialized or black counseling practitioners out there.	0.44
	16. Still seeing that in the vast majority of cases it's nowhere near enough.	0.59
Barriers Due To Trauma		Concept Mean = 0.8
	12. Hopelessness.	0.5
	55. The sense of powerlessness.	0.5
	8. The burden of retelling your story.	0.81
	65. The shame of having to go seek specific supports.	0.81
	66. Misunderstanding from the public, thinking this person hasn't tried hard enough or they're not helping themselves.	0.85
	9. If you've been traumatized, it can take a long time to feel truly safe with somebody.	0.89
	21. If your client is coming out of an intergenerational situation where there is deep disturbance around attachment and abandonment, you can't think your way out of that.	0.91
	57. Fear of judgment is really creating that barrier between us.	0.96
	11. Inability to cope with poverty is not what is causing extreme distress, it a symptom of a much deeper rooted problem.	1
Competing Priorities And Needs		Concept Mean = 0.42
	41. Client(s) challenge with being motivated.	0.37
	32. It's really hard for client(s) to focus on the underlying issues because they have so much going on in the present.	0.38
	33. Mind is on where their next meal is going to come from, or how they're going to pay their rent.	0.38
	42. Client(s) have got some other issues that they're dealing	0.46

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	with besides low income.	
	56. If client(s) are always in crisis mode, there's no space to work on personal issues and growth and positive changes.	0.49
Biased Approaches		Concept Mean = 0.27
	26. I don't find it's helpful to say the way you're perceiving reality is incorrect or wrong, or there's something wrong with the way that you're seeing your situation right now.	0
	37. Changing the way you approach counseling with client(s) just because they're in that lower bracket.	0
	50. Trying to empathize when it's not genuine, client(s) read through that very quickly.	0
	2. Important to not assume other things about someone just based on their income status.	0.06
	39. Failing to consider context.	0.14
	38. Counselors who are not aware of their own privileges.	0.18
	43. A sense of internal pressure to overextend when I actually am also facing low income.	0.22
	54. Wanting to get people out of low income.	0.27
	64. The assumptions, looking at people as if we can understand a person based on their ethnic group or their financial status.	0.29
	63. Systemic pieces and then my own emotions along with all of the stuff that they were bringing.	0.35
	19. Discrimination and prejudice against people who may be low income.	0.46
	52. If you're a white counselor working with racialized clients, we have the capacity to cause a lot of harm if we're not aware of that.	0.54
	14. The judgment we give to people who are less resilient as if like it's somehow client(s) fault for not having been able to recover as well or hide the impact as well.	0.61

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	28. I notice I'm trying to solve the problems when in reality, that's not my job.	0.64
Limits To Real World Helpfulness Of Counselling		Concept Mean = 0.2
	18. The 2 of us in this room are not actually going to change the situation.	0.13
	34. It's not focused on their mental health per se, and I feel like it's really harmful for you to dismiss that, because I think that's what feels biggest to client(s) at that moment.	0.14
	61. The expectation that people can thought record their way out of stress about money.	0.21
	27. Not talking about money. It's a really uncomfortable conversation for myself and for other people, but it's so essential.	0.25
	4. Unreasonable expectations for people who are struggling with poverty.	0.27
Negative Impact Of Systems On And For Counsellors		Concept Mean = 0.33
	47. It is so easy to get into the solution focus mode, and counseling deep work requires attending to a lot of them, slowing it down and attuning to the body.	0.1
	62. Sometimes going into problem solving mode is not helpful.	0.14
	20. I find cognitive models unhelpful and my preference is to work with effective somatic models	0.16
	53. Going in with my own agenda.	0.16
	48. I think the ways in which counseling can't actually fix their problems.	0.26
	23. Recommendations that rely on external factors are not helpful at all.	0.27

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60. Unspoken rules of how counseling should look or should operate.	0.38
59. Other professionals' judgement of the way that I choose to run my services.	0.44
30. Making the assumption somebody has insurance.	0.45
17. Not be empowered to hold space in the way I would have wanted to.	0.64
58. The emotional burden that comes with setting boundaries and setting rates.	0.68

Each statement in Table 2 corresponds to a numbered statement. The distance between statements on the map demonstrates the frequency in which each statement in the concept was grouped together by participants (Finnigan, 2019). The Bridging index, a value between 0.00 and 1.00, found on Table 2 also is an indicator of the frequency in which each statement was grouped together by participants (Finnigan, 2019). A low Bridging Index of 0.00 to 0.25 indicates that the statement was grouped together with other statements closest to it on the map, while a high Bridging Index of 0.75 to 1.00 indicates that the statement was sorted with other statements across all other regions of the map (Finnigan, 2019). Furthermore, the dimension or layering of each concept, as well as bridging indices, indicate how often statements were grouped together by participants, meaning that statements within concepts with fewer layers were grouped together more often than the statements in concepts with more layers.

In the generated statements, terms such as they, them, and their were substituted with client(s) in most of the statements, with exceptions of repeated use, located in Table 2. These terms were substituted with client(s) due to concerns about perpetuating “Othering” and an Us versus Them mentality, which would further pathologize and stigmatize low income clients of counselling, as well as create a power imbalance between low income clients and their

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counsellors. This substitution aimed to correct the unintentional “Othering” in statements made by participants based on previous research that suggests “Othering” is important to examine in research in order to understand the link between minority populations, such as those who are low income, and health inequities (Akbulut & Razum, 2022). It is also important to deconstruct “Othering” when possible to promote health equity for potentially vulnerable and minority groups in hierarchical, social systems (Akbulut & Razum, 2022). This “Othering” was not intentional on part of participants, but rather how the question was posed, “*What have you found to be the least helpful aspects of counselling with clients facing low income?*”, which made participants as clinicians separate the barriers for themselves and the barriers for their low income clients.

Barriers Due To Low Income and Employment

Time and space constraints, as well as access to resources and resource allocation are two important facets of barriers and challenges due to low income and employment which counsellors described as having a strong impact on their work with low income clients in their practice following COVID-19. In this concept, participants indicated that clients’ struggled to find the time and space required for counselling amidst their employment and childcare obligations. For instance, participants described the following situations: “client(s) are working and they can’t take time off”, “client(s) are working 8, 9, 10 hours a day, and sometimes they're getting called into work and have to cancel sessions because as much as they need the sessions, they need the income more”, and “clients facing low income if they are doing a virtual counseling session they may not have the space, the privacy, or feel the comfort.”

Moreover, when demonstrating the barriers to care, client’s access to resources and resource allocation was evident to impact counsellors' work with low income clients. Participants

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listed statements such as the following: “the inconsistency of client(s) attending, they may not receive the full benefit of counseling”, “client(s) need child care, low income social determinants of health, you're probably going to have more issues”, and “don't have access to technology or aren't as tech-savvy”. These statements indicated the effect of resource allocation on counsellors ability to work with low income clients.

