

THE UNIVERSITY OF HULL

An exploration of the aspirations and future orientation of young
people from low-income families

being a Thesis submitted in partial fulfillment
of the requirements for the degree of Doctor of Clinical Psychology

in the University of Hull

by

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Overview

Part One: A systematic literature review, in which the available research regarding effective mental health services for low-income, working age adults, is reviewed.

Part Two: A qualitative investigation using Interpretative Phenomenological Analysis (IPA) to explore the aspirations and future orientation of adolescents from low-income families. This includes adolescents' perceptions of their future, influences on aspiration formation and perceived barriers and facilitators.

Part Three: Appendices including all relevant documents to the systematic literature review and empirical paper. The appendices also include a reflective statement and epistemological statement.

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Part One

Systematic Literature Review

**Effective psychological interventions for low-income adults with depression:
a systematic review**

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This paper is written in the format ready for the submission to the
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Please See Appendix A for the Guidelines to Authors.

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Effective psychological interventions for low-income adults with depression: a systematic review

Abstract

Objectives: Living in poverty is consistently linked to poor physical and mental health. Depression in particular is more prevalent among low-income populations. Worldwide, 2.2 billion people are known to live in poverty. Despite these figures, there are known inequalities in access to adequate mental healthcare. Research has shown that mainstream psychological interventions, such as Cognitive Behavioural Therapy (CBT) and Problem-Solving Therapy (PST) can be successfully adapted for use with disadvantaged groups.

Methods: A systematic literature review was conducted. This paper presents a narrative synthesis of the available literature on the use of psychological interventions for depressed low-income adults.

Results: The heterogeneity of the literature prevents the exact components of effective interventions from being identified, however there are a number of adaptations that can be made to increase the efficacy of psychological interventions with low-income populations.

Conclusions: This review provides some useful considerations for work with low-income depressed adults, however there are some considerable gaps in the literature, with a need for further research to address these.

Key words: *depression, psychological interventions, treatment effectiveness, low-income, economically disadvantaged, adaptations to therapy.*

Introduction

Living in poverty is consistently linked to the development of poor mental and physical health (Santiago, Kaltman and Miranda, 2012). Mental health disorders such as anxiety and depression are known to be more prevalent in low-income populations, and in particular rates of chronic depression are significantly higher (Levy and O'Hara, 2012; Lorant et al, 2003). Despite the fact that numerous low-income individuals are in need of effective therapeutic and support services, many do not receive adequate mental healthcare (Santiago, Kaltman and Miranda, 2012; World Health Organisation, 2011).

According to most recent estimates (2011), 17% of people (just under 1 billion) in the world lived on less than \$1.25 a day, considered below the 'absolute poverty' line (The World Bank, 2014). Many high and middle-income countries have chosen to set 'relative poverty lines' – defined as a household with an equivalised disposable income of less than 60% of the national median (The World Bank, 2015). When the poverty line is set as the average relative poverty line for developing countries (less than \$2 a day), the number of people living in poverty increases to 2.2 billion people in the developing world (The World Bank, 2014). There is also a growing inequality between the richest and the poorest globally. A link has been demonstrated between mental illness and income inequality, with greater disparities in wealth resulting in significantly higher levels of mental illness (Pickett, James and Wilkinson, 2006).

As previously mentioned, those with a low-income are at a higher risk for developing mental health problems, and in particular, depression. Higher risk for mental health problems amongst those on low-income is attributable to higher levels of daily stressors, and adverse experiences, such as stigma and discrimination, violence, conflict, ill health and frequent changes of residence (Santiago, Wadsworth and Stump, 2011). Research has shown that generally, the lower a person's socio-economic status, the worse their health (World Health Organisation, 2015). Further to this, only 36% of people living in low-income countries are covered by mental health legislation, compared to 92% in middle to high-income countries (World Health Organisation, 2011). There is growing recognition that strategies are needed to reduce health inequalities (Lorant et al,

2003), which means that the need for the provision of effective mental health services for people with a low-income is a research priority.

There is a wealth of research documenting the lack of service utilisation among low-income, marginalised populations. There are a number of identified barriers to accessing care, from practical barriers such as being unable to find or afford childcare or transportation, to social and psychological barriers such as stigma and shame (Goodman, Pugach, Skolnic and Smith, 2012; Levy and O'Hara, 2010). The effectiveness of traditional forms of therapy for low-income clients has been further questioned as most treatments are researched in university settings with predominantly Caucasian, middle to high-income individuals and families (Santiago, Kaltman and Miranda, 2012; Kim and Cardemill, 2012). A number of studies have however devised mental health interventions tailored specifically to address the contextual barriers in low-income people's lives, showing positive outcomes (Ammerman et al, 2005; Grote et al, 2009; Miranda et al, 2003).

This paper will provide a systematic review of studies that have evaluated the effectiveness of therapeutic interventions with low-income depressed populations. 'Effectiveness' in this paper relates to reductions in depressive symptoms as measured by standardised measures. However, engagement and retention are also discussed. Treatment of depression will be the focus as a majority of the research in this area has been conducted with depressed patients. A large proportion of the literature thus far has concentrated on reducing depression in low-income women specifically, due to the detrimental effects of maternal depression on children. However, this study will review the literature for both male and females, since depression is not gender-specific, and, worryingly, the suicide rates globally are higher for men than women (15 per 100,000 compared to 8 per 100,000) (World Health Organisation, 2015). The review has also included research focusing on interventions for low-income ethnic minority groups, those with physical health problems such as cancer and HIV/AIDS, and women suffering from peri-natal depression, as these are also representative of low-income populations. The review is not centred on ethnic minority access to services per se, but it is acknowledged that some ethnic minority groups are

prevalent within low-income populations (American Psychological Association, 2015). The research questions of this review therefore are:

Are there effective psychotherapeutic interventions for low-income, working age adults?

And, how can interventions be adapted in a way that makes them more accessible and effective with a low-income population?

Method

Identification of Studies

This review aimed to include and evaluate the current literature on psychotherapeutic interventions for depressed, low-income, working age adults. Studies could include a variety of different therapeutic models and approaches, including adaptations and enhancements made specifically for low-income populations. Four databases were searched: PsycINFO, PsycArticles, CINAHL and Web of Science were chosen in order to cover the fields of psychology and health. Papers were gathered from February 2014, to the end of November 2014.

Inclusion and Exclusion Criteria

A number of limiters were used in the search to ensure that included studies were relevant and of a good quality. The following criteria were applied:

Inclusion Criteria:

- Studies had to be peer reviewed to ensure quality.
- Studies had to be published after 2000, as preliminary searches found that the most relevant research occurred after this time.
- The review applied to working age adults, and therefore studies focusing exclusively on 'older adults' or young people below the age of 18 were excluded.
- Only quantitative intervention studies were included in order to identify effective treatments for a low-income population.

Exclusion Criteria:

- Systematic reviews, literature reviews, book reviews, case studies and discussion papers were excluded.

- Preventative studies were excluded as the review focused on treatment.

Search Strategy and Study Selection

The search terms were composed by examining relevant papers and the variety of terms used within their titles and main text. The following terms were used (* indicates truncation):

- low-income OR disadvantag* OR low SES OR poor OR poverty
- AND depress* OR low mood
- AND psych* AND/OR therap* OR interven* OR treat*

These terms were applied to title only in order to remove the high number of irrelevant papers being returned in searches. This left a total of 265 papers. Following the application of limiters (age 18-69; published after 2000; peer reviewed; language), 184 papers remained. The author initially reviewed the abstracts of the papers resulting in 34 eligible papers. Nineteen duplicates were removed. The remaining 15 papers were read in full in order to apply the inclusion and exclusion criteria. This resulted in a further 3 papers being rejected. Finally, the author manually searched the reference lists of eligible papers, and identified 3 further suitable studies for inclusion. This resulted in a total of 15 papers to be included in the review. Appendix B summarises the selection of studies.

Data Extraction

A data extraction form was created in order to extract relevant information for the purpose of the review (Appendix C). A summary of the data is presented in Table 1. For the purposes of the review, the data extraction focused on sample characteristics and target population, details of the interventions that were used, outcome measures, statistical analysis and main findings. The data extraction was conducted alongside quality assessments of the included studies.

Methodological Quality Assessment

Clinical literature is an important resource by which professionals might guide their decision-making and practice. The evaluation of the quality of literature is therefore an important step in the process of creating a systematic review (Olivo et al, 2007). For the purpose of this review a modified version of

the Downs and Black (1998) quality checklist was used (see Appendix D). This checklist is appropriate for assessing both randomised and non-randomised studies; provides an overall score for both study quality, and an overall profile of scores for the quality of information reporting and internal and external validity. A table of quality assessment scores for all included studies is included in Appendix E.

For the purpose of this review some questions were omitted, new questions were added and some questions were modified to increase their relevance to the research question. Questions were omitted if they were deemed as irrelevant to the question e.g. “Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?”, was removed as no case-control studies were included. Finally, some questions were added. For example, a question was included about the screening of participants as this is important for ensuring that the participants are suitable to the question being asked e.g. how participants were identified as being low-income.

The checklist used a simple scoring system with a score of 1 being awarded if the answer was ‘yes’, and 0 if the answer was ‘no’ or ‘not clear’. The overall score achievable by each study varied depending on its methodology. For Randomised Control Trials (RCTs) the maximum score of 22 could be achieved. For all other studies the maximum score was 20. For the purposes of this review, quality scores were categorised: low <16; average 16-18; high 19-22. A summary of the quality assessment scores is provided in Table 2.

The lead author conducted the quality assessments. An independent rater scored 5 of the studies included in the review to assess inter-rater reliability. The scores awarded by the independent rater were 1-2 points higher than those given by the lead author. No greater differences than this were evident. It is likely that the lead author marked papers more critically, and did not deem certain criteria to be met sufficiently to achieve the mark where the independent rater may have.

Table 1. Characteristics of Included Studies

Pilot and Feasibility Studies						
Author(s)	Cou- ntry	Sample	Intervention(s) of Interest	Comparison/Control Condition	Outcome Measures	Clinical Outcomes
Aguilera and Muñoz (2011)	USA	12 patients (4 men) enrolled in group CBT in primary care outpatient clinic. Average age 52.3. 5 English speaking, 7 Spanish as first language. 8 Latino, 3 European Americans, 1 African American (AA).	Text messaging as adjunct to CBT group. 2-3 messages sent daily asking patients to rate mood from 1-10. Message at end of the day which correlated to CBT module at the time (e.g. number of positive thoughts).	n/a	PHQ-9 Qualitative responses to use of SMS.	9/10 patients said use of SMS made them feel closer to group and their therapists. Some said it improved self-awareness. Suggestion that SMS may increase adherence to homework, and maintain outcomes post-treatment.
Himelhoch et al (2013)	USA	34 patients attending HIV clinic with symptoms of depression. 25 female, 9 male. Mean age of 45.12. Ethnicity mainly AA (32), 1 Indian American, 1 Other.	11 x 45 minute sessions of manualised telephone CBT intervention targeting depression. 1 initial evaluation session, 5 sessions of Behavioural Activation (BA) and 5 sessions of cognitive restructuring over 14 week period.	TAU within the HIV clinic – 11 x 60 minute sessions of non-manualised CBT.	PHQ-9 HAM-D QIDS-SR Baseline, midpoint (7 weeks) and end (14 weeks).	Depressive symptoms were significantly reduced in both treatment arms with large effect sizes and no significant differences in depression treatment outcomes between conditions. Telephone condition increased adherence to HIV medication compared

						to face-to-face therapy.
Beeber, Holditch-Davis, Belyea, Funk and Canuso (2003)	USA	16 mothers in an Early Head Start programme. Mean age 26.6. All below federal poverty line. 10 AA, 6 Caucasian.	Short-term, home-based intervention based on IPT. Provided strategies for managing depressive symptoms, improving problematic life issues, increasing access to social support, and improving parenting. 8 face-to-face contacts over 8-10 weeks. Individualised contracts based on mothers' strengths, energy and ability. Strategies turned into engaging activities e.g. games and role-plays. Significant others included when appropriate. Telephone booster phase of 5 weeks. Termination followed by letter highlighting achievement.	Usual care/waiting list: social support; child development education; guidance on parenting problems; ways to facilitate child's growth.	CES-D Maternal-Child Observations Measures at baseline, 8 weeks and 16 weeks.	Reductions in depressive symptoms were greater for intervention group across all 3 time points. At end of intervention 8 mothers were below the cut-off for depression.
Perez-Foster (2007)	USA	91 Women seeking treatment for depressive symptoms at a	Intervention group: group sessions over 16 weeks. Based on CBT with four modules addressing	Control Group: supportive/exploratory groups already offered at each prospective	BDI-II CES-D Duke Health Profile	All groups showed statistically significant decreases in depressive symptoms

		homeless shelter program and municipal psychiatric clinic for Latino patients. Mean age 44.25. At the homeless shelter 55% were Black, 20% Hispanic and 17.5% Caucasian. At the Hispanic Clinic 95% were Hispanic.	thoughts, moods, behaviours and health. Weekly homework assignments given.	site.	Baseline, 16 weeks post-treatment and 4 month follow-up.	from baseline to post-treatment, which continued through to follow-up.
Heileman, Pieters, Kehoe and Yang (2011)	USA	8, second generation Latino women recruited from healthcare, child development and family service sites. Average age 30; average annual income \$15,080.	Initial interviews included Motivational Interviewing (MI) and collaborative mapping. Each session incorporated CBT techniques, MI and Schema Therapy (ST), with an extra focus on resilience. MI brought a focus on expressing empathy. Basic education on CBT and analysis of automatic thoughts; education on schemas; coping styles; exploration of long-standing patterns	n/a	SCID BDI-II Resilience Scale Measured at baseline, and 1, 3 and 12 month follow-up.	All women had significant decreases in depression scores and increased levels of resilience at 3 months and follow up.

in relation to current problems. Flexible scheduling of sessions and unlimited telephone access to a therapist.

Intervention and Outcome Studies

Author(s)	Cou- ntry	Sample	Intervention(s) of Interest	Comparison/Control Group	Outcome Measures	Clinical Outcomes
CBT Based Interventions						
Miranda et al (2006) Siddique, Chung, Brown & Miranda (2012)	USA	267 disadvantaged, young, minority women. 117 AA; 16 Caucasian; 134 Latina. Mean age 29.3. 149 below federal poverty line; 88 'near poor'; 20 'not impoverished'.	1. Pharmacotherapy Group: Paroxetine for 6 months. 2. CBT Group: 8 weekly group or individual sessions. Extended additional 8 weeks if appropriate.	Treatment as Usual (TAU): community referral - education about depression, and information about local services.	HDRS HAM-A Measures completed monthly for the first 6 months, and then at 8, 10 and 12 months.	Reduced depression symptoms across all 3 conditions at month 6 and 12. Significant difference between medication and CBT group for subjects with 'severe' depression. CBT more effective at 12 months. Pharmacotherapy had better results at 6 months for those with 'moderate' depression, but this difference disappeared at 12 months. >50% of participants who

						completed 9 weeks + Paroxetine, or 6 weeks + of CBT were no longer clinically depressed at 12 months.
O'Mahen, Himle, Fedock, Henshaw and Flynn (2013)	USA	55 pregnant, low-income women with MDD attending an Obstetrics clinic. Mean age 27.4 (mCBT) and 26.62 (TAU). 32 AA; 17 Caucasian; 4 Asian; 2 other.	12 individual sessions of CBT adapted for the perinatal period. Initial engagement session using Motivational Interviewing (MI) followed by three modules: BA; Cognitive Restructuring; Interpersonal Support. Active Outreach strategy for those who missed appointments (multiple phone calls, reminders, flexible hours etc.)	TAU: continued midwife and obstetrical care.	EPDS SCID-II BDI-II Behavioural Activation Scale (part of BADS) Measures completed at baseline, 16 weeks and 3 months after randomisation.	Greater symptom reduction in the mCBT group than pharmacotherapy group at 16 weeks and 3 months. Treatment adherence related to better outcomes. Intensive outreach efforts 'critical'. 72% engaged with treatment (defined by attending first two sessions).
Lara, Navarro, Rubí, and Mondragón (2003)	Mexi-co	135 women attending community health centres in 2 distinct locations. Mean age 35.3 years. Mean family income of 3,416 pesos per month (£149.58).	Group Condition (GC): 8 groups with 5-19 participants. 6 x 2 hour weekly sessions. Program based on CBT. Educational component, and gender perspective (submissive female role	Minimum Individual Condition (MIC): 20-minute individual orientation and psychoeducational material.	CES-D SCL-90R Measurements at baseline, 2 weeks for GC and 1 week for MIC, and again at 4 months.	Both interventions showed a significant reduction in symptoms at post treatment and 4 months, but GC achieved greater reductions in

			seen to be cause of depression). Used simple language and cartoons to describe depression, its causes, and ways of coping.			depressive symptoms, this difference was not significant between groups.
Miranda, Azocar, Organista, Dwyer and Areane (2003)	USA	199 participants recruited from a depression clinic at a hospital. 134 Female. (Mexican American, AA and 'other')	Intervention Group: CBT adapted for a lower literacy level. 12 weekly sessions in 3 modules, covering changing depressogenic thinking, BA and improving interactions with others.	Intervention Group + Supplemental Case Management (CM): A flexible intervention that took place over 6 months. Case managers engaged in active telephone outreach upon referral. They assessed patients' needs in housing, employment, recreation and relationships with family and friends. Goals set together to work towards. CM alongside CBT intervention.	SCID-II BDI-II SAS	Supplemental case management was associated with a lower likelihood of early dropout. The enhanced intervention was effective in reducing symptoms and improving functioning among Spanish speaking patients, but not among English speaking patients. 66% of intervention group engaged with treatment (defined as attending 8-12 sessions), compared to 76% in CM condition.
Rahman, Malik,	Pakistan	903 Married women aged 16-45 in their	Intervention Group: 'Thinking Healthy	Same amount of sessions as	SCID-II HDRS	Integration of a CBT based intervention