Systemic Barriers For Clients

It was evident that rigid policies, limited access and resource scarcity, and difficulty to access resources negatively impacted counsellors' work with low income clients following COVID-19. In this concept, participants indicated that their work with low income clients was negatively impacted in overly structured mental health agencies and systems that enforce rigid rules and policies. Here, the counsellors described the challenges created by restrictive policies and procedures while working with low income clients within mental health agencies and systems: “we are in the structured, therapeutic, mental health agency where we can only talk or provide counseling using a structured format”, “tight restrictive rules around late arrivals and late cancellations and cancellation fees”, “I think one is overly rigid about the location where a client is when they're meeting or the type of session access”, and “mandated services”.

In addition, statements listed by the participants also suggested that limited access and resource scarcity is a pervasive challenge that counsellors who work with low income clients face was depicted in statements including: “If you keep giving client(s) a new counselor every 5 or 10 sessions, you're going to get nowhere”, and “still seeing that in the vast majority of cases it's nowhere near enough”. Statements that also depicted limited access as a barrier counsellors' experience when working with low income clients following COVID-19 include: “the limited number of sessions that client(s) get for very large issues”, and “constraints put on by extended

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health benefit providers”. Moreover, due to the lack of available resources, counsellors noted that low income clients are receiving care from clinicians who may not be able to meet their needs, as demonstrated by statements including: “people who are accessing help from people who aren't actually certified”, and “there aren't a whole lot of racialized or black counseling practitioners out there”.

Furthermore, counsellors indicated the difficulty that low income clients face when trying to access mental health and additional supports. For instance, participants described the following situations: “encouraging low-income clients to lean on social support knowing that access to these supports is still underfunded”, “used to be that have to sit in the waiting room and fill out the form, and half the time they couldn't read the form”. Here, counsellors outright stated the barriers low income clients face due to the difficulty to simply access these supports: “the difficulty in accessing any other resources”, “all the hoops you have to jump through, even if you are successful you have to be very good at navigating systems”, and “there is so much systemic injustice and people really don't have access to the services they need”.

Barriers Due to Trauma

Clients' traumatic experiences, including the resulting internal, emotional experiences and those impacted by external influences were described by participants as negatively impacting their work with low income clients. Here, counsellors described the internal, emotional effects of trauma as a challenge when working with low income clients, evident in statements such as: “the burden of retelling your story”, “if you've been traumatized, it can take a long time to feel truly safe with somebody”, “hopelessness”, “the sense of powerlessness”, “fear of judgment is really creating that barrier between us”, and “the shame of having to go seek specific supports”.

Trauma influenced by external forces, such as poverty, intergenerational trauma, and stigma,

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were also identified as a barrier in counselling work with low income clients in the following statements: “inability to cope with poverty is not what is causing extreme distress, it a symptom of a much deeper rooted problem”, “if your client is coming out of an intergenerational situation where there is deep disturbance around attachment and abandonment, you can't think your way out of that.”, and “misunderstanding from the public, thinking this person hasn't tried hard enough or they're not helping themselves”.

Competing Needs and Priorities

Competing needs and priorities, often due to compounding issues impacting focus and motivation to change, were indicated by participants to be challenges when working with low income clients. These compounding issues impacting client's ability to focus were listed by counsellors in the following statements: “it's really hard for client(s) to focus on the underlying issues because they have so much going on in the present”, “mind is on where their next meal is going to come from, or how they're going to pay their rent”, and “client(s) have got some other issues that they're dealing with besides low income”. Compounding issues impacting motivation to change were also identified as a barrier in statements such as: “client(s) challenge with being motivated” and “if client(s) are always in crisis mode, there's no space to work on personal issues and growth and positive changes”.

Biased Approaches

Counsellors described biased approaches to be a barrier when working with low income clients; this included assumptions and judgement made by the counsellor, lack of awareness by the counsellor, and personal motivations of the counsellor which influenced the course of therapy. Assumptions and judgements were described as unhelpful and a barrier to counselling with low income clients in the following statements: “the judgment we give to people who are

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less resilient as if like it's somehow their fault for not having been able to recover as well or hide the impact as well”, “discrimination and prejudice against people who may be low income”, “changing the way you approach counseling with client(s) just because they're in that lower bracket”, and “the assumptions, looking at people as if we can understand a person based on their ethnic group or their financial status”. One statement in particular noted the importance of not making assumptions in therapy with low income clients, noting it is “important to not assume other things about someone just based on their income status”.

In addition to assumptions and judgements, lack of awareness by the counsellor was also identified as a barrier. This was present in statements including: “I don't find it's helpful to say the way you're perceiving reality is incorrect or wrong, or there's something wrong with the way that you're seeing your situation right now”, “counselors who are not aware of their own privileges”, “failing to consider context”, and “if you're a white counselor working with racialized clients, we have the capacity to cause a lot of harm if we're not aware of that”. Lastly, some counsellors' personal motivations while working with low income clients were perceived to be a challenge. Statements illustrative of counsellors' personal motivations as a challenge included: “I notice I'm trying to solve the problems when in reality, that's not my job”, “a sense of internal pressure to overextend when I actually am also facing low income”, “trying to empathize when it's not genuine, client(s) read through that very quickly”, “wanting to get people out of low income”, and “systemic pieces and then my own emotions along with all of the stuff that client(s) were bringing”.

Limits to Real World Helpfulness of Counselling

Limits to the positive effect that counselling can have on the lives of low income clients outside of therapy were challenges that counsellors faced in their work. The statements:

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“unreasonable expectations for people who are struggling with poverty”, “the 2 of us in this room are not actually going to change the situation”, and “the expectation that people can thought record their way out of stress about money” represent the challenges faced by counsellors with low income clients that comes with acknowledging the limited possibility for change. Other statements, such as “not talking about money. It's a really uncomfortable conversation for myself and for other people, but it's so essential” and “it's not focused on client(s) mental health per se, and I feel like it's really harmful for you to dismiss that, because I think that's what feels biggest to them at that moment” identified communication as essential and a lack thereof, particularly around taboo topics such as income, to be a challenge when working with low income clients, limiting the effectiveness of therapy in low income clients' lives outside the counselling space.

Negative Impacts Of Systems On And For Counsellors

Counsellors spoke about the challenges of navigating systems and therapy with low income clients, particularly in regards to modalities and approaches they found unhelpful, and rigid ideals of professional conduct as a counsellor. Participants also identified personal and professional difficulties experienced by those working within systems that impacted their work with low income clients. Modalities and approaches that counsellors found to limit the effectiveness of counselling were identified in the following statements: “ I find cognitive models unhelpful and my preference is to work with effective somatic models”, “ recommendations that rely on external factors are not helpful at all”, “ it is so easy to get into the solution focus mode, and counseling deep work requires attending to a lot of them, slowing it down and attuning to the body”, and “sometimes going into problem solving mode is not helpful”.

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Other statements indicated that counsellors found rigid ideals of what a counsellor should be to be unhelpful in their work with low income clients. This unhelpful rigidity was represented in statements including: “other professionals' judgement of the way that I choose to run my services” and “ unspoken rules of how counseling should look or should operate”. Personal and professional difficulties experienced by counsellors working within systems were also identified as challenges for those who worked with low income clients as indicated by the following statements: “not be empowered to hold space in the way I would have wanted to”, “making the assumption somebody has insurance”, “I think the ways in which counseling can't actually fix their problems”, “going in with my own agenda”, and “ the emotional burden that comes with setting boundaries and setting rates”.

Summary

Counsellors generated and sorted statements about perceived barriers and challenges they experience when working with low income clients following COVID-19. Barriers due to low income and employment, particularly time and space constraints, as well as resource access and allocation, were challenging for counsellors who work with low income clients. Systemic barriers for low income clients, such as rigid policies, limited access and resource scarcity, and difficulty to access resources were identified as negatively impacting therapy. Clients' traumatic experiences, specifically those influenced by external factors, such as poverty and intergenerational trauma, and clients' emotional experiences, were described by participants as negatively impacting their work with low income clients. Counsellors identified clients' competing needs and priorities, arising due to compounding issues impacting focus and motivation to change, as barriers in their work with low income clients. Counsellors described the ways in which biased approaches, such as assumptions and judgement, lack of awareness by

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the counsellors, and personal motivations of the counsellor, create challenges for those working with low income clients. Limits to real world helpfulness of counselling, notably having to acknowledge limited possibility for change and a lack of communication around taboo topics such as income, were indicated by participants to impact their work with low income clients. Finally, counsellors described the ways in which systems negatively impacted their work with low income clients, such as the modalities and approaches which they found to be unhelpful, the rigid ideals of professional conduct as a counsellor, and personal and professional difficulties they experienced while working within these systems. In the following section, these findings are compared and contrasted with findings from previous literature.

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Chapter 5: Discussion

In this chapter, the results of the research question “*What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*” are compared to Chapter 2, the literature review. Following this, recommendations based on the results from the present study and literature will be discussed.

The concept map for the question “*What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*” depicted seven concepts. These concepts included barriers due to low income and employment, systemic barriers for clients, barriers due to trauma, competing needs and priorities, biased approaches, limits to real world helpfulness of counselling, negative impacts of systems on and for counsellors, and barriers due to low income and employment. Similarities and differences between the results of this study and previous findings are discussed.

As mentioned in the results section, terms such as they, them, and their were substituted with client(s) to correct unintentional “Othering” on behalf of participants. These substitutions did not change the intended meaning of the statements made by participants during the interview process. These changes are in contrast to previous research regarding counsellors’ experiences with and perspectives of barriers to access and engagement for low income clients in therapy, which do not recognize or examine the unintended “Othering” in statements and the importance of doing so. Previous researchers may have been unaware of the occurring “Othering” in the statements and may have also been due to how the question was posed, similarly to the current study.

Barriers Due To Low Income And Employment

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Results from the present study identified barriers due to low income and employment as a challenge that counsellors and their low income clients face. There were many similarities between the present study and previous findings, particularly focused on social determinants of health, such as variable work schedules or inability to take time off work and ability to access affordable and timely childcare in order to attend counselling (McBain, 2018; Ollerton, 1995; Payandeh, 2023). Furthermore, consistent with previous research, inconsistent attendance of low income clients found in the present study (Appio et al., 2013; Ollerton, 1995; Schnitzer, 1996). In addition, similar to previous studies conducted in the general population, participants noted client access to and adeptness to use technology as well as access to a safe, private space for virtual sessions as a barrier or challenge which counsellors who work with low income clients face (Al-Mahrouqi et al., 2022; Gheorghe et al., 2023; Roberts et al., 2021; Spagnolo et al., 2022; Tajan et al., 2023).

Despite the many similarities, there were also notable differences. In particular, the literature identified travel time and costs as additional challenges, while the current study did not (McBain, 2018). This difference may be understood in the context of the population who served as participants, as much of the existing literature focused on the perspectives of low income clients themselves as opposed to counsellors working with low income clients.

Systemic Barriers For Clients

The second concept identified by counsellors were systemic barriers that low income clients face. This concept determined that rigid policies, limited access and resource scarcity, and difficulty to access resources impacted counsellors' work with low income clients. Consistent with previous literature, the present study determined that low income client's limited access to counselling services and resource scarcity within mental health agencies and systems created

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added challenges for counsellors and their clients (i.e. shortage of accessible and qualified counsellors, and constraints due to insurance coverage; Andrade et al., 2013; Moroz et al., 2020; Placzek et al., 2021; Thompson et al., 2015). In addition, the present study identified that additional difficulty for low income clients' to access mental health and other social supports was a barrier to counsellors and their work which was consistent with previous literature identifying systemic barriers which can limit and negatively affect low income client access and ability to participate in the counselling process (i.e. systems navigation and not knowing where to go for help, and lack of integration between different social support agencies; Moroz et al., 2020; Placzek et al., 2021). Furthermore, this study, as well as previous literature, identified rigid policies of mental health agencies and strict program criteria to be an exceptional challenge for those who work with low income clients, such as only being able to provide counselling using a structured format, rigid cancellation fees, and mandated services (Thompson et al., 2015; Placzek, 2021).

Despite the many similarities, there were also notable differences. In particular, previous literature also identified long wait times, cultural and language barriers, pervasive social stigma surrounding mental health, and inequities in service due to physical location or demographic in question (i.e. Indigenous populations, those located in rural communities) as systemic barriers inhibiting access to mental health services (Ballo & Tribe, 2023; Moroz et al., 2020; Placzek et al., 2021; Thompson et al., 2015). Once again, this difference may be attributed to the population whom served as participants (i.e. low income clients themselves as opposed to counsellors). Alternatively, the impact of wait times, social stigma, and cultural and language differences, as well as the geographic location and demographic of their clientele may have been outweighed by

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other more apparent, commonly seen barriers and challenges in their practice at the time of this interview.

Barriers Due to Trauma

There is currently no existing literature concerning counsellors work with low income clients that has defined client emotional experiences with trauma as a barrier to engagement and access to counselling for low income clients, whereas this study has. Subsequently, there is little literature on the barriers due to trauma based on external influences. For example, research conducted by Sharir (2017) only briefly touched on trauma being a challenge, with one participant describing that the systems that help low income clients "... puts them even more at a disadvantage, it's just an ongoing trauma and stressor," amidst questioning regarding how therapists describe their experiences working with those of low income and the impacts of client stress and poverty (Sharir, 2017). This difference and seemingly novel finding may be attributed to the fact that, exposure to trauma is inversely directly related to socioeconomic status and low income is inversely associated with PTSD and other trauma related symptoms (Bradley-Davino & Ruglass, 2008), two avenues which have previously never been examined together in this context.