Sikander, Roberts and Creed (2008)	third trimester of pregnancy, with perinatal depression. Mean age 26.5 (intervention group) and 27 (control group). Recruited from two union council areas.	Programme'. Specially trained 'Lady Health Workers' (LHWs) provided weekly sessions for the last month of pregnancy, three sessions in the first postnatal month and nine monthly sessions thereafter. LHWs were trained in CBT techniques such as active listening, collaboration with the family, guided discovery and homework. Added to routine practice of maternal and child health education.	intervention group delivered by LHWs who had not received additional training on CBT techniques.	Brief Disability Questionnaire Measures taken at baseline, 6 months and 12 months.	into the routine work of LHWs more than halved the rate of depression in prenatally depressed women compared with those in the control group. In addition to symptomatic relief, the women had better social functioning. Results were sustained after 1 year.
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IPT Based Interventions

Toth et al (2013)	USA	128 non-treatment seeking economically disadvantaged women with children and depression were recruited from the community. Mean age 25.4. 76 AA, 49 Caucasian, 25	Interpersonal Psychotherapy (IPT): 14 weekly 1-hour sessions. Interpersonal orientation, with a focus on improving client's ability to cope with, adapt to, and improve their social environment. Flexibility of treatment site was given to	Enhanced Community Standard (ECS): actively offered services typically available in the community (medication; support groups; family/marital counselling; day treatment).	CES-D DIS-IV BDI-II HDRS-R Baseline, post-intervention and 8 month follow-up	Women receiving IPT had significantly fewer symptoms post-intervention compared to those in ECS group, and these gains were retained at the 8-month follow-up. 84% of participants completed all 14
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		Hispanic, 3 Other.	reduce stigma. Avoided use of the word 'depression'.			sessions.
Grote et al (2009)	USA	53 women from a public care outpatient obstetrics and gynaecology clinic with peri-natal depression. 33 AAs, 15 Caucasian, 2 Latina and 3 other. Mean age 24.3 (IPT), 24.7 (EUC).	Multi-component IPT: engagement session including MI and ethnographic interviewing and addressing barriers to engagement. 8 sessions with BA between sessions. Bi-weekly or monthly maintenance IPT sessions were provided for up to 6 months. Free bus passes, childcare and access to social services was given. Sessions were provided in the gynaecology clinic to reduce stigma.	EUC: given written educational material and encouraged to seek treatment. Provided free bus passes etc. Social worker was also contacted and asked to encourage referral to treatment.	EPDS BAI SAS Measures obtained before childbirth, 3 months after baseline and 6 months postpartum.	Those in the IPT group gained significantly greater reductions in depression diagnoses and symptoms at all time points. 68% of the IPT group completed full course of treatment (7-8 sessions). Outcomes were maintained at 6 months post-partum.
Problem Solving Therapy						
Ell, Katon, Xie and Lee (2010)	USA	387 patients with diabetes and a score of more than 10 on the PHQ-9. 318 were women. 279 participants aged 50+. 352 were not born in the USA.	12 month intervention based on a stepped care algorithm. Participants began the program with problem-solving therapy (PST) and/or antidepressants (Step 1). Participants who had not	EUC: standard clinic care and patient and family focused educational pamphlets. Patients were also given service and resource lists, could receive	SCL-20 PHQ-9 SF-12 BSI Measured at baseline, 6, 12, and 18 month follow-up/	The intervention group had significant reductions in symptoms and improvements in emotional and functional outcomes compared with

			<p>responded to treatment by week 9 had the addition of antidepressants, PST, or a different antidepressant (Step 2). Once patients had a full response to treatment (Step 3), they were moved to maintenance, relapse prevention and telephone monitoring. Sociocultural enhancements: psychoeducation; sessions tailored to literacy levels; focus on coping with economic stress.</p>	<p>anti-depressants and be referred to community mental health care.</p>		<p>enhanced usual care. Participants had significantly higher rates of participation to PST, increased adherence to medications and a high degree of treatment satisfaction despite difficulty in recruiting ethnic minorities.</p>
Ell et al (2011)	USA	<p>472 patients with depression symptoms recruited from oncology clinics. 399 Female. Majority (415) Hispanic.</p>	<p>IMPACT (Improving Mood-Promoting Access to Collaborative Treatment). Personalised treatment plans that included patient's preference for antidepressants or PST. PST addressed four rational problem-solving skills aimed at the recovery of adaptive coping responses in 6-12</p>	<p>Standard oncology care from treating oncologists. Educational pamphlets were provided and a list of financial, psychosocial, transportation and childcare services.</p>	<p>PHQ-9 FACT-G BSI BPI Baseline, over 12 months, 18 months and 24 month follow up.</p>	<p>At 24 months, 46% of patients in the intervention group, and 32% in the control group had 50% + reduction in symptoms. Significant differences between those who received counselling or PST disappeared at 24 months.</p>

sessions. Telephone help was provided when necessary. Up to 12 months after treatment patients received monthly phone calls to monitor symptoms and 1-2 booster sessions.

Multi-Component Intervention

Rojas et al (2007)	Chile	230 mothers with major depression, attending postnatal clinics. Mean age 26.6	Multicomponent Intervention (MCI): Psychoeducational groups and structured pharmacotherapy. Group sessions weekly for 8 weeks. Sessions based on BA, problem-solving and cognitive techniques. Childcare was offered.	TAU: all services usually available at clinics (antidepressants; brief psychotherapeutic interventions; medical consultations or external referrals).	EPDS Baseline and 3 and 6 months.	Large significant clinical improvements for mothers who had moderate or severe depression in the MCI group compared to those in the TAU group. Differences disappeared at 3 months, but gains in the MCI group remained better at 6 months.
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Notes: Patient Health Questionnaire (PHQ-9) (Kroenke and Spitzer, 2002); Hamilton Anxiety Rating Scale (HAM-A) (Hamilton, 1959); QIDS-SR (Quick Inventory of Depression Symptomatology – Self Report) (Rush et al, 2003); Centre for Epidemiologic Studies Depression Scale Revised (CES-D) (Eaton, Muntaner, Smith, Tien and Ybarra, 2004); Beck Depression Inventory (BDI-II) (Beck, Steer and Brown, 1996); Duke Health Profiles (Parkerson, Broadhead and Tse, 1990); Structured Clinical Interview for DSM-III-R Personality Disorder (SCID-II) (First, Gibbon, Spitzer, Williams and Benjamin, 1997); Hamilton Depression Rating Scale (HDRS) (Spitzer, Williams, Gibbons and First, 1991); Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960); Symptom Checklist (SCL-90) (Derogatis, Rickels and Rock, 1976); Brief

Disability Questionnaire (Von Korff, Ustun, Ormel, Kaplan and Simon, 1996); Social Adjustment Scale (SAS) (Weissman and Bothwell, 1976); Brief Symptom Inventory (BSI) (Derogatis and Melisaratos, 1983); Short Form Health Survey (Stewart, Hayes and Ware, 1988); Functional Assessment of Cancer Therapy – General (FACT-G) (Cella et al, 1993); Symptom Checklist (SCL-20) (Derogatis, Lipma, Rickels, Uhlenhuth and Covi, 1974); Diagnostic Interview Schedule for DSM-IV (DIS-IV) (Robins, Cottler, Bucholz and Compton, 1995); Brief Pain Inventory (BPI) (Cleeland and Ryan, 1994); Behavioural Activation Scale, from the BADS (Kanter, Rusch, Busch and Sedivy, 2009); Beck Anxiety Inventory (BAI) (Beck and Steer, 1990).

Data Analysis

Despite the fact that all of the included papers were quantitative, a meta-analysis was not appropriate to review findings due to the heterogeneity of the papers (Higgins and Green, 2011). Sources of heterogeneity included sample characteristics (e.g. depression as primary concern; depression secondary to health concerns; peri-natal depression); use of a range of different therapeutic approaches; use of different statistical analyses. Subsequently, a narrative synthesis was used to summarise the results.

The studies and results have been divided into ‘pilot and feasibility studies’ and ‘intervention and outcome studies’. Pilot and feasibility studies provide an insight into new and novel approaches that are not yet widely used, and do not have a strong evidence base. Intervention and outcome studies provide more robust data on the use of established therapeutic approaches that have often been adapted in order to aid their use with low-income populations. These studies have been further grouped by therapeutic approach (CBT, IPT, PST or Multi-Component), and the therapeutic and practical adaptations to each approach have been discussed.

Results

Characteristics of Included Studies

A brief outline of the characteristics of the 16 included studies is provided in Table 1. All of the studies are quantitative. Eleven studies are Randomised Control Trials (RCTs), two are small-scale pilot studies, one is a cluster RCT and one is a comparative study. A majority of the studies were conducted in the USA (12 studies), with the remaining taking place in Pakistan (1 study), Chile (1 study) and Mexico (1 study).

Pilot and Feasibility Studies

These five studies are all small pilot or feasibility studies. The mean number of participants recruited to each study was thirty-two, and three of these studies focus solely on interventions for depressed low-income women. All of the studies were conducted in the USA. Three of the studies investigate the

efficacy of an adapted form of CBT, one uses an Interpersonal Therapy (IPT) approach and the last combines Schema Therapy (ST) with Motivational Interviewing (MI). Given the small sample sizes of pilot and feasibility studies, results are not generalisable. In addition to this, quality scores vary, ranging from 14-20. Despite this, these papers present some interesting and novel approaches that may warrant further research.

One of the main methodological issues identified within these studies was the operationalisation of low-income, with a number of studies failing to describe how participants were identified as low-income, or including participants who were not considered to be low-income (Himelhoch et al, 2013; Heileman, Pieters, Kehoe and Yang, 2011). In addition to this, inclusion and exclusion criteria were often unjustified, further reducing generalisability. For example, the study conducted by Perez-foster (2007) excluded women who did not have an grade reading level (equivalent to year 9 in the UK). It is likely that a large proportion disadvantaged adults have not attained such a high reading level (Department for Business, Innovation and Skills, 2013), and therefore this greatly reduces the generalisability of the study. Himelhoch et al (2013) also excluded patients who were not interested in the study due to the possibility of being randomised to the face-to-face condition, despite the fact that these are the very people for whom this therapeutic approach may have been most useful.

Despite the small sample sizes, two of the pilot studies demonstrated good methodological rigor (Beeber et al, 2003; Perez-Foster, 2007). In addition to this, the study conducted by Perez-Foster (2007) recruited homeless women as participants, providing an insight into the use of therapy with some of the most deprived of the low-income population. Furthermore, the approaches used are novel, such as the use of mobile phones to deliver interventions (Aguilera and Muñoz, 2011; Himelhoch et al, 2013), or the incorporation of novel therapeutic approaches, such as collaborative mapping (Heileman, Peters, Kehoe and Yang, 2011).

Intervention and Outcome Studies

The ten clinical trials included within this section consist of eight RCTs, one cluster RCT and a comparison study. The mean sample of these studies is

258. A majority of the studies (7) were conducted in the USA, one in Mexico, one in Pakistan and one in Chile. The studies are of varying quality (range 15-22), with a mean quality score of 19. The studies have been organised by therapeutic approach (5 CBT, 2 IPT, 2 PST and one Multi-Component Intervention), and are further discussed in relation to the therapeutic and practical adaptations that have been made for low-income populations.

CBT Based Interventions

Five clinical trials investigated the efficacy of a CBT based intervention. These studies are of a low to high quality (range 15-19). A total of 1,559 participants were included in these studies (mean 311). Three of the studies were conducted in the USA, one in Mexico, and one in Pakistan.

As previously mentioned, quality within these studies is compromised by sample characteristics, leading to a lack of generalisability. Four of these studies either did not specify how participants were known to be low-income or included participants whose income suggested that they would not be considered low-income (Miranda et al, 2006; O'Mahen et al, 2013; Lara, Navarro, Rubí, and Mondragón, 2003; Rahman et al, 2008). For example, in the study conducted by Miranda et al (2006) participants were described as 'below, or near the poverty line', with 33 of the participants described as 'not impoverished', and in the study by O'Mahen et al (2013) some of the participants included are stated as having incomes in the region of \$60-80,000 per annum.

Quality was further reduced by a lack of internal validity, such as a lack of adherence to the intervention and assessor bias (O'Mahen et al, 2013; Miranda et al, 2003; Lara, Navarro, Rubí, and Mondragón, 2003). For example, in the study conducted by Miranda et al (2003) the addition of supplemental case management improved outcomes in functioning and depressive symptoms for Spanish speaking patients but not for English speaking patients. As noted by the authors, this finding is likely due to a lack of adherence to the intervention, with Spanish speaking participants receiving more home visits than their English speaking counterparts.

Overall, the quality of CBT studies falls in the average range, but is of lower quality than studies investigating the use of IPT and PST. The studies presented here suggest that CBT may be a useful treatment approach with low-income adults with depression; however a stronger evidence base is needed.

IPT Based Interventions

Two of the studies included in this review investigated the use of an IPT based intervention with low-income women with depression (n=181). They are both RCTs conducted in the USA.

The two studies investigating the use of IPT are of high quality, scoring 20 and 22 on the quality assessment. These studies suggest that IPT could be an effective treatment for depression for low-income adults. The study conducted by Toth et al (2013) also produced one of the highest retention rates, with 84% of participants completing all 14 sessions of treatment. Further research is needed to build upon these results.

PST Based Interventions

The two studies investigating the effectiveness of an intervention based on Problem Solving Therapy included low-income men and women with depression and a health condition (diabetes and cancer). Both of the studies use what is known as a 'stepped care algorithm', whereby patients have a choice of first-line treatment, and treatment changes are made based on ongoing progress. Both of the studies are RCTs conducted in the USA, with high quality scores (19, 20). There are 859 participants included in these studies in total.

Again, the two studies presented here are of good quality, and results suggest that PST could be a useful intervention for low-income adults with depression. However, given that both papers were led by the same principal author, and the follow-up data provided by the second paper (Ell et al, 2011) showed a loss of significant differences between the intervention and control group at 24 months, further research on the use of PST with this population is needed.

Multi-Component Intervention

The final intervention study was conducted in Chile, by Rojas et al (2007). This study scored highly on the assessment tool (20/22). However, this study demonstrated a lack of control of the independent variable, with the intervention containing a number of different treatments (including pharmacotherapy), meaning that it is difficult to ascertain the effects of isolated components. For this reason, further research would be needed to understand the benefits of the intervention used.

Conclusions

Pilot and Feasibility Studies

The studies included in this section are preliminary studies, and therefore the scope for drawing conclusions is limited. However, two of the studies (Beeber et al, 2003; Perez-Foster, 2007) were methodologically robust, despite their small size. Both of these studies integrate mental health treatment into existing services (homeless shelters; in-home visitations). This type of integration is further discussed in relation to the outcome and intervention studies. The study by Heilemann et al (2011) is the only study in the review to use schema therapy. Results from the feasibility study are promising, with 8/9 participants completing all sessions, and exhibiting significant improvements. Schema therapy is an intervention that could be further investigated for use with low-income populations.

The use of technology in the delivery of interventions, as presented by two of the pilot studies, may warrant further investigation as a feasible adaptation or enhancement to treatment for low-income populations. The studies conducted by Aguilera and Muñoz (2011) and Himelhoch et al (2013) use telephone communication as a way of delivering or enhancing their interventions. Text messaging as an adjunct to CBT appeared to be well received by participants, with positive qualitative data being received. In addition to this, CBT delivered by phone was found to provide similar outcomes to face-to-face therapy, with the added benefit of increasing medication adherence.

Mobile phones are an accessible and affordable means of communication, and are widely used in both developing and developed countries, with 95% of countries in the world having mobile phone networks (Cole-Lewis and Kershaw, 2010). Text messaging, video messaging and voice calling have been used in therapeutic interventions, as a means of prevention, treatment, increasing medication adherence and monitoring outcomes (Cole-Lewis and Kershaw, 2010; Mohr et al, 2005).

In addition to this, the widespread use of mobile phones is also providing access to the Internet for many who would otherwise be unable to get online (Cole-Lewis and Kershaw, 2010). With the growing use of mobile phones, tablets and computers, and the emergence of applications that can provide psychoeducation, self help guides and treatment programs, there are serious implications for the development of mental health service delivery. One of the main benefits for the use of technologically based therapies over face-to-face therapies for low-income populations is the scope to overcoming barriers such as childcare, transportation and stigma. The use of such interventions is beginning to be documented, an example being the growth in the use of mHealth (mobile health care) (Price et al, 2014). There is a paucity of data regarding the effectiveness of interventions delivered via phone, text or Internet, particularly in relation to low-income, or minority populations.

Intervention and Outcome Studies

Overall 8 of the 15 studies are considered to be high quality, with a further 5 falling in the average category. The studies included in this review utilise a number of different therapeutic approaches, with varying sample characteristics, making it inappropriate to make conclusive arguments for specific therapeutic interventions for low-income populations. Samples include men and women, from a number of different ethnic minorities, some of whom also have chronic health problems (e.g. diabetes and cancer). Four of the studies were aimed at mothers with children and peri-natal depression.

There are a number of ways in which the literature regarding interventions for low-income populations could be strengthened and improved, and there are significant gaps that need to be addressed. Available literature suggests that

mainstream interventions, such as CBT and IPT, can be modified in ways to make them effective in reducing depression in disadvantaged adults. A majority of these adaptations aim to reduce the barriers to care which cause poor engagement and retention. Overcoming barriers to care appears to be most important in creating interventions that are acceptable and effective for low-income populations. The literature does however show that although overcoming barriers is necessary for engagement, it is not in its self sufficient, and further adaptations and considerations are required.

A summary of adjustments and adaptations used in the included studies will be described, followed by a description of the main limitations of the literature, and suggestions for improving future research.

Adaptations to Interventions

Low-income populations face a number of significant barriers to care, including logistical barriers (e.g. childcare, transport, working hours, multiple jobs), and social and psychological barriers (e.g. stigma, perceptions of services). A number of the studies included utilise approaches aimed at reducing the impact of these barriers. It has been suggested that those studies that do not make a concerted effort to address such barriers have higher levels of attrition (O'Mahen et al, 2013), and those that do address barriers have better outcomes (Levy and O'Hara, 2010). The following is a summary of the adaptations made.

1. Embedding Services Outside of Mental Health

Three of the studies placed their interventions outside of specialty mental health care and within existing community services (O'Mahen et al, 2013; Grote et al, 2009; Rahman et al, 2008). For example, in the study conducted by O'Mahen et al (2013), mental health services were provided within an Obstetrics clinic that was already attended by the participants. Placing mental health interventions within existing public health clinics serves a number of purposes. Firstly, the services are already known and accessed by the local community, reducing fears about attending an appointment in an unknown environment, with unfamiliar faces. Secondly, concerns about stigma are reduced, as individuals are

not seen to be accessing mental health services. Thirdly, if patients already have to attend clinics, appointments can be arranged in concordance, hopefully resulting in higher levels of attendance, as patients are already required to be in the building.

The stigma surrounding mental health is an international concern. The World Health Organisation's (Hopper, Harrison, Janca and Sartorius, 2007) International Study of Schizophrenia (ISoS) suggested that the differential outcomes witnessed for those with serious mental health issues are in part caused by variations in cultural norms, attitudes and behaviours to mental illness across countries (Hopper, Harrison, Janca and Sartorius, 2007). Outcomes for schizophrenia were preferable in developing countries, where there were higher levels of poverty, and less access to mental health services. Research has not yet provided a reason for this result, however a number of suggestions have been made, such as the effect of collectivistic versus individualistic societies, and subsequent differences in social acceptance, support, family cohesiveness and variations in expressed emotion (Kulhara, 1994)

It has further been suggested that individuals from ethnic minorities may be reluctant to access care in traditional mental health settings due to fear and mistrust stemming from historical persecution and racism (Santiago, Kaltman and Miranda, 2013). Interventions that have overcome this barrier have integrated well into community settings and shown high levels of engagement and retention (Grote et al, 2009; Miranda et al, 2003; Perez-Foster, 2007). Research has shown that although racial and ethnic matching between client and therapist does not have a significant effect upon treatment outcome, matching is something that most people from ethnic minority groups would prefer (Shin et al, 2005). If services are seen to be present within an ethnic minority community, delivered by practitioners who are active and known within the community, this may increase accessibility. Further to this, it is likely to be beneficial to recruit practitioners who fully understand the cultural and health needs of a community to increase cultural competency.

2. Omitting the word 'Depression'

Two of the studies included in this review have avoided the use of the word 'depression', and instead used words such as 'worries' or 'stresses', in order to avoid the negative associations and stigma that may cause disengagement (Toth et al, 2013; Grote et al, 2009). Individuals who have been given mental health diagnoses often experience stigma from both professionals and non-professionals (Sartorius, 2002). The prejudices associated with certain diagnoses such as depression, may prevent people from accessing services. This may be particularly pertinent among low-income and ethnic minority populations, where attitudes towards mental health issues and mental health services may be more ambivalent (Diala et al, 2000). This is also important when considering the differences in the conceptualisation of the word 'depression' across cultures, and difficulties in translation. It may be that by avoiding the use of western diagnostic labels, individuals may find it more acceptable to access services (Lawrence et al, 2006).

3. Engagement Sessions

Difficulties faced by clinicians in engaging and retaining low-income populations in therapy are well documented (Levy and O'Hara, 2010). One way in which studies have attempted to address this issue is through the addition of engagement sessions and additional educational meetings (Grote, 2009; O'Mahen et al, 2013; Miranda et al, 2003). The primary aim of an engagement session is to help individuals acknowledge their symptoms and problems, and consider the causes and consequences of these. This is done through the gathering of information, which can also serve as an opportunity to begin the development of a therapeutic alliance. An important component of engagement sessions is to elicit an individual's goals for treatment, and also facilitate discussions around barriers to the achievement of these goals, or engagement in general. Clinicians can then problem solve with clients to identify solutions to these barriers.

Psycho-education can be interwoven with engagement sessions, or be offered as sessions within themselves. Teaching individuals about the causes, prevalence and signs of illnesses like depression allows for a fuller understanding of mental health issues, serving as an intervention in its own right, whilst also empowering patients (Bäumel, Froböse, Kraemer, Rentrop, and Pitschel-Walz, 2006). Research has documented the benefits of psychoeducational interventions

for individuals with schizophrenia, with results suggesting improvements in the clinical course, treatment adherence and psychosocial functioning of patients (Batista, Baes and Juruena 2011; Colom et al, 2003). There is minimal literature on the use of psychoeducation in the treatment of depression, however a recent review suggests similar benefits for depressed populations (Tursi, Baes, Camacho, Tofoli and Juruena, 2013).

Feelings of ambivalence, and a lack of motivation for change have been identified as significant barriers to care for low-income populations (Lara et al, 2003). Some studies have incorporated aspects of motivational interviewing and ethnographic interviewing within their initial sessions in order to enhance the engagement process (Grote et al, 2009; O'Mahen et al, 2013). These studies have still experienced high levels of attrition. Despite this, motivational interviewing in particular has been shown to be successful in engaging low-income families in treatment (Ingoldsby, 2010). In addition to this, ethnographic interviewing is a useful way in which to elicit information about a person's culture, in order to understand how best to adapt interventions to make them more accessible. There is further evidence to suggest that openly addressing any evident difference and diversity within therapy facilitates engagement (Jackson-Gilfort, Liddle, Tejada and Dakof, 2001; Kim and Cardemil, 2012).

4. Active Outreach and Flexibility

Four of the studies included in this review employed an Active Outreach strategy (O'Mahen et al, 2013; Miranda et al, 2003; Grote et al, 2009; Ell, 2011). In the study conducted by Miranda et al (2003), the addition of case management (including active outreach from referral) to a CBT intervention increased engagement from 66% to 76%. Studies employing an active outreach strategy had higher levels of treatment engagement and completion than those that did not. Active Outreach included multiple reminder phone calls; flexible appointment re-scheduling; maintaining positive contact with family members/friends who could support attendance; flexible site delivery; sessions conducted over the phone if needed (O'Mahen et al, 2013; Grote et al, 2009). In addition to this, treatment was frequently offered at home if there were difficulties or reservations about attending a clinic. In the study conducted by Toth et al (2013) 84% of participants completed a full course of treatment, with 85% of these sessions taking place

outside of the clinic. These results suggest that flexibility of delivery site may be crucial to retaining low-income patients in treatment. It is likely that there are individual preferences about delivery site based on a person's subjective situation, however evidence does suggest that home-based interventions are preferred by populations who would not usually seek services for themselves (Leis, Mendelson, Tandon and Perry, 2008).

5. Language and Accessibility

A number of the studies reported adaptations to the materials used within their intervention in order to make them more accessible for low-income populations (Lara et al, 2003; Miranda et al, 2003; Toth et al, 2013; Ell et al, 2010). This included ensuring that language was simplified where necessary, and at times replaced with images or cartoons. Adults living in disadvantage are more likely to have lower levels of education (Santiago, Kaltman and Miranda, 2003). Interventions must be accessible for adults who may have lower literacy and reading levels. Failure to ensure that material is accessible will result in low levels of engagement and worse outcomes.

Further efforts are made by investigators to provide multi-lingual interventions (Grote et al, 2009; Miranda et al, 2003; Lara et al, 2003). Given that ethnic minorities are over-represented within low-income populations (American Psychological Association, 2015), the need for interventions that can be effectively delivered cross-culturally is essential. A recent meta-analysis exploring effective cross-cultural interventions reported that interventions created to target a specific cultural group were four times more effective (Griner and Smith, 2006). In addition to this, interventions delivered in the client's first language were twice as likely to deliver good outcomes (Griner and Smith, 2006). This is often unattainable for services that may not have access to bi-lingual clinicians, and therefore the use of interpreters is an essential component of delivering culturally competent care (Anderson et al, 2003).

6. Addressing Difference and Diversity

Factors such as race, culture, sexuality, gender, disability and income-level, intersect with poverty in the construction of identity (Kim and Cardemil,

2012). It has been suggested that by ensuring that attention is explicitly paid to all aspects of an individual's identity, and their subsequent challenges and needs, patients will feel providers are more likely to understand their circumstances (Grote et al, 2009). This requires a thorough assessment, with issues of diversity being sensitively but openly discussed between the client and clinician. Following from this, treatment can be enhanced by incorporating relevant factors into treatment. Examples from studies within this review include an added gender perspective to address women's position in communities (Lara et al, 2003), behavioural activation that focuses on the use of cheap or free activities (Miranda et al, 2003), and the inclusion of family in interventions (Rahman et al, 2008).

Class competence is particularly pertinent to working with low-income individuals, particularly when there is an economic disparity between clinicians and their clients. In these scenarios, service users can often feel that there is no way that they could ever be understood by someone who appears to be so different to themselves. This has been evidenced by a qualitative study conducted by Thompson, Cole and Nitzarim (2012) who used a grounded theory approach to explore the experiences of low-income adults within a psychotherapy relationship. The results pointed to the importance of acknowledging social class within therapy, which resulted in patients feeling understood and accepted. Further to this, Goodman, Pugach, Skolnik and Smith (2013) have made suggestions for increasing cultural competence amongst providers, which includes: considering awareness of own social class; awareness of assumptions about poverty, class and therapy; knowledge of poverty's psychosocial impact; and knowledge of effective interventions for addressing the negative effects of poverty.

7. Overcoming Practical Barriers

A majority of the studies included offered a number of additional services for overcoming practical barriers to care (Siddique et al, 2012; O'Mahen et al, 2013; Miranda et al, 2003; Toth et al, 2013; Grote et al, 2009; Rojas et al, 2007). Adaptations included offering childcare; providing free transportation; bus passes; access to social services (to identify sources of food, job training, housing and baby supplies). Most of these studies have good levels of retention and engagement. Addressing practical barriers to care is inherently important in this population, and studies that fail to do so demonstrate high levels of attrition (Levy

and O'Hara, 2010). As previously mentioned, although addressing such barriers is essential to engagement, it is not in itself sufficient.

8. Adopting an Advocacy Role

It has been suggested that clinicians working in poverty stricken communities need to improve their practice by integrating advocacy into their roles (Goodman et al, 2013). This is controversial to some psychologists who might argue that this is not within their remit, and that such work may interfere with the therapeutic frame and blur boundaries (Jordan and Marshall, 2010). Five of the studies included here provide advocacy in the form of making referrals, linking clients with local services, and providing resource lists (Siddique et al, 2012; Miranda et al, 2003; Toth et al, 2013; Grote et al, 2009; Ell et al, 2010). These services however were not always provided by the lead clinicians, and instead were more frequently provided by social services. By providing clients with the resources they need to meet their basic needs, individuals are hopefully being empowered to provide for themselves and their families. Similarly to Maslow's (1943) hierarchy of needs, a person must meet their lower level basic needs before progressing on to meet higher-level growth needs. By addressing service user's most basic needs, it is more likely that they will be able to attend to their psychological health (Levy and O'Hara, 2010).

9. Follow Up Sessions

Four of the included studies provided 'maintenance' or 'booster' sessions following the end of treatment (Siddique et al, 2012; Grote et al, 2009; Ell et al, 2010; Ell et al, 2011). These were provided in the form of additional therapeutic sessions, telephone monitoring of symptoms, or a continuation of therapy for a longer period. The aim of booster sessions following an intervention is the maintenance of treatment-induced behaviour change (Whisman, 1990). The studies that have used maintenance sessions suggest that such sessions may be effective in retaining treatment gains to follow-up. This may be particularly important for low-income populations, as despite having completed a course of therapy, it is unlikely that environmental stressors will have significantly reduced. Follow up sessions may provide reminders about coping with adverse circumstances. The importance of providing a 'good ending', regardless of the

therapeutic approach, is vital in ensuring a lasting positive impact, not only in terms of treatment gains, but also in instilling feelings of accomplishment and solidifying positive associations with clinicians and services (Davis, 2008).

10. Providing Choice

Finally, it has been suggested that including people in decisions about their care, such as type of treatment, or number of sessions etc. may be linked to improved adherence and clinical outcomes, and also goes some way in providing culturally acceptable care (Ell et al, 2010; Levy and O'Hara, 2010). Two of the studies included provide an intervention based on a stepped care algorithm, which allows participants to choose their first-line treatment, which is then monitored and changed if it is proving ineffective (Ell et al, 2010; Ell et al, 2011). Stepped care models are being proposed as a means of potentially increasing the efficiency of service provision in order to overcome the current gap between demand and supply in mental health services (Bower and Gilbody, 2005). These models require further investigation, however the prospect of providing choice of treatments is supported by current legislation surrounding mental health service provision in the UK (Department of Health, 2012), and may provide a number of benefits for working with low-income populations, such as minimising power differentials, providing empowerment, and increasing acceptability of care.

Discussion

This is the first review to summarise the existing literature on effective interventions for both low-income men and women with depression. The aims of this review were to identify effective interventions for low-income populations, and any ways in which interventions could be adapted to make them more accessible and acceptable. The findings of this review suggest that mainstream interventions, such as CBT, IPT and PST can be adapted to be effective with low-income populations.

Despite this, there are certain adaptations that appear to be essential to making mental health treatment accessible to low-income populations, such as active outreach, flexible treatment delivery and overcoming practical barriers to

care. It is also evident however, that these adaptations on their own are not sufficient, and there are further efforts to be made, such as providing culturally competent care. This is supported by the findings of a similar review conducted by Levy and O'Hara (2010), which investigated effective interventions for low-income women with depression.