Competing Needs and Priorities

The fourth concept was low income clients' competing needs and priorities and counselling. This concept determined that low income clients experience additional stressors and that impact their ability to focus and motivation to change in counselling. In this study, counsellors' identified compounding issues their low income clients face, such as struggling to meet their basic needs of food and shelter and dealing with other more pressing issues that may

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not be able to be addressed in counselling; these results are consistent with that of previous literature (Sharir, 2017; Smith et al., 2012; McBain, 2018).

Biased Approaches

Many similarities existed regarding biased approaches, such as attitudes, assumptions, and biases, as perceived barriers in the present study and previous literature. For example, it has been demonstrated that counsellors' attitudes, assumptions, judgements and biases can create challenges for low income clients in counselling, especially in regards to the development of therapeutic alliance and trust (Lavell, 2014; Millard, 2017; Smith et al., 2012). Furthermore, similar to previous literature, the present study has identified lack of socio economic and context awareness by the counsellor to be a barrier for low income clients as perceived by counsellors (Lavell, 2014; Smith et al., 2012, Thompson et al., 2012). Finally, consistent with previous research, the present study identified personal motivations and challenges for counsellors to be a challenge in their work, especially with low income clients (Smith et al., 2012).

Although significant similarities were found between the present study and existing literature, one notable difference was present. In pre-existing literature, counsellor preparedness and lack of training in regards to counselling low income clients specifically were identified by counsellors to be a barrier for low income clients in therapy (McBain, 2018; Thompson et al., 2015; Tucker et al., 2021), however these concepts were not identified in the current study. These differences can be understood in the context of population size for the sample in question; currently, the CCPA has over 9000 members, 3222 of which participated in the initial survey, 113 who participated in interviews, and 29 who completed the sorting activity for this question. Given that this study only interviewed a small portion of qualified CCPA counsellors in Canada,

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roughly 1.25 percent, only a small range of perspectives and experiences may have been obtained for analysis.

Limits to Real World Helpfulness of Counselling

There was significant overlap between the current study and past research regarding the acknowledgement of limited possibility for change and a lack of communication to be a challenge for low income clients and their counsellors. Specifically, the present study and existing research identified the importance of acknowledging income differences and the challenge that arises when those differences go unacknowledged in the counselling space (Appio, 2012; Appio et al., 2013; Kim & Cardemil, 2012; Lavell, 2014; Thompson et al., 2012).

There were also differences between the findings of the current study and previous literature. In particular, previous literature identified that a client's perception of their counsellor's income impacts the therapeutic relationship whereas this study did not (Balmforth, 2009). This difference may be attributed to the fact that the data obtained was from the counsellors' perspectives rather than that of their clients. In addition, the present study identified that counsellors perceived acknowledging the limited possibility for change to be important but challenging when working with low income clients, such as being unable to change their financial or current situation outside of the counselling space. This new information identified in the present study could be interpreted within the context of the population in which the counsellors are working with, as low income individuals may have limited access to other necessities (i.e. food and shelter) that would allow and assist them to progress in counselling and overall self-growth.

Negative Impacts Of Systems On And For Counsellors

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There were many differences between the results of the current study and the existing literature regarding the negative impact of systems on and for counsellors. Particularly, the current study identified certain modalities and approaches, such as solution focused and problem solving work, to be challenges for counsellors working with low income clients whereas the literature suggests these approaches to be helpful with this clientele (McBain, 2018); the current literature has also not identified cognitive modalities or approaches relying upon external factors to be a barrier for counsellors and their low income clients. This difference may be attributed to the plethora of existing research regarding potentially effective mental health treatments for low income individuals rather than identifying those that do not work for this population.

Furthermore, in line with the pre-existing literature which identified counsellors' emotional reactions and their own identities and experiences in relation to low income (Smith et al., 2013; Thompson et al., 2015), the present study identified personal and professional difficulties in regards to counsellors personal experiences of working with low income populations such as not feeling empowered to support clients or the emotional toll that comes with setting professional boundaries. Finally, the current study identified rigid perspectives of professional conduct to be a challenge which counsellors' who work with low income face, which at time of writing, is not present in the current literature. This potentially novel theme, rigid perspective of professional conduct, identified by counsellors could be attributed to the fact that majority of research regarding counsellors' experiences with low income clients often focus solely on the impact of systems on clients rather than both the client and the clinicians themselves.

Summary of Similarities and Differences

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In regards to the study question, “*What are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*”, the findings of the current study are consistent with many of the themes and findings outlined in the existing literature and, therefore, speak to the credibility of these findings. These similarities were found across studies employing various different methodologies, both qualitative and quantitative, and across different countries, indicating that these results may be reflective of counsellors’ experiences with low income clients globally. Nonetheless, after comparing and contrasting the findings, several differences were apparent, although no results contradicted previous findings. These differences can be attributed to many factors, including the population who served as participants, the size of the sample which may not be representative of all perspectives, barriers and challenges which may have overshadowed or taken precedence over by others seen in the literature, the fact that the data obtained was from the counsellors’ perspectives rather than their clients’, and counsellors’ social locations.

In addition, the results of the present study have built upon the existing literature by providing further information regarding barriers and challenges directly from counsellors working with low income populations. Moreover, the results of the current study identified additional barriers and challenges which counsellors and their low income clients face, such as rigid policies of mental health agencies, barriers due to clients’ experiences of trauma, and rigid perspective of professional conduct. In comparison to previous research, the present study focused on the challenges and barriers for counsellors’ and their low income clients from the perspective of the counsellor rather than simply clinicians’ observations of these barriers and how they impact their low income clients solely. Furthermore, it was identified that counsellors

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and their low income clients face challenges and barriers outside of the generally assumed income-related and systemic barriers, allowing for new insights regarding their experiences.

Limitations and Recommendations

The following section consists of limitations to the present study and recommendations of future directions for research, counselling, policy, and advocacy in regards to the perceived barriers and challenges counsellors experience when working with low income clients in their practice following COVID-19. These recommendations have been based on findings from the current study and pre-existing literature.

Limitations

While the present study contributes new information to the literature regarding barriers and challenges for counsellors and their low income clients to access counselling following COVID-19, it is not without its limitations. First, the sample was composed of primarily white, female counsellors and, therefore, perspectives gained in interviews may not be reflective of the perspectives of more racially and gender diverse counsellors. Additionally, the majority of counsellors who participated in the study were located in Ontario, Alberta, and British Columbia, and perspective of barriers and challenges may not be reflective of the experiences of low income clients and their counsellors in less represented locations such as the Northwest Territories, Prince Edward Island, or Quebec. Overall, counsellors' lived experiences and intersections of identity, such as racial and gender identity, as well as location served, may have influenced some of their responses and the results of this cannot be generalized or understood to be the perspectives of all counsellors in Canada.

Recommendations

Research

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Based on the results of the current study, it is recommended that future research regarding the barriers and challenges for low income clients to engage the population which is being studied indirectly (i.e. low income clients themselves) using methods such as PAR and concept mapping. This line of questioning is important as novel and important information can be obtained, as found in the present study. Furthermore, working with populations of interest using PAR can uncover new information that has the potential to directly and positively impact the lives of the population with which the research was conducted, which, in this case, is low income clients of counselling. This new information can help clinicians identify solutions to the barriers and challenges that low income clients experience in regards to access counselling services.