In many ways, the results formed from this literature review present good recommendations for work with any client group, not just those with a low-income. For this reason, it is interesting to reflect on how psychological interventions with people from low-incomes really differ from that of the general population. It may be that framing research and services in this way adds to division, and a sense of 'them and us'. Statistics suggest that people from low-income communities are harder to engage, and that there are barriers to care, however this is also true of many other client groups, such as the male population, ethnic minorities, and army veterans. It is important that 'an inability to engage in psychological interventions' is not another label assigned to 'low-income' groups.

Despite this, the psychological consequences of disadvantage are undeniable, and mean that many vulnerable people with low-incomes are in need of emotional (and practical) support. This is particularly pertinent at a time when a recent global financial crisis has led to austerity policies that involve significant cuts to welfare - disproportionately affecting those already in need. Regardless of the availability of individual interventions for those already in poverty and struggling with the psychological consequences of this, more needs to be done to understand and address the psychological issues such as stigma, shame, mistrust, insecurity and isolation, that are so prevalent in disadvantaged communities (Psychologists Against Adversity, 2015). It seems that a community psychology approach would be useful to understand how societal constructs of low-income populations impact upon the distress caused by poverty.

Further to this, more could be done to prevent people from insecurity and disadvantage. Psychologists are well placed to understand the detrimental effects of poverty on peoples' health and wellbeing. Worrying statistics show that suicides have increased in European countries where cuts to the welfare state have been made, but not in those countries where it has been protected (Karanikolos et

al, 2013; McKee, Karanikolos, Belcher, Stuckler, 2012). It has been noted, that as professionals, we hold a position of power, and have a subsequent responsibility to speak out about the damage caused by welfare cuts (Psychologists Against Austerity, 2015). This damage is caused not only by the cuts themselves, but also in the depiction of people who receive welfare payments, which perpetuates stigma and unnecessarily increases distress. This is something that needs to change.

Strengths, Limitations and Areas for Further Research

Efforts have been made to ensure that all of the studies published from January 2000 to November 2014 that have investigated treatment for current depression in low income populations have been included. Four databases were used, meaning that the criteria for conducting a comprehensive literature search, as stated within the Assessment of Multiple Systematic Reviews (AMSTAR; Shea et al, 2007), was met. Despite this, authors were not contacted for information regarding additional relevant papers. Additionally, by excluding papers that were published prior to the year 2000, some relevant research could have been missed. It should be considered that the reliability of the checklist may have been affected by the modifications made for the purpose of this review.

The generalisability of the results presented in this review are limited for a number of reasons. Firstly, by excluding studies with samples of older adults, and studies investigating the treatment of anxiety in low-income populations, further useful insights into interventions with this population may have been missed. Furthermore, a large majority of the studies reviewed, excluded participants who had co-morbid mental health problems, or issues with substance misuse. People living in disadvantage are considerably more likely to have co-morbid mental health diagnoses, and misuse alcohol and drugs (Santiago, Kaltman and Miranda, 2003). By excluding these participants, samples are less representative of a low-income population.

Secondly, this review was the first to include studies with samples of both males and females. Despite this, the overall sample of the included studies is overwhelmingly female, with only five studies including men, and an overall sample of 211 men compared to 2,779 women included in the review (14% of the sample). This is concerning, particularly given that in the USA, where a majority

of the studies included in this review were conducted, the suicide rate among men was 27.3 per 100,000 compared to 8.1 per 100,000 for women between 2005 and 2009 (Centers for Disease Control and Prevention, 2014). It has been noted that mental health research has focused on women, due to their high rates of diagnosed mental illnesses (Riska, 2009). This has left the area of men's mental health understudied, and subsequently there is little understanding of men's gendered experience of mental health (Riska, 2009). There is clearly work to be done in finding ways to engage men in mental health interventions and research.

Finally, there are vast differences in the provision of mental health services internationally, as well as cultural differences in perceptions of mental health problems and how they are treated, making comparability difficult. A majority of the studies included were conducted in the USA. The findings presented here need to be viewed with this in mind. Despite this, during the past decade, a number of studies from culturally distinct, and resource-constrained countries have demonstrated the effective treatment of depression. This research includes studies described in this review conducted in Chile, Mexico and Pakistan. A further study has been conducted in Uganda, which used Group IPT to reduce depressive symptoms among HIV stricken communities (Bolton et al, 2003). This suggests that interventions such as CBT, IPT and PST are feasible, and potentially effective when applied across cultures. Despite this, further research internationally is needed.

When drawing upon this research it is difficult to form exact conclusions, or isolate the precise components of interventions or adaptations that made interventions more or less effective, due to the heterogeneity of both samples and therapeutic approaches used. This is a difficulty for all studies attempting to investigate the efficacy of interventions with low-income populations, as disadvantage affects a diverse range of people, where 'low-income' may be the only unifying factor of many other variables. There have been large-scale research studies conducted, such as the World Health Organisation's 'Collaborative study on determinants of outcome of severe mental disorders' (Jablensky et al, 1992), and the International Pilot Study of Schizophrenia (Hopper, Harrison, Jablanca and Sartorius, 2007) that have highlighted the impact of culture on mental health outcomes. Understanding the complexities in the interactions between culture,

class, mental health and subjective experience is a huge undertaking, and as such, further research is still needed.

This review was conducted in the UK. It is interesting that given the economic disparities in the UK, and subsequent significant levels of poverty (Department for Work and Pensions, 2014), that none of the studies included in this review were conducted in the UK. The National Health Service in the UK provides health and social care (including mental health) free at the point of access for all. Subsequently, paying for mental health interventions is not a barrier for low-income populations in the UK. Despite this, there are still significant barriers to care, and difficulties in engaging and retaining these populations in mental health services. This highlights the issue of inequality and access to healthcare, even when the barrier of financial cost is removed. Some causes that have been suggested include a lack of knowledge or information about available services among the public, and a lack of cultural competency amongst clinicians (Horner et al, 2004). Given that further research is needed to contribute to evidence of effective interventions for low-income populations, researchers in the UK could add significant contributions to the literature.

An issue that was highlighted in a number of papers in this review was the way in which 'low-income' was operationalised. Firstly, there were a number of studies that did not explain how participants were identified as having a low-income. Most of the papers that described their process identified their samples as low-income by their eligibility for welfare services, or Medicaid (federal-state program in the USA providing low-cost or free health care to categories of 'low-asset' people). Eligibility for welfare state programs is based on household income, relative to the number of people within a house, and the federal poverty level. There are some limitations in relying solely on measures of income as an indicator of deprivation. Level of income is an indirect measure of poverty, as it relates to potential resources, rather than the outcome – living standards. For example, consider someone may have a low-income, but live in and own a well-maintained, comfortable house, with friends and relatives nearby. It has been suggested that deprivation indicators can be useful for addressing the limitations posed by the use of income measures (Calandrino, 2003). Deprivation indicators aim to identify living standards by looking at the enforced lack of material goods

or social activities. If poverty is described as exclusion from adequate living standards (poverty) as a result of a lack of resources (low-income), then a better measure of deprivation would include both measures of income as well as measures of deprivation. This is something to consider in future research.

The overall quality of the studies included in this review is relatively good, with 8 studies being considered as 'high quality, and a further 5 as 'average quality'. Despite this, the heterogeneity of the studies means that it is difficult to draw conclusions, or identify individual components of interventions that may have been beneficial for the target population. Further good quality research is needed in order to create a larger evidence base, from which more robust conclusions may be drawn.

The review presented here provides a comprehensive description and assessment of the literature available regarding effective interventions for low-income populations. An 'a priori' design was adopted, and clear research questions, and inclusion and exclusion criteria were applied. Characteristics of included studies have been provided, and quality assessments have been conducted by both the lead investigator and a peer reviewer. The methods used to combine the findings of the included papers were not assessed, and the review may have benefited from the use of a random effects model to ensure that this was appropriate. Additionally, no assessment of publication bias has been conducted. Despite this, this paper presents a summary of the most up to date research in the area, and clear implications for practice, and directions for future research have been presented.

Conclusions

This review has identified a number of adaptations and adjustments that can be made to psychological interventions, such as CBT, IPT and PST in order to make them acceptable and effective with low-income populations. The current literature in this area is of a mixed quality, and more research is needed in order to strengthen the evidence base. There are also a number of issues that need addressing in order to improve the quality of future research, such as the operationalisation of low-income, and the lack of male participants in research. Despite this, there are a number of useful recommendations that can be drawn

from the literature, which should be considered in clinicians' work with low-income populations.

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Part Two

Empirical Paper

**An exploration of the aspirations and future orientation of adolescents from
low-income families**

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An exploration of the aspirations and future orientation of adolescents from low-income families

Abstract

This study used Interpretative Phenomenological Analysis to explore the future orientation and aspirations of young people from low-income families. There is currently a lack of research providing this population with a voice. Current literature suggests that young people living in low-income households are likely to have lower aspirations than their peers, and are subsequently more likely to be unemployed. Facilitating aspirations has been suggested as a possible means of preventing intergenerational cycles of low attainment and subsequent disadvantage. This study aimed to explore young people's perceptions of their aspiration formation, and perceived barriers and facilitators in the fulfilment of these. Ten young people were recruited from a local secondary school. Participants were asked to take photos with the instruction to show 'where you see yourself in ten years' time'. The resulting images provided the basis for semi-structured interviews. Three super-ordinate themes and nine sub-themes emerged from the data. Results suggested that the young people included had concrete and realistic ideas about what they wanted to do in the future, and were hopeful about their ability to achieve these things. These results are discussed in relation to their implications, and directions for future research are suggested.

Key words: *aspirations, future orientation, low-income, disadvantaged, adolescents, young people*

Introduction

National statistics on Households Below Average Income (HBAI) from June 2012, suggest that 27 percent of children (3.6 million) in the UK live in low-income households, defined as a household with a total income of less than 60% of the average (Department for Work and Pensions, 2007). Many of these children live in public housing, often within council estates, excluded from private housing, shops, jobs and opportunities, described condemningly as ‘social concentration camps’ (Dugan, 2009). Living in a low-income household is linked to poorer social, emotional and psychological outcomes for young people (Ridge, 2011; Lee, Hill and Hawkins, 2012). When investigating the longitudinal influence of select social demographic variables, Rojewski and Yang (1997) found that socio-economic status had a significantly higher effect on adolescent’s aspirations than any other factor. It has been suggested that young people who grow up in low-income households are less optimistic about their futures, with lower educational and occupational aspirations than their peers, more perceived barriers to success and a greater discrepancy between their aspirations and actual expectations (Cook et al, 1996; Mello et al, 2009; McLoyd, Kaplan and Purtell 2011; Berzin, 2010).

Research further suggests that aspirations in adolescence predict educational and occupational attainment, meaning that low-income youths may become stuck in an ‘inter-generational cycle’ of low aspirations, and subsequent poor attainment (Lee, Hill and Hawkins, 2011; Berzin, 2010; Rojewski and Yang, 1997). Despite this, research has shown that harbouring a more optimistic view of the future may enable greater educational attainment and employment outcomes, thereby facilitating social mobility (McLoyd, Kaplan and Purtell, 2008). It is therefore important to investigate the means by which young people from lower-income families form their ideas about the future, and how they consider that they may be supported or hindered in their realisation of these.

Future Orientation

The concept of future orientation is inextricably linked to, and derived from theories and models involving Aspirations and Expectations (Gottfredson, 1981), Hopes and Fears (Nurmi, 1989) and Possible Selves Theory (Markus and Nurius, 1986). Beal (2011) argues that whilst none of these theories or models are

identical in their construction of future orientation, there are a number of conceptual overlaps and common assumptions which allow for a shared definition. This includes the idea of future orientation as relating to the subjective construction of one's future (Seginer and Lilach, 2004). Adolescence is seen as a critical period for preparation to adulthood, when aspirations for the future are formed and explored (Beal, 2011; Hill et al, 2004).

The conceptualisation of future domain is commonly regarded as thematic in nature (Nurmi, 1989; Seginer and Lilach, 2004), with certain life domains: social relations (marriage and family) and higher education (work and career). Furthermore, these themes are classified in relation to their temporal distance as 'near' and 'far' future domains (Seginer and Lilach, 2004). For example, for some college might be a near future domain, whereas marriage and family might be considered a distant future domain.

Current Research

Participation in school is a key mechanism through which preparation for early adulthood takes place, and a time when children learn about their talents and preferences as a means of developing feasible career aspirations (Hill et al, 2004). During this time adolescents can develop an extended future orientation as they anticipate school completion and plan for their next steps (Beal and Crockett, 2010). A number of studies describe a change in adolescents' aspirations over time (Gottfredson, 1981; Beal and Crockett, 2010). Nurmi (1994) describes this as beginning with one's vague initial aspirations, which revolve around societal norms and parental expectations, and are later refined with growing knowledge of one's self-knowledge and strengths and weaknesses.

The role of parents in the determination of children's aspirations has been explored, with a focus on parental involvement in education (Astone and McLanhan, 1991; Rojewski and Yang, 1997; Mohr, Zygmunt and Clark, 2012). Crosnoe, Mistry and Elder (2002) reported that parents within low-income families held a more pessimistic view of their children's chances of succeeding academically, and were therefore less involved in their children's education. The impact of cross-cultural differences in parental aspirations for children have also

been investigated (Cooper et al, 1994, Hill et al, 2004; Hill, Ramirez and Dumka, 2003).

Amongst the limited research pertaining to young people's future orientation and aspirations in low-income families, there is a distinct lack of qualitative research investigating young people's own perceptions of their future aspirations. In addition to this, the research presented here employs a novel approach with the use of photo elicitation, with the aim of balancing power differentials between participants and researcher, and providing an opportunity for young people to bring things that are of importance to them to the interviews. The research aims for the present study therefore are:

1. How do young people from low-income families perceive their aspirations?
2. How do young people from low-income families consider their aspirations to be influenced and formed?
3. What do young people perceive as barriers or facilitators to achieving their aspirations?
4. What role does environment and wider context play in how young people from low-income families perceive their future?

Methodology

Design

Interpretative Phenomenological Analysis (IPA) was adopted for this study. IPA is a qualitative research approach which aims to explore how people make sense of their personal and social world by examining the meanings participants ascribe to particular experiences and events (Smith and Osborn, 2003). For this reason IPA can provide a useful insight into the subjective perception of the construction of young people's aspirations and future orientation. IPA acknowledges the dynamic between the participants' responses, and the researcher's interpretation of these (Smith and Osborn, 2003). The researcher has considered the effect of their own experiences and assumptions, and how this may have influenced the interpretation of results (See Appendices F and G for Epistemological and Reflective statements).

This study will also employ photo elicitation, which involves using photographs or films as part of the interview process (Margolis and Pauwels, 2011). This study will use auto-driven photo elicitation (images created and chosen by the participant), as empowering young people to create their own images allows them to decide what should be included or excluded from the photographic representations of their lives.

There are a number of documented benefits for the use of photo-elicitation when interviewing young people. Firstly, verbal interviews between adults and young people contain a power imbalance, with an expectation of the adult as authoritative within the communication (Epstein, Stevens, McKeever and Baruchel, 2008; Clark, 1999). Using photos within an interview may provide a way of minimising this power differential (Epstein, Stevens, McKeever and Baruchel) 2008), and a possible means of ‘breaking the ice’.

Semi-Structured Interview Schedule

The schedule for the semi-structured interview was developed following Smith’s (1995) recommendations, meaning that questions aimed to be open-ended, and attempted to encourage participants to narrate and reflect upon their views. Additionally, question ordering was less important, with freedom to explore the respondent’s interests or concerns. Questions were derived from concepts within Future Orientation, and current literature regarding aspirations.

Questions covered topics relating to aspirations in the life domains identified in Future Orientation. In line with future orientation, the value of aspirations and one’s expectation of achieving their aspirations (e.g. sense of internal control; support/barriers) were explored. Following the literature review, topics such as the influence of role models, parental expectations, environments, and socio-economic status were included.

When using IPA it is important that questions do not make too many assumptions about the participant’s experiences or concerns. Theory and literature were used to guide the interviewer in possible topics that may have been important to ask

about, rather than leading the participants in particular directions. The interview schedule was followed loosely, and served as a prompt when interviewing young people who were more reserved.

The interview schedule was piloted with a group of adolescents from a local charity supporting young people in need. The group were given information about the research, and asked about any topics or particular questions that they deemed to be important to the research area and study. The interview was considered acceptable by all young people, with an additional topic of the influence of extracurricular activities being suggested. Ethical Approval was granted by the University Ethics Committee (See Appendix H).

Procedure

Ten young people were recruited from a local secondary school. The researcher met with staff at school in order to identify students who met the inclusion and exclusion criteria. All participants were either currently on free school meals, or had been in the last three months (1 participant); were aged 15-17 years; and had English as a first language. Participants were excluded if they were currently involved with mental health services; were looked after children; had a learning disability or autism. Eligibility for free school meals required parents or carers to be in receipt of any one of a number of benefit schemes such as income support or job seekers allowance (as of April 2015).

A Student Services Administrator (SSA) randomly selected ten suitable students. Demographic characteristics are presented in Table 1. The researcher met with the students as a group at school in order to provide information about the project. Five students attended the first group and agreed to participate in the research. Eight more students agreed to take part in subsequent group meetings, of which three later dropped out. The main reason for drop out was lack of time due to examinations and personal circumstances. Once participants had expressed an interest in taking part, they were given information sheets, consent forms (for participants and parents), demographic questionnaires (See Appendices I-N), and digital cameras. The participants were given the instruction to “take photographs that show how you see your life in ten years time”. The instruction aimed to provide explicit guidance, as ‘future’ is an abstract concept. It is likely that in the

next ten years young people would complete education, begin work, and find meaningful relationships, and therefore this was a focused time frame for young people to consider.

Participants were asked to create 10 images they would like to discuss, and were given a time period of two weeks to do this. Participants were provided with contact details for the researcher in case they had further questions, or wished to withdraw from the research. The SSA organised interview times to take place during the school day. The school requested that the SSA was present during interviews. The SSA accompanied students to their meeting with the researcher, and then remained in the room, but did not contribute to interviews. The researcher explained confidentiality, anonymity and right to withdraw with students prior to the interview. Participants were also given a chance to ask any questions. Following the interview participants were provided with a debrief sheet, including the contact details of local services (see Appendix O).

Participant	Gender	School Year	Occupational Aspiration	Other Aspirations
1	F	Year 11	Accountant	Travelling; Fundraising
2	M	Year 10	Drama Teacher	Land Rover Evo
3	F	Year 11	Teacher	Marriage and Family
4	M	Year 11	Band; Teaching; Music shop	
5	F	Year 11	Play Specialist	BMW
6	M	Year 10	Medical Technician or Paramedic	Volvo X60
7	F	Year 11	Photographer	Travelling; Motorbike
8	F	Year 11	Animal Management	Owning a horse
9	M	Year 10	Mechanic; Army	BMW
10	M	Year 10	Building and Construction	

Table 1. Demographic Characteristics and Aspirations

Data Analysis Procedures

Interpretative Phenomenological Analysis (IPA)

Data analysis began with the reading and re-reading of transcripts. The importance of understanding the content and complexity of meanings is central to this type of research, and involves the researcher obtaining a sustained engagement with the pieces of text, and the process of interpretation (Smith and Osborn, 2003). Initial thoughts and comments were annotated as transcripts were collected (see Appendix P for example of coding). Initial themes were drawn from each transcript, and connections between these explored. Themes were read against the transcripts, and further refined in an attempt to reflect the participant's experiences. Sub-ordinate themes were grouped by the stories they seemed to tell, and super-ordinate themes were created. Finally, the results were written up – a process which allowed for further reflection and refinement of the themes.

Results

Nine themes emerged from the data (See Table 2), with three super-ordinate themes: 'it just happened', 'just being there' and 'expectations of success'. These themes and their sub-themes suggested that the participants had clear career and education oriented future aspirations, with a number of ideas about how these had been formed and influenced. The first super-ordinate theme reflects the participants' stories about how they had come to make decisions about their hopes for the future. The second super-ordinate theme reflects the ways in which participants felt they had been facilitated in forming their aspirations for the future, which led on to the final super-ordinate theme, which echoes the participant's expectations of their success. These themes will be described in more detail here.

Super-ordinate Themes	Sub-themes
It just happened	1. Strengths and interests 2. Family scripts 3. It's personal
Just being there	4. Being there 5. Helping practically 6. Not giving up
Expectations of success	7. Positivity 8. Being realistic, but having dreams 9. Getting the grades

Table 2. Super-ordinate and Sub-themes

'It just happened'

The first super-ordinate theme encompasses three sub-themes, which relate to the construction of future orientation. The sub-themes reflect the ways in which participants perceived their aspirations to have been informed, which at first was perceived to be a product of coincidental interests, but later reflected more personal experiences, such as stories by family members, which are described here as ‘family scripts’.

Strengths and Interests

All participants wanted to pursue further education and employment, and each had a clear idea of the type of employment they hoped to obtain. A number of participants talked about the role of hobbies and interests as being instrumental in the construction of their career oriented aspirations:

“I don’t know. It’s just, all from pets really. And the big idea that, I can go further with the pets. And then, there’s all of the jobs I’ve been looking into and [college name]. Then once I found out animal care was in school, that’s where I had the idea that I can, get a job, with animals.” (Participant 8; Lines 121-124)

“... it’s just been a hobby but, now I’m set on it being my future and, being something that I enjoy so I want to do more of it.” (Participant 7; Lines 193-194)

Although participants felt that their extracurricular activities and interests had informed their future orientation, a majority of participants perceived their hobbies and interests, and subsequently their aspirations, to have ‘just happened’:

“I don’t know, just, I don’t really know it’s just like something that I’ve always wanted to be... Like, I had a phase in like Year 9 where I wanted to be a midwife, but then I changed my mind because I thought it was a bit gross, and then went back to being a teacher.” (Participant 3; lines 60-65)

“Started helping Dad do a bit of physio in ergh I helped him out, then joined St John six years ago, and then started teaching four years ago, and then stayed ever since.” (Participant 6; Lines 53-55)

Interests and activities preceded and informed the direction in which participants were pursuing future attainment and careers. Participants' particular strengths and weaknesses were also discussed as informing future decisions:

"I'm very like... drawer. I can't – I'm not so good with words, but with pictures and music and all stuff I'm better." (Participant 7; Lines 74-75)

Family Scripts

Some participants considered how the pursuits of their family members influenced their own aspirations. A couple spoke about the unfulfilled aspirations of others, and how this can be passed down through the family:

"Cos I've always wanted to go in the army, it was – it was my brother's dream first, but he didn't follow through with it, but I think I want to, cos I've always wanted to go in the army." (Participant 9; Lines 86-88)

"...my great grandma, she wanted to be a teacher, but... erm, she-she never got to do it. And, she told me, cos I told her that I wanted to be a teacher, and she said, that she thinks I should do it for her as well as myself, because she never got to do it, and she regretted it. " (Participant 3; Lines 199-203)

Although this was a positive experience for some, others perceived this as a possible negative:

"...my grandma was actually one like that like erm, I think my grandma wanted my mum to be a dancer, or something like that erm... cos my grandma never really got to do that, and it was something she wanted to do, so... my mums not one of those who tries to force their sort of, wishes onto their child or anything so." (Participant 4; Lines 178-182)

One participant talked about the transfer of values from parents, but also the desire to do something different:

“...my Mam and all my sisters have been like carers, and like, always putting, others first, that’s helped me choose that but, I didn’t want to go down the same path, I wanted to do my own thing.” (Participant 7, Lines 239-242)

It is apparent that the career paths chosen by participants were influenced by familial values, ideas and experiences, with some participants wanting to ‘carry forward’ the career aspirations of family, and others wishing to ‘make their own way’.

It’s personal

A number of participants discussed adverse events within their families, such as death and illness. These experiences were seen as having influenced values and actions, and also wishes for the future:

“Erm, that’s a picture of... my nephew, and a red ribbon, cos I am a fundraiser for meningitis now. Cos my nephew passed away with it, and I’d like to continue that. In the future... That is quite important cos I wanna like... I wanna give other families like, and like the people that are suffering from it, things that some people can’t get. Like, I want them to have the things that they can and, hopefully, a cure for it, and like vaccinations and everything.” (Participant 1; Lines 48-52, 64-67)

It could be that there are wishes to provide some reparation after the event of losing a family member, or prevent others having to experience the same thing. One participant talked about being able to ‘help out’ his family:

“It means I can like provide, cos in case like my brother, he, could become short or something, I might be able to help him out a bit.” (Participant 9; Lines 153-154)

One participant also talked about how the experience of caring for her sister in hospital had provided her with a viable career option that she enjoyed:

“It’s where like ergh, when kids are, in hospital and they’ve got nothing to do an you just like, take em’ out places, and you do arts and crafts at the side of their

bed... Cos when my sister was poorly I used to like, do loads of stuff with her, and I just. I just really liked it.” (Participant 5; Lines 35-41)

In addition to the influence of personal experience upon future aspirations, participants also seemed keen to do something meaningful (serious, important or worthwhile):

“I wanna like go and take, inspiring images and like, see what I can see, and, make other people happy. I wanted to do wedding photography, because, it makes other people happy, and makes memories for other people, and makes them feel better.” (Participant 7; Lines 56-59)

“...I think I wanna help out, like people who’ve like lost family members to try and fight back, say that we’re not backing down just cos we’ve lost a few people and like, power on.” (Participant 9; Lines 170-172)

Just being there

This super-ordinate theme is composed of three sub-themes relating to the ways in which young people describe being facilitated and supported in striving to achieve future aspirations.

Being there

All participants discussed people supporting their decisions, and ‘being there’ for them. In addition to this, others’ support is mentioned as always being there, with a suggestion that this support is unconditional:

“Well my mum’s the main one who like really supports me in whatever I want to do and whatever decision I’m making, she’ll support me all the way through it” (Participant 4; Lines 147-149)

“My Mam... Because, she’s helped me. Because like, she’ll stand by me whatever decision I choose and stuff like that.” (Participant 2; Lines 138-139)

This support is considered in more detail, such as how it is communicated:

“...they’re always like saying you can do it and stuff like that. If you get good at it you’ll make a good enough name for yourself, and make you feel better about yourself in the future.” (Participant 7; Lines 251-253)

All participants discussed the value of someone having ‘belief’ in them and their abilities. A majority felt that their parents provided this support, but one participant also talked about gaining this from staff at school:

*“They’re [teachers] just there for me when I feel down, and like push my spirits back up and like, help me try and do better in my work and stuff like that.”
(Participant 7; Lines 228-229)*

Helping Practically

Some participants make a distinction between moral/emotional support, and practical, ‘hands on’ support. For one participant support had been noted through the payment of lessons:

“And there’s people like ergh, my grandma, who pays for my guitar lessons, because she wants to see me do well in it and everything.” (Participant 4; Lines 164-166)

For some, practical support was more about providing direct help with work and revision:

“Erm, [they] explain it easier. Or read it to me and then I’ll understand it better, then if I just read it out of a book. Or worksheets and that... Be there for ya, if your like stuck or, if you need to talk to them or, stuff like that.” (Participant 6; Lines 136-141)

*“My Mam and my Dad will probably help me push myself... Like, they tell me if like, if it was good or if it was bad, and like, help me improve myself a bit more.”
(Participant 7; Lines 149-154)*

Not giving up

Participants acknowledged that working towards their goals was not going to be easy, and that a key role of supporters was to encourage persistence:

“He encourages me to keep on going on it, cos, if everyone just gave up at the first hurdle no one would be really happy, they’d always be stuck, so if you just keep powering on you might get somewhere in life.” (Participant 9: Lines 215-218)

“He just tells me don’t give up.” (Participant 10; Line 121)

“She ergh, talks to me when I’m, sort of having second thoughts about things and tries to push me back against things I want to do and everything, she tries to get me-my head back into, the game and stuff...” (Participant 4; Lines 161-164)

One participant also discussed admiring a family member for their persistence, and not letting a potential barrier stopping her from achieving her goals:

“I just think that it’s like good how she’s like worked around it and stuff like, she did start training like when she left college and university. But, then obviously she had kids, so - she waited, and now she’s gone back to that, she’s not forgotten what she wanted to do.” (Participant 3; Lines 216-219)

Expectations of Success

This super-ordinate theme is composed of three sub-themes which all relate to the participant’s perceptions of the likelihood that they will achieve their desired future.

Positivity

Despite acknowledging that things might be hard, and that there was a need to ‘not give up’, all participants discussed their plans for the future with confidence and certainty:

“I’ve already passed my maths, for my, erm, accountancy bit, and then I’m gonna go to university and do it, and then, think I’m gonna work in Hull for a bit, and then...” (Participant 1; Lines 83-86)

“Well I’ve just applied for college, and I’ve had an interview, and I’ve got a secure place. Erm, and then obviously after college you have to go to university.” (Participant 3; Lines 144-146)

Participants seemed to have thought in detail about the ‘near’ future (next 2-3 years), and talked about some of their plans (such as university) as non-negotiable, as something they ‘had to do’.

Being realistic, but having dreams

When considering why it was important for participants to have the things that they desired in the future, a number of participants talked about being practical and realistic:

“Like, just like, what you need in life really, necessities and stuff like that... family’s important int it because you can’t really live without family [laughs]. And, you need money to live because, you need a house and stuff like that.” (Participant 3; Lines 105-110)

“Yea cos like, I know that everyone like, dreams of like a big house and stuff like that, but. You’ve got to like think realistically haven’t ya. And, I know that I’ll get a normal house, but not like a massive house, so.” (Participant 3; Lines 157-159)

In addition to having ‘realistic’ life aspirations themselves, participants also seemed to appreciate that others just wanted them to have what they needed, or a ‘good life’:

“She just wants to see me, do the best of what I want to do really.” (Participant 4; Lines 182-183)

“She just says she wants me to have a job and a good life.” (Participant 5; Line 130)

Although all participants had ‘realistic’ aspirations, some of the participants also acknowledged that they had dreams that might be harder to achieve:

“I mean like, dream job, I’d want to be in a band... Erm, but I mean there’s all sorts of different paths you can go with music and everything.” (Participant 4; Lines 50-53)

“Like, my friend [name] she said, one day we’ll get a horse and do like, some ranch or whatever. And then, me and my friend [name], its – it’s a big dream (pause). Hopefully though.” (Participant 8; Lines 108-110)

Regardless of the achievability of future aspirations, participants expressed the importance of doing something that they loved, and were passionate about:

“Yea there’s a few idols that I look up to and everything... how they’re able to do something they love for a living, rather than like, working in like a corner shop or something bad like that.” (Participant 4; Lines 115-122)

Getting the grades

When discussing any barriers or challenges that might exist in relation to achieving aspirations, a number of the participants talked about the need to ‘get the grades’, or work hard enough:

R: “And do you think there’s anything that might make it harder to get those things?”

Pt: “Not having the grades.”

R: “And why might that happen?”

Pt: “Not doing well in the exam.”

R: “Is that something you worry about or...”

Pt: ... “Yea. Yea.” (Participant 6; Lines 123-129)

“Some [people] might have better grades than you so you’ve gotta like show you’re better than them by like trying to get better grades than them, so you can get the job...” (Participant 9; Lines 191-193)

Although some participants were concerned about the possibility of not achieving the grades they needed in order to be able to do what they want, they acknowledged their own role in achieving success:

“Like, I’ll get what I want if I want it” (Participant 2; Line 71)

“Erm, like not working hard enough in lessons to get like, good grades that I want. But if I’m motivated then I can.” (Participant 2; Lines 80-81)

Participants talked about the need to enjoy an occupation, and feeling passionate about it, in order to have the motivation to succeed:

“...I think if there’s more passion towards something then you’ve got more reason to want to do it, so then you work harder at it, and then you get better at it, and it sort of becomes a bigger thing for you.” (Participant 4; Lines 98-101)

*“Enjoying it really. Like if, if I like something, I like to do it more, so.”
(Participant 7; Line 144)*

Conversely, a couple of the participants also acknowledged the part of fate:

“A lot of people, do ask me about like what I want to do in the future and everything, and what I thinks going to happen in the future and I think it’s just gonna roll the way it rolls.” (Participant 4; Lines 129-131)

“...When it happens it’ll happen.” (Participant 7; Line 177)

Discussion

Strengths and Limitations

This study is one of few giving young people from low-income families a voice about their aspirations for the future. The use of photo elicitation is novel, and served to empower young people to bring topics of their interest to the interview.

Despite the uniqueness of this research, there are some limitations in research methodology, and thus considerations for future research. This study aimed to explore all aspects of future orientation, moving away from a focus solely on academic and occupational achievement. However, at the school's request interviews were conducted within school, in the presence of a staff member (Student Services Administrator), which is likely to have enforced the idea in young people's minds that the research was related to school and educational attainment. In addition, the presence of the SSA may have inhibited the participants' ability to talk freely. Nevertheless, the researcher agreed to the school's stipulations as the SSA had a good relationship with all of the students, which was evident in the interactions witnessed prior to the interviews. For some students the presence of the SSA was reassuring.