An additional recommendation for future research would be to examine how counsellors' different intersections of identity (i.e. gender, race, age, ability and income) impact the barriers and challenges which they experience and perceive in low income clients accessing counselling services. This line of questioning is important as counsellors with different social locations may perceive different and unique or additional barriers based on their lived experiences (i.e. non-white counsellors may perceive more race related barriers to counselling for low income clients). This new information may be able to help clinicians identify gaps in current mental health services for low income individuals of diverse genders, races, abilities, and ages.

Counselling

After examining findings from both the present study and existing literature, it is evident that low income clients have complex needs that are often not being fully met in current counselling contexts. It was also evident that current mental health services assisting low income clients are not truly accessible and available to meet those complex needs. Based on findings

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from the current study, a recommendation for counsellors would be to actively engage in ongoing reflection of their own biases, assumptions, judgements, and motivations to avoid imposing these beliefs on their clients and negatively impacting therapeutic trust and the therapeutic relationship. In addition, it is recommended that counsellors acknowledge low income clients' competing priorities and needs and the limits to real world helpfulness of counselling in session with clients when necessary. This acknowledgement will allow clients to take the onus of therapeutic progress off of themselves and acknowledge the systemic inequalities that they face that make it more challenging for them to actively engage in the therapeutic process.

Furthermore, it is recommended that counsellors engage in trauma informed practice with low income clients to minimize the negative effect of clients' trauma in regards to the therapeutic process and relationship. It is also recommended that counsellors tailor their practice to their clients and not rely solely upon a structured format, as therapy is not a one size fits all solution; this concern and recommendation will also be addressed in the policy section. In addition, it is recommended that counsellors meet clients where they are at, both emotionally and physically, addressing their immediate emotional needs and allowing for alternative locations for session, both in person and virtual, as it was noted in the current study that rigid constraints regarding location of session were viewed by counsellors to be unhelpful. The process of increasing physical accessibility for low income clients of counselling could include creating partnerships with local community organizations, such as community centres and libraries, who are able to offer private rooms for clients to attend virtual sessions closer to their primary location and reduce client commute time and cost to therapy.

Policy

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Based on pre-existing literature and the current study, it is recommended that policy makers in the government and mental health agencies work with low income clients to determine a number of things. These recommendations include involving low income clients regarding appropriate funding for low income mental health supports, and how to increase ease of access and length of access to counselling services, also in regards to late arrivals and cancellation fees. Given the complex needs of low income clients, it is of utmost importance to involve this population in identifying further gaps in care, developing plans to address these gaps, and determining what is needed in regards to policy change. It is also recommended that mental health agencies create local and nationwide partnerships with provincial, federal, and local government, as well as other social supports, to decrease low income clients' difficulty in navigating systems. By developing these relationships between organizations and perhaps an increase in funding, mental health services for low income clients could be more accessible and effective.

In regards to mental health agency specific policy changes, it is recommended that mental health agencies use more accessible language in the development of intake and other forms for therapy to accommodate all client education levels, as well as offer these forms in a variety of languages to increase accessibility for those whose first language is not English. In addition, it is recommended that mental health agencies hire more diverse counsellors who are reflective and understanding of the populations in which they serve (i.e. gender diverse low income clients may not feel understood by a cisgender counsellor). Moreover, it is recommended that mental health agencies not dictate the therapeutic modalities which their counsellors use with low income clients or enforce rigid structured formats, but rather base these decisions on client need and presenting problems on a case by case basis. By approaching counselling with low income

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clients in a client centred way, client's needs will actually be addressed rather than what is dictated by the organization to be the client's present issue. Additionally, it is recommended that mental health organizations and colleges empower their counsellors to hold space for clients and run their practice the way they see fit, in regards to modalities used, and rates and boundaries set, within the guidelines set out by their governing body. By empowering counsellors, mental health agencies may be able to decrease turnover to private practice and providers may feel more supported and willingly able to continue to provide mental health services and support to their low income clients who often present with more complex problems, which may weigh on the counsellor without support.

Advocacy

Finally, based on the results of the present study and pre-existing literature, it is recommended that counsellors raise awareness of systemic injustices both within and outside the context of therapy, such as in the general public and their everyday interactions with others. It is also recommended that counsellors and their regulatory bodies continue to advocate for more coverage for counselling services covered by extended health benefit providers. By addressing both of the aforementioned recommendations, it would be possible to increase effectiveness of public mental health services and make private counselling services more readily accessible and available for low income clients.

Knowledge Mobilization

To mobilize the knowledge obtained from this line of questioning, researchers hope to disperse findings to other researchers, the public and policymakers, community agencies, service providers, and counsellors who work with low income individuals and families. Moreover, researchers hope to present their findings at conferences, both within and outside the field of

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counselling psychology, whether that be in the form of poster presentations or talks. These strategies will be employed with the hopes of contributing to counsellors' self-reflection, competency, and practice with low income clients and the implementation of public policies or services to decrease the barriers within the therapeutic setting for low income clients and better meet their needs overall.

Conclusion

To review, this study aimed to answer the question, “*what are the perceived barriers or challenges counsellors experience when working with low income clients in their practice following COVID-19?*”. Relevant literature was reviewed in the context of counsellors and low income clients. Canadian counsellors from across Canada were interviewed and participated in a sorting activity which, after analyses, produced seven themes, including: barriers due to low income and employment, systemic barriers for clients, barriers due to trauma, competing needs and priorities, biased approaches, limits to real world helpfulness of counselling, and negative impacts of systems on and for counsellors. The current study revealed themes that were consistent with those outlined in pre-existing literature, as well as identified additional barriers and challenges which counsellors and their low income clients face, all of which have built upon the existing literature base by providing essential supplementary information regarding barriers and challenges directly from counsellors’ perspectives who work with low income populations. Recommendations were made based on the results of the present study and existing literature. These results and recommendations emphasize the significance of determining and addressing imbalances for low income clients in accessing and engaging in counselling to make mental health services accessible and available regardless of income or lack thereof. These results and

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recommendations are important as they may serve to lessen the mental health inequity experienced by those of low income.

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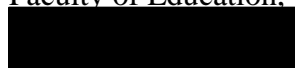
BARRIERS WORKING WITH LOW INCOME CLIENTS

Appendix A

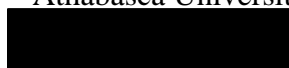
Letter of Information, Consent, and Counsellors Survey


**Impact of the COVID-19 Pandemic on Counselling with Low-Income Clients
Letter of Information**
Principal Investigator

Dr. Jason Brown
Faculty of Education, Western University

**Co-Investigator**

Dr. Melissa Jay
Athabasca University

**Project Coordinator**

Charlotte Finnigan (Carrie), MA, PhD
Candidate
Faculty of Education, Western University
redacted

**Co-Investigator**

Dr. Marguerite Lengyell
Faculty of Education, Western University



The investigators are receiving financial payment from the Social Sciences and Humanities Research Council of Canada (SSHRC) to help offset the costs of conducting this research.