Interpretative Phenomenological Analysis does not attempt to create theories or generalisations about certain populations, but instead focuses on the subjective meaning that something has for a person (Smith and Osborn, 2003), and for this reason a small sample size is acceptable. However, all participants were recruited from the same school, and lived in the local area, and consequently the influence of culture, within both the school and wider community, should be considered.

The recruitment process may reflect selection bias, as although the SSA identified students randomly from a list, certain students were not approached as they were known to be experiencing difficult personal circumstances at the time.

Additionally, some students dropped out of research due to 'personal reasons'. The exclusion criteria are also likely to have influenced the findings of this study, however these were applied in order to maintain a level of homogeneity that would allow for the examination of convergence and divergence between the participants (Smith and Osborn, 2003).

A difficulty inherent in research involving economically 'disadvantaged' populations is the conceptualisation of 'low-income'. Eligibility for free school meals is based upon household income, however level of income is an indirect measure of poverty as it relates to potential resources rather than living standards (Calandrino, 2003). In addition, low-income is transient for some, particularly in the current economic climate. Information about the length of time students had

been on free school meals may have been beneficial. Nevertheless, even temporary unemployment and low-income can undoubtedly cause stress to a family, and consequently young people.

Aspiration Formation

The results provide an interesting insight into how young people from low-income families perceive their aspirations. Overall the young people were positive, enthusiastic and hopeful when describing their aspirations. This is in contrast to current literature suggesting that young people from low-income families hold more pessimistic views of the future than their more affluent peers (Lee, Hill and Hawkins, 2012; Berzin, 2010; Rojewski and Yang, 2007). All participants had clear occupational aspirations, and a majority had ambitions to attend college and university. Participants had a good knowledge of the action that they needed to take in order to achieve their desired future, such as the qualifications required for specific occupations. This is in line with the behavioural variables described within the concept of future orientation which describes the 'exploration' of options via the seeking of information and consideration of their feasibility, followed by a 'commitment' to pursue one of the given options (Seginer and Lilach, 2004).

Participants talked about their future endeavours, such as university, with certainty, as if not pursuing higher education was not an option. In addition, all participants acknowledged their own role in achieving aspirations, as seen in the theme 'getting the grades', suggesting that they have an internal locus of control, and a sense of self-efficacy. This demonstrates the 'motivational' variables of future orientation, which include the expectations of attaining a given future (including hopes, wishes, plans, and positive beliefs), and the sense of 'internal control' one perceives as having in the materialisation of these goals and plans (Seginer and Lilach, 2004). Self-efficacy beliefs have been linked to key indices of academic motivation, and there is evidence that self-efficacious students are more willing to participate, work hard, and demonstrate persistence in the face of challenges (Bandura, 1977; Zimmerman, 2000). Again these results contrast with current literature, suggesting that young people from low-income families harbour lower occupational expectations than their peers (McLoyd, Kaplan and Purtell, 2008).

The occupational aspirations of participants could be considered achievable and pragmatic, and a number of young people talked about being 'realistic', or 'just having a good life'. Arguably, rather than having pessimistic aspirations in comparison to 'better off' peers, it is possible that these young people actually nurture more realistic aspirations. Having 'realistic' aspirations suggests a higher likelihood of success, although it could be considered that perhaps a 'ceiling' has been placed on these young people's hopes for the future, where it may not have been for their peers. The similarities and differences between aspirations of low-income and middle/high-income adolescents would be an interesting area for further investigation.

Interestingly, although all participants had thought about their future careers, and most had considered the type of house they might live in, or the car they would drive, only one participant had thought about her 'future family'. This is in stark contrast to the findings of Banbury (2014), in her study of aspiration formation in looked after children. In this study, all but one of the participants talked about their desire for a family and children of their own in the future. There are evidently key life experiences that influence the focus of future aspirations.

The participants' perceptions of their aspirations are overwhelmingly positive, and suggests that these young people have not experienced any of the adverse events commonly associated with low-income status. However, this is not the case. A majority of the young people mentioned bereavements and chronic illness within their immediate families, and a couple mentioned violence and intimidation in their communities. The influence of illness within the family is reflected for some in the sub-theme 'it's personal'.

A majority of participants felt that their subjective hopes for the future had 'just happened'. Participants did however link their aspirations to hobbies they were engaged in, or subjective strengths and weaknesses. This is in line with Nurmi's (1994) description of the development of future concept mentioned earlier. The role of hobbies was particularly pertinent, and was also highlighted by the young people reviewing the interview prior to data collection. This contributes to the literature pertaining to the role of extracurricular activities in identity formation,

which suggests a link between hobbies and adult attainment (Eccles, Barber, Stone and Hunt, 2003).

Some participants discussed the influence of their families – with some wanting to ‘carry forward’ the aspirations of family members, and others wanting to ‘strike out’ and do their own thing. This suggests that people may choose to re-create experiences given to them by their parents, or create their own reparative experiences (changing things that they would have liked to have been different). The conflict between following in parental footsteps, or branching out is consistent with Erikson’s (1959) stages of psychosocial development, where adolescents face the crisis of identity versus role confusion – striving towards independence to establish an identity.

A potential barrier to achieving aspirations, mentioned by all participants, was the possibility of not ‘getting the grades’, with a couple of participants discussing competition within the job market as a potential concern. It is interesting that no further concerns were raised about the current economic climate, given that a lack of employment opportunities, raise in university fees and cost of living and housing have been a strong focus of media attention in recent years.

A main source of facilitation and support, as mentioned by all participants, was the encouragement of family members, and the importance of ‘being believed in’. Considerable attention has been paid to the effect of parental and teacher expectations on eventual attainment. Students whose parents hold higher expectations have more academic success, persist longer in education, and have higher aspirations for college and university (Davis-Kean, 2005; Peng and Wright, 1994). The level of impact that teachers’ beliefs in student success have upon their academic achievement, and the possible role of self-fulfilling prophecies has also been long debated (Jussim and Harber, 2005). Although expectations undoubtedly play a role in student success, participants discussed being believed in unconditionally, regardless of what they wanted to do. This suggests that the participants are discussing futures inspired by the belief they have in themselves to achieve what they want, rather than fulfilling parental expectations for a particular goal. This is consistent with self-efficacy and social cognitive theory (Bandura 1986, 1977), which purports that social persuasion

(direct encouragement from others), such as a parent's belief in their child's ability, is a key mediator of self-efficacy.

The final question posed by this study involved the role of environment and wider context in low-income adolescents' perceptions of the future. The participants in this study did not seem to think environment and wider context had played a role in the formation of their aspirations. This is inconsistent with current literature, suggesting that council estates are increasingly 'cut-off' from the rest of society, and as such deprive young people of the experiences or networks that would allow them to aspire to the jobs or successes of middle and high-income youth (Abelev, 2009; Gregory, 2009). In addition, young people are often acutely aware of their family's financial circumstances, with the effects of inadequate finances becoming more restricting as children transition to adolescence (Attree, 2004; Gregory, 2009). Nine of the young people included in this study lived within large council estates in the local area, but interestingly none of the participants discussed their environment in relation to their future aspirations. Again, none of the young people talked about their financial circumstances, or any implications for their futures.

There are a number of potential reasons for this. As previously mentioned it is possible that this study captured the views of a sample who are low-income, but not deprived in terms of resources. Additionally, the school has a large proportion of students who qualify for free school meals, and therefore, it is likely that this was the norm. A lack of economic disparity may mean that the participants were in the majority, and were subject to less social comparison with wealthier peers. In future it would be interesting to investigate young people's perceptions of the link between environment and aspirations directly. Finally, schools play a significant role in young people's lives, and it is possible that the environment provided by school mediated any potentially negative effects of wider settings. Further research with larger samples, drawing data from pupils across different schools would be useful to clarify this.

Clinical Implications and Future Research

This study provides an insight into how young people perceive their aspirations were formed, and also provides direction for future research, and some

considerations for clinical work with young people. Some of the most important informers of young people's aspirations included hobbies and interests, personal experiences and being believed in (facilitating a sense of self-efficacy). For young people from low-income families, hobbies and interests provided a direction for their future oriented actions, and also a motivation to succeed in something that they found personally interesting. The benefits of extracurricular activities are well documented (Eccles, Barber, Stone and Hunt, 2003). In the current economic climate, many services that provide an environment for young people in need to participate in activities such as music, dance, drama and sport are having their funding cut, and are disappearing. It is likely that such services, or access to such activities, provides a significant role in aspiration formation for disadvantaged young people, and the consequences of such service closures would be detrimental to their progression into work.

Another key factor in aspiration formation related to the personal meaning of future orientations, or the wish to do something worthwhile. This is linked to the concept of Narrative Identity, and the idea that we construct stories to create meaning in our lives, and to make sense of our place in society as we have been, are being and could be (McAdams, 2008). It is interesting to consider the role of the interviews that took place during this research in the creation of this story. A number of young people reported not having spoken about their future aspirations previously, and similarly to Banbury (2014), many reported this as a positive experience. Providing young people with a space in which to discuss and consider their future in detail, in a protected environment, may be an intervention that merits further investigation in itself, as a facilitator for aspiration formation.

Again this research highlights the importance of young people feeling that others have a belief in their ability to achieve, and a commitment to support them in whatever endeavour they may choose. For most of the participants this was gained from parents and wider family, but it is important to remember the importance of other adults, such as teachers, support staff, and club leaders in forming a young persons hopes and achievements - particularly if this is something that they are not getting at home.

Positivity stands out from the themes created. This leads one to wonder how different these young people's aspirations actually are in comparison to their peers. In addition, aspirations are distinct from achievement, and despite the positivity with which future orientations have been presented, it is possible that they do not materialise. Certainly current literature and statistics suggest that young people from low-income families would be less likely to fulfil their occupational aspirations (Lee, Hill and Hawkins, 2012; McLoyd, Kaplan and Purtell, 2008). Longitudinal research may provide more insight into the development of aspirations into action, and the subsequent achievement, loss or change of the desired for future.

Finally, there is a need for more research that directly explores young people's perceptions and beliefs of the world that they are growing up in. There is a general lack of qualitative research giving a voice to children and adolescents, particularly in low-income populations. Although it was important for young people to be the centre of this research, it would have been interesting to include parents' views alongside their children's in order to look for convergence and divergence between stories, and also potentially add another level of understanding to aspiration formation. Unfortunately this fell outside the scope of this research, but it is important for future research.

Conclusions

This study has provided an insight into the aspirations of young people from low-income families. The results provide an alternative viewpoint to existing literature, with a more positive outlook. There may be important reasons why the young people included in this research have portrayed more optimism, and this study has identified key factors important in the development and facilitation of future aspirations for this group of young people. The relevance of access to different experiences and activities, as well as the support of parents and families have been emphasised. This research has given young people a voice, and provided a base from which more research is needed to understand how young people from low-income families construct their future orientation and are facilitated in realising their hopes. By supporting young people to think about their futures, and feel empowered to achieve their dreams, it is hoped that they will be able to live the lives they want to live, whatever that life may be.

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Appendix A: Instructions to Authors

Effective psychological interventions for low-income adults with depression

Cultural Diversity and Ethnic Minority Psychology

Cultural Diversity & Ethnic Minority Psychology[®] seeks to advance the psychological science of culture, ethnicity, and race through the publication of empirical research, as well as theoretical, conceptual, and integrative review articles that will stimulate further empirical research, on basic and applied psychological issues relevant to racial and ethnic groups that have been historically subordinated, underrepresented, or underserved.

Submission

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Types of Articles

Multi-study papers

Multi-study reports involve quantitative and qualitative research with 2 or more studies using different samples. Multi-study papers are more integrative in nature and provide a strong theoretical and empirical contribution to the literature. Manuscripts are limited to 10,000 words of text, including abstract, though shorter manuscripts are strongly encouraged. The word limit does not include reference pages, tables, and figures. Manuscript longer than 10,000 words need to be approved by the editor prior to submission and must make a truly outstanding contribution.

Single study reports

Single study reports of quantitative and qualitative research are between 4,000 and 6,000 words of text (including abstract). The word limit does not include reference pages, tables, and figures. Theoretical, conceptual, and integrative review manuscripts also must adhere to this word limit.

Brief reports

Brief reports are between 2,000 and 3,000 words of text (including abstract). The word limit does not include reference pages, tables, and figures.

Submissions involving pilot data findings, replication of published study findings, psychometric investigations of culture-specific measures, or substantial cultural adaptation of existing measures are most suitable for brief reports. Mere translation and validation of existing psychological measures that are not culture-specific are not appropriate for the journal.

Special Issue and Section Protocol

Cultural Diversity and Ethnic Minority Psychology welcomes proposals for special issues or sections that address a substantive area in the psychological study of culture, ethnicity, and race.

The editorial team will collectively review and approve all proposals. An Associate Editor will serve as the action editor for all special issues/sections and work closely with the guest editor(s) of the special issue/section.

In addition, the journal editorial team (composed of the Editor and Associate Editors) will initiate special issues and sections to address gaps in the literature. In these instances, a call for papers will be announced and widely distributed to solicit manuscripts.

Authors wishing to submit a proposal for a special issue or section should submit the following to the editor.

Proposals must include the following information in this order.

- Clearly describe the topic or theme for the special issue/section and a rationale for why the special issue/section is needed right now. Be sure to articulate how it is directly related to the advancement of the psychological study of culture, ethnicity, and race. This description should be no longer than 2 paragraphs or 1 page.
- Briefly explain whether the solicited or accepted papers will be empirical or integrative reviews. A collection of position papers is strongly discouraged unless they include empirical data or integrative reviews. Empirical papers will be given a higher priority as well. Only one commentary by a distinguished expert in the field is allowed for a special issue/section.
- Denote whether it will be a special issue or special section. Special sections (approximately 6–7 papers) are preferred, especially if contributing authors and papers are already identified.
- Specify whether the papers are still to be invited through an open call or whether it is a set of proposed papers that have already been identified. Provide a rationale for either approach.
 - If a call for papers, provide the actual call for papers announcement that will be distributed. Provide examples of how proposals will be solicited, reviewed, and selected.
 - If a set of proposed papers, provide the titles, authors, and abstracts.
 - If a commentary is part of the special issue/section, provide the name and affiliation of the commentator, including areas of expertise.

- Provide the name and contact of the proposed guest editor, as well as a brief description of the person's qualifications to serve in this capacity. All guest editors will work with the assigned Associate Editor, who will make the final editorial decisions.
- Provide a timeline for the special issue/section, including solicitation dates, submission due dates, review and revision completion deadlines, and publication target date.
- A list of potential reviewers and some information on their areas of expertise.

Peer Review

Because *Cultural Diversity and Ethnic Minority Psychology* uses an anonymous peer-review process, authors' names and affiliations should appear only on the title page of the manuscript.

Style of Manuscripts

When providing racial or ethnic designations, please use initial capital letters. *Webster's New World Dictionary of American English, 3rd College Edition*, is the accepted source for spelling. Define unusual abbreviations at the first mention in the text.

The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Title Page

The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address, telephone and fax numbers of the author responsible for correspondence.

Please include the word count of the text and abstract.

Authors should also provide a short title of not more than 45 characters (including spaces), and up to 5 key words, that will highlight the subject matter of the article.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. For commentaries, the abstract is limited to 150 words. For research and review articles, the abstract is limited to 250 words and the following headings are required:

- **Objectives:** Study aims or hypotheses
- **Methods:** Sample description (including size, race or ethnicity, gender, average age) and research design
- **Results:** Results that pertain to study aims or hypotheses

- **Conclusions:** Implication of findings After the abstract, please supply up to five keywords or brief phrases. Phrases are limited to three words maximum.

Participants: Description and Informed Consent

The Method section of each empirical report must contain a detailed description of the study participants, including (but not limited to) the following:

- age
- gender
- ethnicity
- SES
- clinical diagnoses and comorbidities (as appropriate)
- any other relevant demographics

In the Discussion section of the manuscript, authors should discuss the diversity of their study samples and the generalizability of their findings.

The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians) and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Measures

The Method section of empirical reports must contain a sufficiently detailed description of the measures used so that the reader understands the item content, scoring procedures, and total scores or subscales. Evidence of reliability and validity with similar populations should be provided.

Statistical Reporting of Effect Size and Confidence Intervals

We now require that authors report means and standard deviations for all continuous study variables and the effect sizes for the primary study findings. Note that the *Publication Manual of the American Psychological Association* (APA, 2001, pp. 25–26) emphasizes the importance of reporting effect sizes in addition to the usual tests of statistical significance.

Effect sizes, or similar statistics such as "goodness-of-fit" indicators for structural equation modeling, can be generated by most statistical packages that are used in the behavioral sciences. If effect sizes are not available for a particular test, then authors should convey this in their cover letter at the time of submission.

Citations in the Text

In the text, references should be cited by the name and date system. Both names are cited for a work with two authors. When a work has fewer than six authors, cite all names the first time the reference in the text appears; subsequent citations should only cite the first author's name, followed by "et al." When a work has six or more authors, cite only the first author's surname, followed by "et al." Refer to the following citation examples.

- In a similar case study, Haley (1973) utilized...
- One authority (Green, 1991) suggested...

Reference List

References should be arranged in alphabetical order of the author's names. Multiple entries by one author are arranged chronologically, with the earliest publication appearing first. When more than one publication by the same author is cited for a year, arrange the citations alphabetically by title and distinguish the citation by lowercase letter: 1991a, 1991b, etc.

Publications by two or more authors should come after all publications by senior author alone. They are arranged alphabetically, after the first author's name, by the names of the second authors, and so on. Multiple books by the same pair or the same group of authors should be arranged chronologically.

The first line of the reference should be indented; subsequent lines should be flush left. Please adhere to stylistic guidelines set forth in the *Publication Manual* when preparing your reference list. Please note that the page numbers should be inclusive and journal or monograph series titles should not be abbreviated.

Note the punctuation in the following examples:

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Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151. <http://dx.doi.org/10.1037/a0028566>
- **Authored Book:**
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Tables

Each table must have a title and should be self-explanatory. Avoid duplicating information in the text. Number tables with Arabic numerals in order of appearance in the text. Indicate in the text where tables should be inserted.

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Prepare manuscripts according to the [Manual of the American Psychological Association \(edition\)](#). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

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Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

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- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

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6. Appropriate measures of effect size (such as partial eta squared for ANOVAs, Cohen's d for t-tests) are included.

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State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

Results

Results should be clear and concise.

Discussion

This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions

The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

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- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
- **Author names and affiliations.** Please clearly indicate the given name(s) and

family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**

- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required (Maximum words = 250). The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should be avoided, but if essential they must be defined at their first mention in the abstract itself.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See <http://www.elsevier.com/highlights> for examples.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American-English spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Following APA guidelines, all but most familiar abbreviations should be used sparingly. Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Math formulae

Please submit math equations as editable text and not as images. Present simple formulae in line with normal text where possible and use the solidus (/) instead of a horizontal line for small fractional terms, e.g., X/Y. In principle, variables are to be presented in italics. Powers of e are often more conveniently denoted by exp. Number consecutively any equations that have to be displayed separately from the text (if referred to explicitly in the text).

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the bottom of the page. Do not include footnotes in the Reference list.

Table footnotes

Indicate each footnote in a table with a superscript lowercase letter.

Tables and Figures:

Embed tables and figures in text, close to where they are called out.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was

last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software

Most Elsevier journals have a standard template available in key reference management packages. This covers packages using the Citation Style Language, such as Mendeley (<http://www.mendeley.com/features/reference-manager>) and also others like EndNote (<http://www.endnote.com/support/enstyles.asp>) and Reference Manager (<http://refman.com/support/rmstyles.asp>). Using plug-ins to word processing packages which are available from the above sites, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style as described in this Guide. The process of including templates in these packages is constantly ongoing. If the journal you are looking for does not have a template available yet, please see the list of sample references and citations provided in this Guide to help you format these according to the journal style.

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List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Appendix B: Selection of Studies

PsycArticles Total n=6	PsycInfo Total n=81	CINAHL Total n=57	Web of Science Total n=121
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n=265; Limiters applied:
 peer review rejected n=2; date of publication rejected n=32; age rejected n=44; language rejected n=3

n=184
Abstracts read n=184 rejected n=150 (34 remaining)
Duplicates removed n=19 (15 remaining)
Full texts reviewed and inclusion/exclusion criteria applied: rejected n=3
Included articles n=12
Manual search of reference lists n=3
Total number of articles n=15

Appendix C: Data Extraction Form

Author (s)	
Title of Study and Year of Publication	
Research Aims	
Target Population	
Participants (Age/Gender/Ethnicity)	
Sample Size	
Theoretical Model Specified	
Intervention Used (Aim/focus, number of conditions, content of intervention model, theoretical model if specified, duration of intervention, delivery mode of intervention, any mediating variables specified).	
Outcome Measures (Method of measurement, direct/indirect, who completed, what measured, when measured – baseline/post-intervention, reliability and validity of measures reported?)	
Statistical Analysis (Techniques, any follow up data included?)	
Main Findings	
Conclusions (Both authors and reviewers e.g. limitations of method, sample etc).	

Appendix D: Quality Checklist

	Question	Yes (1)	No (0)
1	Is the evidence base/theory underpinning the study described? <i>Rationale for chosen Interventions etc.</i>		
2	Are the aims/objectives of the study clearly described?		
3	Are the main outcomes to be measured clearly described?		
4	Are the characteristics of the participants included in the study clearly described?		
5	Do participants go through a screening process?		
6	Were the subjects who participated in the study representative of the entire population from which they were recruited?		
7	Is the procedure clearly described?		
8	Is the study design appropriate?		
9	Were the main outcome measures used valid and reliable?		
10	Are the interventions of interest clearly described?		
11	Are the people delivering the interventions qualified to do so? <i>E.g. attended adequate training/professional experience.</i>		
12	Is there a comparison group?		
13	Are participants randomly assigned to groups?		
14	Were blind assessors used?		
15	Is data reported on attendance and attrition rates?		
16	Were the statistical tests used to assess the main outcomes appropriate?		
17	Are the main findings of the study clearly described?		
18	Have actual probability scores been reported for the main outcomes? <i>E.g. 0.035 rather than <0.05.</i>		
19	Was adherence to the intervention(s) monitored? <i>E.g. use of taped sessions to monitor compliance?</i>		
20	Is follow up data provided?		
21	Have the limitations of the study been described?		
22	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?		
Total			

Appendix E: Quality Assessment Results

Article/Question	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total
Pilot Studies																							
Aguilera and Munoz (2011)	1	1	1	1	0	0	1	1	1	1	0	0	0	0	1	1	1	1	0	1	1	0	14
Himelhoch et al (2013)	1	1	1	1	1	0	1	1	1	1	0	1	1	0	1	1	1	1	0	0	1	1	17
Beeber et al (2003)	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	20
Perez-Foster (2007)	1	1	1	1	1	1	1	0	1	1	1	1	1	0	0	1	1	1	1	1	1	1	19
Heileman et al (2011)	1	1	1	1	1	0	1	1	1	1	1	0	1	0	0	1	1	1	1	1	1	0	17
Intervention Studies																							
Miranda et al (2006)	1	1	1	1	1	0	1	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	18
O'Mahen et al (2013)	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	0	1	1	1	19
Lara et al (2003)	1	1	1	1	0	0	0	1	1	1	1	0	0	0	1	1	1	1	0	1	1	1	15
Miranda et al (2003)	1	1	1	1	0	1	1	1	1	1	1	1	1	0	1	1	0	1	0	1	1	1	18
Rahman et al (2008)	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	18
Toth et al (2013)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	22
Grote et al (2009)	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	20
Ell et al (2011)	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	20
Ell et al (2010)	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	19
Rojas et al (2007)	1	1	1	1	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	20
Total	15	15	15	15	11	4	14	14	15	14	11	11	13	5	12	15	14	15	8	14	14	13	

Appendix F: Epistemological Statement

As a psychologist I believe that people's experiences, beliefs, attitudes and thoughts are highly subjective, and influence their experience of life. In addition to this, through the use of talking therapies, I assume that people can put words to these experiences, and in doing so, allow me an insight into their lived worlds. I also think that I sometimes have a part to play in the uncovering of these experiences, as they are not always consciously available, and therefore I provide a dialogue that might facilitate the creation of these descriptions. I am my own person, with my own set of experiences, beliefs, attitudes and thoughts, and as such, in the dynamic interplay between myself and my clients (or research participants), although I may try to remain neutral, the questions that I deem important to ask, and the points that I may choose to pick up on will be influenced by my own lived experience, and in this way the resulting descriptions of experience are co-constructed. This does not make the resulting product any less representative of the experience of the client or participant, but does mean that it could have differed slightly should they have been talking to someone else at the time (Ponteretto, 2005).

These opinions and values represent my epistemological and ontological stance. Epistemology relates to the theory of knowledge, and how we know what we know (Carter and Little, 2007; Ponteretto, 2005). I am aligned with a constructivist-interpretivist stance, in that I believe that reality is socially and subjectively constructed, and that the dynamic interaction between the researcher and the researched is essential to capturing the 'lived experience' of the participant (Ponteretto, 2005). This stance is related to Social constructivism, which is concerned with the importance of culture and context in the development of a person's understanding of what happens in society – a position which is often associated with developmental models such as Vygotsky's Social Development Theory (1980), and Bandura's Social Cognitive Theory (1977). This position fits with the subject of my empirical paper – the development of adolescents' aspirations. In addition to this, I assume that through the discussion of certain topics, such as future orientation, that both the participant and I will reach a deeper insight.

Ontology is related to the nature of reality and being – what is reality, and what can be known about it (Ponteretto, 2005)? The constructivist-interpretivist stance posits that there are multiple, different constructed realities rather than a single, true reality (the

relativist position) (Ponteretto, 2005). Following from this, the constructivist-interpretivist researcher assumes that there are different meanings about certain phenomena in the minds of each who experience it, as well as a number of different possible interpretations of the resulting data (Ponteretto, 2005). For this reason, the researcher does not attempt to uncover a single truth, or gain verification on the meanings that have been uncovered, as the purpose of research is not about establishing what is right or wrong. In this way this research is idiographic (from the Greek *idios*, which means applying to the individual), with a focus on understanding the individual as a unique, complex entity, rather than understanding human behaviour more generally (Ponteretto, 2005).

Epistemology has important influences on the method of research that is chosen. However, objectives, research questions and research design also shape the choice of methodology, and vice versa (Carter and Little, 2007). The decisions made about methodology will in turn produce different research products. As a researcher it is important to understand our own epistemological and ontological stance in order to conduct research that is aligned with our beliefs, and provide a connection between research practice and formal theories of knowledge. In addition to this, it is important to understand the theoretical and historical bases of our chosen methodologies, in order to be able to use them confidently, and develop reflexivity (Finlay, 2002). The theoretical underpinnings of my chosen research method of Interpretative Phenomenological Analysis (IPA) are described in more detail (albeit, briefly) here.

Finally, Axiology relates to the role of the researcher's values in the research process (Ponteretto, 2005). Constructivist-interpretivists acknowledge the role of the researcher's values and experiences within the research process, and there is an understanding that it is not possible for these to be removed from the research (Ponteretto, 2005). For this reason, it is important instead that the researcher remains aware of their values and biases, in order to try to 'bracket' them, rather than removing them completely (Ponteretto, 2005). I have attempted to explain some of my own experiences, and subsequent values and biases, in relation to my research area both here, and within my reflective statement (see Appendix G). I have also kept a reflective diary throughout the research process, and attended monthly reflective groups in order to facilitate this reflection.

Interpretative Phenomenological Analysis (IPA)

The aim of this study was to explore the perceptions of young people from low-income families in relation to their aspirations and future orientations. It was also hoped that this would give a voice to a group that are often unheard. IPA has an idiographic focus, which means that it is aligned with my constructivist-interpretivist stance. The research process of IPA aims to ensure that the participants' beliefs and understandings are expressed as accurately as possible (Smith and Osborn, 2003), and in this way it provides a sensitive approach to exploring young people's aspirations.

IPA is underpinned by a number of theories and concepts that emphasise its relevance for the empirical research presented here. These include Idiography (see above), Phenomenology and Hermeneutics.

Phenomenology

Phenomenology is related to the study of experience, and what being a human is actually like (Smith, Flowers and Larkin, 2009). In this sense, it is not only a person's lived experience of something that is important, but also their interpretation of that experience, or the meaning they ascribe to it. This understanding has been developed more recently to encompass a view of a person as embedded within their own relationships, cultures and societies, which subsequently provides a complex interplay in which we are active participators in our own worlds (Smith, Flowers and Larkin, 2009). In this way, a person's experiences are perceived and understood in the context of their lives.

Hermeneutics

Hermeneutics relates to the theory of interpretation, and is concerned with the methods and purposes of interpretation; whether or not it is possible to uncover the intentions or original meanings of the author; and the relationship between the context at the time the meaning was made with the context at the time of interpretation (Smith, Flowers and Larkin, 2009). The most important concepts resulting from the study of hermeneutics is the hermeneutic circle, and the double hermeneutic.

The hermeneutic circle is concerned with the dynamic relationship between the part (e.g. a single word or phrase) and the whole (e.g. the sentence or complete text), on a series of levels (Smith, Flowers and Larkin, 2009). For example, the meaning of a word

is only clear in the context of the sentence, but the meaning of the sentence is made up of the meaning of the words. On a higher level, the interpretation of a piece of a text is influenced by what the reader has already read, and is also changed by encounters with new pieces of text (Smith, Flowers and Larkin, 2009). This provides a useful way of looking at the research process, in that the process of analysis is iterative rather than linear, with the researcher's thoughts about the text constantly changing and shifting.

The double hermeneutic refers to the way in which the researcher is making an attempt to 'make sense' of the participants 'making sense' of their world (Smith and Osborn, 2003), requiring the researcher to play an active role through two stages of interpretation.

Reflexivity and Reflexive Statement

Reflexivity refers to the impact that the researcher has on the research process, which includes the impact of the researcher's beliefs, attitudes, values and experiences on the research (and subsequent personal responses and interpersonal dynamics), and the impact of the position and presence of the researcher (Willig, 2004; Finlay, 2002).

Reflexive practice is therefore an analysis or examination of how the researcher and intersubjective elements impact on research (Finlay, 2002).

For this research it was important that I reflected upon my own beliefs and attitudes towards 'low-income' populations. Having considered this I have realised that I have always felt that I have been given more opportunities than many of my peers - through the opportunities and experiences paid for by my parents, and also through the networks provided within their social circles. When thinking about young people who live in disadvantage, images that come to my mind are of absentee parents (single mums, or parents working on evenings and weekends), children playing on the street, and a general lack of places to go, or things to do. I have always strongly believed that there are inequalities that tip opportunities in favour of those who have money, and there's also a lack of protection for a lot of young people who live in vulnerable circumstances, and I feel very strongly that more could be done to help.

I also had to consider my position in relation to the young people I was interviewing, as there were a number of power differentials at play. Firstly, I am older than my interviewees, and my decision to contact participants through the school meant that it

was possible that I was considered a part of the 'school staff'. Secondly, I am someone who grew up in a middle-class home, went to university, and am now working in a relatively well-paid discipline. There are a number of ways in which differences between the participants and me could have influenced the dynamics and discussion during my interviews. I kept a reflective diary throughout the interview process, in order to try and capture such dynamics, and used supervision to discuss and reflect upon these experiences.

In addition to this, I noted in my clinical work with children and adolescents that in circumstances where a young person did not harbour many aspirations for the future, or a lack of desire to do anything, I often felt that this was a fault of the parents. I frequently had to 'check-in' with myself when interacting with parents to bring these feelings into awareness, and not allow them to cloud my clinical work or judgement. This isn't necessarily linked with my feelings about 'low-income' populations, but refers to my ideas around aspiration formation and attainment, and therefore it was something to consider within my interviews - the questions I asked, and points I picked up on.

Finally, over the last year there have been a number of television programmes broadcast in the UK that relate to low-income populations, and in particular, families on benefits. These programmes have been controversial, and I myself have perceived them to be sensationalist and stigmatising. As these programmes were broadcast during the time that my research was underway, they had a significant emotional impact. I felt angry about the way in which people were being portrayed, which was often as people who had no desire to work or contribute to society. Issues of disadvantage were instead portrayed as life choices. I am aware that this gave me a desire to counteract this negative portrayal of low-income populations, and this may have influenced the construction of questions within interviews.

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Appendix G: Reflective Statement

From the initial excitement of the first year research fair, and all of the possibilities that were presented to us, along with the option of ‘doing our own thing’, I was already relatively fixed on the idea of doing research with low-income children or adolescents. I grew up in a middle-class house, surrounded by council estates, in the centre of a city. As I grew up I became aware of the economic disparities around me – an awareness that was heightened by my socially conscious parents, and also by my vivid memory of the book ‘The Happy Prince’, by Oscar Wilde. These things have undoubtedly contributed to where I am today.