Introduction

We are pleased to invite you to participate in this online survey looking at counsellors' social locations and perceptions on the impact of the pandemic on accessibility to counselling. This is phase 1 of a larger study examining the impact of the COVID-19 pandemic on counselling, and the helpful aspects of counselling, with low-income clients, from the perspective of counsellors and clients. You have been asked to participate in this study because you have been identified as a member of The Canadian Counselling and Psychotherapy Association (CCPA) who holds some form of counselling designation in Canada.

Background/Purpose

The purpose of this study is to identify counsellors' social locations and their perceptions on the impact of the COVID-19 pandemic on accessibility to counselling for low-income clients.

How long will you be in this study?

The survey takes approximately 20 minutes to complete.

What are the study procedures?

You will be asked to answer a series of closed and open ended questions relating to your social location, the causes of low-income, the impact of low-income, and the impact of the pandemic on accessibility to counselling for individuals with low income. You are encouraged to answer as

BARRIERS WORKING WITH LOW INCOME CLIENTS

honestly as possible. You may choose to not answer any specific questions that you do not feel comfortable answering. All recorded responses will be anonymous.

At the end of the survey, you will have the opportunity to enter into a draw to win one of two iPad's (estimated value of \$1000/iPad) that are being raffled as compensation for your participation by providing your first name and email address on a separate survey link. For any draw, the odds of winning a prize depend on how many people are entered in the draw; as we do not know how many people will participate in this study and related draw, we cannot predict what will be the odds of winning a prize. The draw will take place in Spring of 2023; winners will be notified by email. You will also have the option to enter your email address to also be entered into the pool of participants to be contacted for a Zoom interview at a later time.

What are the risks and harms of participating in this study?

Some questions within this survey may be perceived as sensitive content to some participants. Participants may experience uncomfortable feelings during discussions about social location, their personal and professional experiences with low-income, and the impact of the COVID-19 pandemic. There are also questions about personal demographic information. You are welcome to choose not to answer specific questions or exit the survey at any time if you do not feel comfortable.

What are the benefits of participating in this study?

You may not directly benefit from participating in this study, but information gathered may provide benefits to society as a whole. This study will contribute to professional practice, scholarly literature, and advocacy efforts regarding the practices helpful to low-income clients in the COVID-19 era. This study will identify the impact of the COVID-19 pandemic on access to counselling and what counsellors identify as helpful aspects of counselling with low-income clients. The end of the survey will also offer the option of providing contact information to be contacted to participate in a Zoom interview to delve deeper into the topics brought up in the survey, and thus offer you the opportunity to further voice your experiences and perspectives. There is no obligation to participate in the Zoom interview upon being contacted even if you initially indicate interest in participating.

Can participants choose to leave the study?

If you do not wish to continue the survey, you may simply exit the survey page at any time and your data will not be used. Due to the survey data being collected anonymously, your data cannot be withdrawn after completion of the survey.

How will participants' information be kept confidential?

The data provided will be secured by a password protected computer at all times. Only the primary investigators and project coordinator will have access to this computer. However, representatives of Western University's Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

Your survey responses will be collected through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western's Qualtrics server is in Ireland, where privacy standards are

BARRIERS WORKING WITH LOW INCOME CLIENTS

maintained under the European Union safe harbour framework. The data will then be exported from Qualtrics and securely stored on Western University's server.

If the results of this study are published, only de-identified information will be made available.

The researcher will keep all personal information about you in a secure and confidential location. The data will be stored on a secure server at Western University and will be retained for a minimum of 7 years. A list linking your name and email address, if you opt to be entered into the draw or be contacted for the in-depth interview, will be kept by the researcher in a secure place, separate from your study file. Your data will be retained for 7 years and could be used for future research purposes (e.g., to answer a new research question). By consenting to participate in this study, you are agreeing that your data can be used beyond the purposes of this present study by either the current or other researchers.

Are participants compensated?

You will have the opportunity to enter into a draw to win one of two iPad's being raffled as compensation for participating in the survey.

What are the Rights of Participants?

Your participation in this survey is voluntary. You may decide to not be in this study. Even if you consent to participate, you have the right to not answer individual questions or to withdraw from the study at any time. Participants are entitled to be entered into the draw for compensation even if they withdraw partway through the study; this can be done by contacting the project coordinator directly. If you choose not to participate or to leave the study at any time it will have no effect on your professional or employment status. You do not waive any legal right by consenting to this study.

Whom do participants contact for questions?

If you have questions about this research study please contact Charlotte Carrie, Project Coordinator, [REDACTED] or the primary investigators.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics [REDACTED]. The Research Ethics Board is a group of people who oversee the ethical conduct of research studies. The Non-Medical Research Ethics Board is not part of the study team. Everything that you discuss will be kept confidential.

This letter is yours to keep for future reference.

Dr. Jason Brown [REDACTED] Dr. Melissa Jay [REDACTED]; Dr. Marguerite Lengyel [REDACTED]

By selecting the next arrow to begin, it indicates that you have read the above Letter of Information, and that you agree to participate. If you do not wish to continue, simply close this window.

BARRIERS WORKING WITH LOW INCOME CLIENTS

In what type of community do you currently reside?

BARRIERS WORKING WITH LOW INCOME CLIENTS

- Remote/Northern (1)
- Rural (2)
- First Nations Community (3)
- Métis Settlement (4)
- Small Town (50,000 people or less) (5)
- Small City (50,001-500,000 people) (6)
- Large City (over 500,000 people) (7)
- Other (please specify): (8) _____

In what province or territory do you live?

- Alberta (1)
- British Columbia (2)
- Manitoba (3)
- New Brunswick (4)
- Newfoundland and Labrador (5)
- Northwest Territories (6)
- Nova Scotia (7)
- Nunavut (8)
- Ontario (9)
- Prince Edward Island (10)
- Quebec (11)
- Saskatchewan (12)
- Yukon (13)
- Other (14) _____

BARRIERS WORKING WITH LOW INCOME CLIENTS

In what province or territory do you normally work?

- Alberta (1)
 - British Columbia (2)
 - Manitoba (3)
 - New Brunswick (4)
 - Newfoundland and Labrador (5)
 - Northwest Territories (6)
 - Nova Scotia (7)
 - Nunavut (8)
 - Ontario (9)
 - Prince Edward Island (10)
 - Quebec (11)
 - Saskatchewan (12)
 - Yukon (13)
 - Other (14) _____
-

Are you First Nations, Métis or Inuk (Inuit)?

Note: First Nations includes Status and Non-Status

- No (1)
 - Yes, First Nations (2)
 - Yes, Métis (3)
 - Yes, Inuk (Inuit) (4)
-

BARRIERS WORKING WITH LOW INCOME CLIENTS

What is your current employment status?

Please choose all that apply:

- Working Full-time (1)
 - Working Part-time (2)
 - Self-Employed (3)
 - Not Employed and Looking for Work (4)
 - Not Employed and Not Looking for Work (5)
 - Retired (6)
 - On Leave (7)
 - Other (please specify): (8)
-

Which of these options best describes the location of your primary worksite?

- Remote/Northern (1)
 - Rural (2)
 - Métis Settlement (3)
 - First Nations Community (4)
 - Home Office (5)
 - Small Town (50,000 people or less) (6)
 - Small City (50,001 - 500,000 people) (7)
 - Large City (over 500,000 people) (8)
 - Other (please specify): (9) _____
-

BARRIERS WORKING WITH LOW INCOME CLIENTS

How do you meet your clients?

- In Person (1)
- Virtual (2)
- Both (3)
-

For how many years have you been practicing within the counselling field?

- 0-5 Years (1)
- 6-10 Years (2)
- 10-15 Years (3)
- 16-20 Years (4)
- 21+ Years (5)

What is your employment setting?

E.g., Community Mental Health, Corrections, Education, Healthcare, Human Services, Private Practice, etc.

What is your registration status?

Please choose all that apply:

- Regulatory bodies (1)
- Professional associations (2)
- Designations (3)
- Other (4) _____

BARRIERS WORKING WITH LOW INCOME CLIENTS

Please list the regulatory bodies that you belong to:

E.g., College of Psychologists of Ontario, College of Alberta Psychologists, College of Registered Psychotherapists of Ontario (CRPO), etc.

Please list any professional associations that you are a member of:

E.g., Canadian Counselling and Psychotherapy Association (CCPA), Canadian Psychological Association (CPA), Psychologists' Association of Alberta (PAA), etc.

Please list your designations:

E.g., Registered Psychotherapist, Canadian Certified Counsellor, Registered Social Worker, Psychologist, etc.

What languages do you speak?

Please choose all that apply:

- English (1)
- French (2)
- Sign Language (3)
- Other (4) _____
-

BARRIERS WORKING WITH LOW INCOME CLIENTS

Are you a NIHB provider? (non-insured health benefits)

- No (1)
- Yes (2)

What is your age?

Please indicate the highest degree you have been awarded.

- Diploma (1)
- Bachelors (2)
- Masters (3)
- Doctorate (4)
- Other (5) _____

Please indicate your racial identity.

E.g., e.g. Black, East Asian, Indigenous, Latino, Middle Eastern, South Asian, Southeast Asian, White, etc.

Please indicate your class identity.

E.g., low, middle, upper middle, working class, working poor, etc.

BARRIERS WORKING WITH LOW INCOME CLIENTS

Please indicate your religious/spiritual identity (if any).

E.g., Christianity, Hinduism, Islam, Judaism, Sikhism, Buddhism, Agnostic, etc.

Do you identify as a person with a disability? If yes, please indicate how you identify.

E.g., Deaf or hard of hearing, mental health conditions, physical disabilities, learning disabilities, etc.

No (1)

Yes (2) _____

The following are short answer, open-ended questions. Please utilize as much space as needed to answer each question.

What do you see as the main causes of low income?

In what ways does low income affect wellbeing?

BARRIERS WORKING WITH LOW INCOME CLIENTS

What is the impact of the pandemic on accessibility to counselling for individuals with low income?

Thank you for completing this survey and for contributing to our understanding of the impact of the COVID-19 pandemic on you personally and professionally. While there is no follow up required, if you would like to join the pool of potential participants for a Zoom interview lasting 30-60 minutes, please follow the link on the subsequent slide and provide your name and email address. While the interview will be taking place via Zoom, you will have the option to join virtually or to phone in. Your email address will be used to contact you to arrange an interview at a day and time that is convenient for you (please note that email is not a secure form of communication). We acknowledge that counsellors are very impacted and in the spirit of reciprocity we offer an honorarium of \$50 to compensate you for your time and expertise in the Zoom interview.

Please click next in order to join the pool of potential Zoom interview participants and/or to be entered into the draw to win one of two iPad's being raffled as compensation for completing the survey. While we appreciate your willingness and enthusiasm to participate in our survey, **please note that you may only participate in the completion of the survey one time**. Thus, if you fill out the survey multiple times, only your first set of responses will be utilized and your name will only be entered into the draw one time.

Please read the following options carefully, and copy and paste the link for your desired option into your browser **in a new tab** and then enter the corresponding information. Please enter your information into only one of the three below links, based on your preference.

Interview & Raffle Interest

If you are interested in joining the pool of potential participants for a Zoom interview lasting 30-60 minutes **AND** being entered into the draw to win one of two iPad's being raffled as compensation, please use the link below and then enter your first name and email address.

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https://uwo.eu.qualtrics.com/jfe/form/SV_5hZlaADiyH3LF6S

Raffle Interest Only

If you do **NOT** wish to be entered into the pool of participants for the Zoom interview, please copy and paste the following link into your browser and enter your email address in order to be entered into the draw to win one of two iPad's being raffled as compensation for completing the survey.

https://uwo.eu.qualtrics.com/jfe/form/SV_6f1eaV3IB8z4iHA

Interview Interest Only

If you do **NOT** wish to be entered into the draw to win one of two iPad's being raffled as compensation for completing the survey, but you would like to join the pool of potential participants for a Zoom interview lasting 30-60 minutes, please use the link below and enter your first name and email address.

https://uwo.eu.qualtrics.com/jfe/form/SV_1zRMvGf19tVn6JM

***Please note:** The information from the following links is stored separately from your survey responses so that there will be no possibility of connecting your survey answers with your contact information.*

BARRIERS WORKING WITH LOW INCOME CLIENTS

Appendix B

Counsellors Interview



ID _____

Date of Interview _____

Interviewer _____

Close-Ended Interview Questions**1. In what type of community do you currently reside?***Please choose only one of the following:*

- a. Remote/Northern
- b. Rural
- c. First Nations Community
- d. Métis Settlement
- e. Small Town (50,000 people or less)
- f. Small City (50,001-500,000 people)
- g. Large City (over 500,000 people)
- h. Other (please specify): _____

2. In what province or territory do you live?

- a. Alberta
- b. British Columbia
- c. Manitoba
- d. New Brunswick
- e. Newfoundland and Labrador
- f. Northwest Territories
- g. Nova Scotia
- h. Nunavut
- i. Ontario
- j. Prince Edward Island
- k. Quebec,
- l. Saskatchewan
- m. Yukon
- n. Other: _____

3. In what province or territory do you normally work?

- a. Alberta

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- b. British Columbia
- c. Manitoba
- d. New Brunswick
- e. Newfoundland and Labrador
- f. Northwest Territories
- g. Nova Scotia
- h. Nunavut
- i. Ontario
- j. Prince Edward Island
- k. Quebec,
- l. Saskatchewan
- m. Yukon
- n. Other: _____

4. **Are you First Nations, Métis or Inuk (Inuit)?**

Note: First Nations includes Status and Non-Status Indians.

- a. No
- b. Yes, First Nations
- c. Yes, Métis
- d. Yes, Inuk (Inuit)

5. **What is your current employment status?**

Please choose all that apply:

- a. Working Full-time
- b. Working Part-time
- c. Self Employed
- d. Not Employed and Looking for Work
- e. Not Employed and Not Looking for Work
- f. Retired
- g. On leave
- h. Other: _____

6. **Which of these options best describes the location of your primary worksite?**

- a. Remote/Northern
- b. Rural
- c. Metis Settlement
- d. First Nations community
- e. Home Office
- f. Small Town (50,000 people or less)
- g. Small City (50,001-500,000 people)
- h. Large City (over 500,000 people)
- i. Other: _____

7. **How do you meet your clients?**

- a. in person

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- b. virtual
- c. Both

8. **For how many years have you been practicing your current profession?**

- a. 0-5 years
- b. 6-10 years
- c. 10-15 years
- d. 16-20 years
- e. 21+years

9. **For how many years have you been practicing your current profession?**

- b. 0-5 years
- c. 6-10 years
- d. 10-15 years
- f. 16-20 years
- e. 21+years

9. **What is your employment Setting?**

E.g. Community Mental Health, Corrections, Education, Healthcare, Human Services, Private Practice, other

10. **What is your Geographic Location?**

e.g. Urban/Rural

11. **What is your registration Status?**

- a. Regulatory bodies
- b. Professional associations
- c. Designations
- d. Other:

12. **Please indicate the number of years since professional registration:**

13. **Are you a NIHB provider? (non-insured health benefits)**

- a. Yes
- b. No

14. **What Languages do you speak?**

- a. English
- b. French
- c. Sign Language
- d. Other: _____

BARRIERS WORKING WITH LOW INCOME CLIENTS

15. **What is your age?**

16. **What is the highest degree you have been awarded?**

- a. Diploma
- b. Bachelors
- c. Masters
- d. Doctorate
- e. Other: _____

17. **What is your gender identity?**

e.g. Agender, Cisgender Female, Cisgender Male, Genderqueer, Non-binary, Transgender Female, Transgender Male, Prefer not to say

18. **What is your ethnic identity?**

e.g. Canadian, Chinese, Dutch, East Indian, English, Filipino, French, German, Indigenous, Iranian, Irish, Italian, Jamaican, Korean, Pakistani, Polish, Portuguese, Scottish, Sri Lankan

19. **What is your racial identity?**

e.g. Black, East Asian, Indigenous, Latino, Middle Eastern, South Asian, Southeast Asian, White

20. **What is your class identity?**

e.g. low, middle, upper middle, working class, working poor

21. **What is your religious/spiritual identity (if any)?**

e.g., Christianity, Hinduism, Islam, Judaism, Sikhism

22. **Do you identify as a person with a disability? If yes, how do you identify?**

E.g., Deaf or hard of hearing, mental health conditions, physical disabilities, learning disabilities, etc.

- a. No
- b. Yes: _____

BARRIERS WORKING WITH LOW INCOME CLIENTS

Open-Ended Interview Questions

1. **In which categories do you believe you are advantaged or disadvantaged relative to the majority or dominant groups and why? Participants will also be asked:**
2. **How does your own experience with low income impact your counselling? (personal and professional)**
3. **What have you found to be the most helpful aspects of counselling with clients facing low income?**
4. **What have you found to be the least helpful aspects of counselling with clients facing low income?**
5. **How has the pandemic impacted your work with low-income clients? (access, relationship, continuity, funding, scheduling, helpfulness, usefulness,)**
6. **How does your experience supporting low-income clients impact your work outside of the counselling space? (advocacy, teaching, policy, community, politics,.....)**

BARRIERS WORKING WITH LOW INCOME CLIENTS

Appendix C: Ethics Approval



Date: 24 August 2022

To: Dr. Jason Brown

Project ID: 121415

Study Title: Impact of the COVID-19 Pandemic on Counselling with Low-Income Clients: Perspective of Service Providers

Short Title: Counselling with Low Income Clients: Impact of COVID-19

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 09/Sept/2022

Date Approval Issued: 24/Aug/2022 16:22

REB Approval Expiry Date: 24/Aug/2023

Dear Dr. Jason Brown

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Counsellor Interview Guide	Interview Guide	19/Jul/2022	1
Sorting Activity- Counsellor Instruction Script	Other Data Collection Instruments	19/Jul/2022	1
COVID:Counselling End of Study Template	End of Study Letter	19/Jul/2022	1
Survey- Counsellor Email Recruitment Script	Recruitment Materials	19/Jul/2022	1
Counsellor Compensation Only Survey (Qualtrics) (version 2)	Online Survey	03/Aug/2022	2
Counsellor Interview Interest & Compensation Survey (Qualtrics) (version 2)	Online Survey	03/Aug/2022	2
Counsellors Survey (Qualtrics) (Version 2)	Online Survey	03/Aug/2022	2
Counsellors Interview Only Survey	Online Survey	03/Aug/2022	1
Interview- Counsellor Email Recruitment Script	Recruitment Materials	02/Aug/2022	2
Sorting- Counsellor email script	Recruitment Materials	02/Aug/2022	2
Phase 2 (interview and sorting) Letter of Information (Version 3)	Verbal Consent/Assent	22/Aug/2022	3
Phase 1 (Qualtrics) Letter of Information:Consent (Version 3)	Implied Consent/Assent	22/Aug/2022	3

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Support Services	Other Materials	19/Jul/2022	1

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate

BARRIERS WORKING WITH LOW INCOME CLIENTS

hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms. Zoë Levi, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

BARRIERS WORKING WITH LOW INCOME CLIENTS

Curriculum Vitae

Name: Riley Keast

Post-secondary Education and Degrees: The University of Western Ontario
London, Ontario, Canada
2018-2022 B.Sc. (Honours)

Honours and Awards: Canada Graduate Scholarships - Master's (SSHRC)
2023-2024

Canada Graduate Scholarships - Master's Indigenous Scholars Supplement
2023

TC Energy's Indigenous Legacy Scholarship
2023

Nancy K. Innis Memorial Award
2022

F.E. Shaw Scholarship
2018-2021

Dean's Honor List
2019-2020, 2022

Related Work Experience

Research Assistant
The University of Western Ontario
Psychobiology of Eating and Related Disorders Lab, Supervisor: Dr. Lindsay Bodell
2021-2022

Research Assistant
The University of Western Ontario
Stigma, Objectification, Bodies, Resistance Lab, Supervisor: Prof. Rachel Calogero and Dr. Angela Meadows
2019-2022

Publications:

R. Keast, S. Withnell and L.P. Bodell, "Longitudinal associations between weight stigma and disordered eating across the weight spectrum", *Eating Behaviors* (2023),
<https://doi.org/10.1016/j.eatbeh.2023.101788>