I have also been noticing recently, in myself and my peers and relatives, that at least within our generation (or maybe within all generations) there seems to be a period of time where there is a yearning to do something meaningful or worthwhile – something that makes a *difference* (also a theme in my research!). This desire is something that has most certainly influenced my decisions regarding my research, and has filled me with varying emotions, that have certainly altered from the beginning to now.

My initial research idea centred on theories of resilience, and the idea that some young people prospered against adversity, when others did not. Reviews of the literature in this area led me to think about the causes of resilience, and to ideas around hopes and aspirations. In discussions with my research supervisor I became aware of the research of Sarah Banbury, a trainee in the year above me. I not only liked the application of theories around hopes and aspirations to young people from low-income families, but I also loved the idea of getting the young people to create images. Having previously used Interpretative Phenomenological Analysis (IPA) in my undergraduate research, I was familiar with the research processes involved, and the theories and constructs underpinning IPA fitted with my research area. Given that I was interviewing a group of people who were so often overlooked, I felt that it was of great importance that the research provided as authentic an account as possible of the young people’s unique experiences.

In my initial literature searches I came across many articles that talked of the injustices done to low-income populations by successive governments, the discrimination, benefit

cuts and seclusion of people into council estates. In addition to this, in piloting my research I had visited RAPP (the Rights and Participation Project), and Freedom Road, and the many young people in need who are supported through their community and creative arts. This service clearly provided an important and highly valued role in the lives of the young people who took part, and provided a safe place, friendships, confidence, connections and skills to the many vulnerable young people who attended. At the time I visited the service had lost local authority funding, and funding from Children in Need, and were being moved from their purpose built building (known as the warren), which had been decorated by young people who visited, to a tall, unwelcoming, business-like, glass fronted building monitored by a receptionist. I could not comprehend how a service that contributed so much to the community of young people in the local area could be so undervalued and misunderstood. This, coupled with the information gathered from my literature searches, filled me with anger, and made me want to use my research to tell people about what was happening to these people.

Research Proposals

The construction of research proposals seemed to fly by, which was an exciting stage, as the research I was hoping to do proved to be feasible and possibly (dare I hope) worthwhile. My proposal was presented to peers and staff at the university, and I gained positive feedback. I also presented my research to the Child Special Interest Group in Hull, and despite my overwhelming nerves the presentation went well. Discussions during both of these presentations gave me ample opportunity to reflect. A concern that was raised was the danger of placing value judgements upon those that I was interviewing, and the importance for me to understand my feelings towards people who were considered to be 'low-income'. This was particularly important given my choice of research methodology (IPA), as an important theoretical current for IPA is the double hermeneutic. This refers to the meaning-making process within research and the fact that as a researcher, I am trying to make sense of the meaning given to something by someone else (Smith and Osborn, 2003). There is therefore a double process of interpretation, with the participants making sense of something, and me trying to make sense of their understanding. In this way, my own context and beliefs and understandings will inherently have an influence on the interpretations that are made, and it is important that I am aware of these influences. I have tried to reflect on this processes here, and within my reflexive statement (see Appendix F).

The Beginning

My initial task of finding a school that was willing to give me access to students was very frustrating. Schools in Hull were undergoing many changes at the time, and many schools were subject to frequent OFSTED inspections. This meant that schools were wary of 'outsider involvement', and seemed concerned that my research may implicate them in an accusation of unambitious students. There was much relief when a school eventually agreed to participate, with an agreement being made that interviews would begin in the new school year, prior to the anxiety of GCSEs that many of my eligible participants would be facing in May and June. This provided a period of inactivity, and what felt like the 'calm before the storm'.

By September I was raring to get going, so contacted the school in eager anticipation. I was linked to a teacher at school to initiate the identification of students. What ensued in the following months was a number of unanswered emails, calls and meetings. My teacher, like most teachers, was very busy, and did not have time or resources to help me. These few months began in a frustration that grew into disbelief and panic, as the time that I had set aside to complete my data collection, within ample time of the deadline, quickly flew past. Eventually, I was put in contact with the Student Service Administrator (SSA). The SSA quickly noted all of the things I needed, and set about identifying students and booking meetings for that week. She was my saviour.

The day before my first interview I was informed that the school were insistent that the SSA sat in on my sessions. In addition to this, I was told we would be using the schools meeting rooms - which were glass fronted meeting rooms off the main entrance hall (which was also glass fronted). I expressed my concerns about the lack of privacy, and need to ensure that students felt that they could talk openly in a private and safe environment. I was assured that at the times we would be completing interviews, no other students would be in the corridors, and that the SSA had a very good relationship with students, and therefore it shouldn't concern any of the students to speak openly in her presence. The school was unwilling to negotiate, and I did not have a second school to go to.

These conversations with school are very interesting to reflect on. I felt very much like an outsider, being permitted entrance through the school gates with caution. I felt that

the school suspected me of trying to ‘trick’ the students into saying something negative about the school, and therefore I had to be supervised in all of my encounters. These feelings were definitely present within my first two interviews, where conversation felt stilted, and everyone seemed very cautious of each other. I felt that I needed to be careful what I asked, and I was also concerned about keeping the SSA for longer than necessary. This meant that things probably weren’t followed up as they would have been had I been feeling more comfortable.

Thankfully, at the end of the second interview I was afforded some time with the SSA, and although she had heard me describe my research to the students previously, she had many questions about what I was expecting or hoping to find, what I would do with the findings, and how I had gotten interested in the subject area. From this point the feelings of mistrust and caution dissipated, and I felt that the SSA was genuinely interested and intrigued. In each interview she remained at the back of the room, completely silent, and at the end of each interview, she expressed sincere gratitude and delight at the stories told by the students. As promised, students were never in the corridors during interviews, and the only issue caused by the glass box meeting rooms was overheating on a sunny day. Despite this, if I have the chance to do similar research in the future, I would hope that I would have more time to try and mediate with a school over such issues, to find preferable accommodation, and gain enough trust to be allowed to work independently with students. In the future, this might be something that I would try to discuss more openly with the school, in order to understand their precise concerns, and work towards overcoming them.

In the interviews that followed a majority of the young people spoke very freely and openly, albeit very ‘succinctly’. I felt that I had to ‘work’ quite hard to encourage the young people to elaborate, and ask questions multiple times to gain more insight into their thoughts. This was worse during two interviews in particular, where the students were inherently shy, and gave one-word answers to a majority of questions. When this happened, I found myself moving on to the next question quite quickly, or trying to change the topic in order to get rid of that ‘uncomfortable’ feeling. I was able to reflect on this feeling of ‘rushing’ in supervision, and in my later interviews I felt more comfortable to sit with silences, and stick with the same topics in order to try and encourage more reflection.

In addition to this, many of the young people reported finding the photo elicitation task very difficult, which meant that many students did not bring photos with them. Students reported being unsure of what to take photos of, or feeling uncomfortable taking pictures in public spaces. Now that the excitement of the research construction has dissipated, I can see that 'future' is a very abstract concept to capture, and photographs can be quite limiting. If I were to do this project again, I might consider the use of mixed media, drawing, painting and also the retrieval of images from magazines or the internet – the main forums for today's youth.

Transcribing and Data Analysis

I began transcribing interviews as I collected them, which was helpful in reflecting on the interview process, and the ways in which I could improve the interviews that followed. This was also important to the process of IPA, and the need to become 'submerged' in my data, and the voices of my participants. I knew that I had enjoyed transcribing during my undergraduate dissertation, as I liked that I could sit at a table for so many hours, and get a considerable quantity of work done (as opposed to the feeling I often get when writing essays). Therefore my transcriptions were completed fairly quickly, and as I read and re-read the transcripts ideas began forming in my mind about some of the important themes that were emerging.

The prospect of analysing the data seemed altogether more daunting, but following the recommendations of Smith, Larkin and Flowers (2009), I began with the first interview, and worked steadily through the rest. Themes fitted together more easily than I had anticipated, and there seemed to be a clear 'story' emerging from people's accounts, even with the inevitable convergence and divergence in experiences. There had however been areas that I had thought would be of more importance to the young people, that were not discussed, such as the role of their home environment (council estates), the portrayal of families on benefits in the media, and the recent attention given to the difficulties young adults are currently having in finding employment. As I was midway through interviews, I wondered whether or not I should have asked more explicitly about these topics, however on reflection I do feel that if these areas were of importance to the participants, they would have been brought up.

The writing of the results section was by far the most enjoyable part, providing the first evidence of the fruits of my labour, and proving that what I had done, and what the

young people had provided, was actually very interesting, and more than that – worthwhile.

Systematic Literature Review

The most difficult part of the systematic literature review by far, was starting the systematic literature review. The process of constructing a question seemed to take an eternity, with frequent ‘light bulb’ moments, only to discover that someone else has previously had such an epiphany - and gotten it published. Once I had a feasible review identified, the next task was identifying papers. Although this was tedious at times, it was also very interesting, and reading about the many different ways in which psychologists can adapt their work for low-income populations really made me reflect on my own clinical work with disadvantaged families. Despite this, I remember feeling consistently anxious that I might have missed a vital paper somewhere, and trawling through the search results numerous times. In addition to this, it took me quite some time to organise my search results in such a way that I was aware what papers I had, and where they were from. I felt that completing a systematic literature review was a huge task, and a steep learning curve.

This was a feeling that did not leave, and throughout my SLR I felt that I was unsure of what I was doing, and tasks, such as quality assessments and data extraction were repeated numerous times, as I often felt that I had done things wrong, and needed to double check my work. I would like to think that having had this experience, I would feel more confident and knowledgeable if ever undertaking a systematic literature review in the future. I do feel that my current SLR is of value, and provides a contribution to the current literature pertaining to working with low-income adults.

Overall, I have enjoyed the process of research, and I acknowledge and value the contributions that research can make to clinical work, policy and our own ability to think deeply and critically about important issues.

References

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Smith, J. A. & Osborn, M. (2003) Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.

Appendix H: Evidence of Ethical Approval



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Hull
HU6 7RX

FACULTY OF HEALTH AND
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T: 01482 464330
E: j.dyson@hull.ac.uk

OUR REF: 136
22 July 2014

Dear Orla

Re: An exploration of aspirations and future orientation in young people from low-income families

Thank you for your clarification of the points raised by the Faculty Ethics Committee following your second resubmission. I am delighted to grant Chair's approval.

I wish you every success with your study.

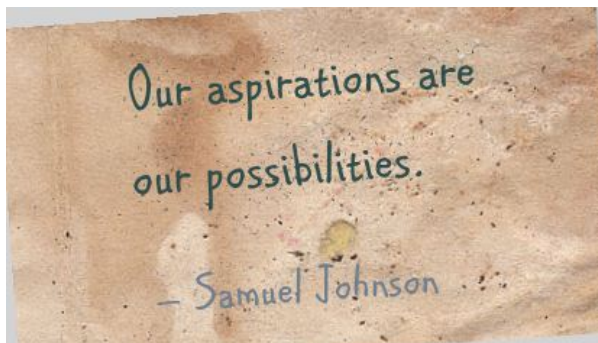
Yours sincerely

Dr Judith Dyson
Chair, Research Ethics Committee
cc: file/supervisors

Appendix I: Participant Information Sheet

Your Ideas For Your Future

An exploration of the aspirations of young people on free school meals



Information Sheet

Hello, I'm XXX. I'm a Trainee Clinical Psychologist at the University of Hull. I am doing this research as part of my project.

It's about what ideas you have for your future.

This sheet will tell you what the project is about and what you would have to do if you wanted to take part in the research. Use this information to help you decide if you would like to take part or not.

If there is anything that you are not sure about, you can ask your parents, or you or your parents can get in touch with me to ask me about anything you're unsure about.

What is this study about?

This study is trying to find out about the aspirations (hopes for the future) of young people in Hull who get free school meals. This is because not much is known about what young people who are on free school meals think about their future.

It is hoped that this research will give young people who receive free school meals a chance to express themselves as this has never been done before.

Do I have to take part?

No. It is completely up to you to decide. If you decide that you would like to take part, you will need to sign a form to say that you would. Even if you say you would like to take part, you can quit at any time. If you decide that you would like to quit, you won't get into any trouble and nobody will mind.



Can I ask questions before I decide?

Yes. I have put my email address and phone number on the forms you have been given so you can call or email me, or ask your parents to if you would prefer.

What will happen if I take part?

If you would like to take part you will need to sign a form that says you want to take part in the project. After that, I will come to meet with you either at home, or school or wherever you feel comfortable. I will also tell you about a task I would like you to do which involves taking some photographs. I will give you a camera to take home with you for 1 or 2 weeks to do the task. When you have taken the photographs, we will meet again and I would like you to talk to me about the photographs you have taken.



I would like to know what ideas you have for your future. This will include things like what job you would like to do, where you would like to live and what your friends and family might look like. While we are talking, what we say to each other will be recorded on a dictaphone. This is so that later I can listen again and write down your ideas. Altogether, you will probably be talking to me for about 1 hour.

Will what I say be kept private?

Yes. Only you and your parents will know you are taking part in the study. I will use a code instead of your name on the copy of your interview so that only I will know it is yours. The interviews will be kept in a locked cabinet so no one else can listen to them.



The only time I will have to tell someone about you is if I am worried that you or somebody else is not safe. But I will always tell you first if I need to talk to someone.

What will happen to the information XXX collects?

I am going to write about what I find out for my studies. I might also talk to people who work with young people to tell them about what I've found out. If you or your parents want to know about what I have found out, I will tell you, and you can have a summary of the finished project.

What if there is a problem?

If you have any worries or questions about the study, you or your parents can call or email me to talk to me. My contact details are below.

Thank you for reading this information sheet.

XXX

Appendix J: Information Sheet for Parents

Parent Information Sheet

An exploration of the aspirations of young people who receive free school meals

My name is XXX and I am a trainee clinical psychologist on the Doctorate in Clinical Psychology course at the University of Hull. I am required to carry out research as part of my course. I have chosen to look at the thoughts and ideas young people have about their future.

The school may have asked your son/daughter to take part in this research. This information sheet gives you information about the research. Please read it carefully to ensure that you are happy with your son/daughter taking part should they wish to do so. If there is anything you are unsure about or you have any questions, please contact me using the details provided below.

Part 1 – information about the study and what it involves

Part 2 – more detailed information about the research

Part 1

What is the study about?

This study aims to find out about the aspirations young people have for their futures. My research focuses on young people living in lower income families and that is why only young people receiving free school meals will be included in this study. Many different populations are used in research, and young people who are not from wealthy backgrounds have not previously been given a chance to express their views. Very little is known about the aspirations of young people from these families. It is hoped that by doing this research we will be giving young people a voice, find out more about what inspires and influences the aspirations of these young people, and give them a chance to share their experiences.

What do I have to do?

You have been identified as a parent for a young person aged between 15-17 years. Your consent is therefore being sought for your son/daughter to participate in the study.

Does my son/daughter have to take part?

Nobody is under any obligation to take part in this study. It is up to the young people whether or not they would like to participate. If they decide they would like to participate, you will be asked to sign a consent form. Your son/daughter is free to withdraw from the study at any point and will not have to give a reason why.

What will happen if I take part?

If your son/daughter decides to take part in the study, please contact the researcher using the details provided below. The researcher will then contact your son/daughter to arrange a meeting that is convenient for them. You do not have to attend these meetings if you do not want to, but you would be more than welcome to attend the first appointment and ask any questions you may have. The first meeting can take place at a location that all involved would prefer.

At the first meeting, the researcher will explain in more detail what the research involves, and give instructions for taking part. You and your son/daughter will need to

sign a consent form that states that you both agree to take part in the study. Your son/daughter will be given a task, which they will have 1-2 weeks to complete, and can spend as much or as little time as they like doing. This involves taking photographs of their ideas for the future, and the researcher will provide your child with a digital camera to use for the task. You and your son/daughter will also be given further opportunity to ask questions.

At the end of the first meeting, the researcher will arrange with your son/daughter another time that is convenient to meet to talk about the photographs they have taken. This interview will involve just your son/daughter and the researcher and is expected to last approximately one hour. The interview will involve your son/daughter talking about what photographs they have taken and why. They will also be asked additional questions about their ideas for their future.

Will it cost anything?

No, there is no cost involved in taking part in this study.

If after reading the information in Part 1 you are still interested in taking part, please continue to read Part 2 for further details.

Part 2

Will information be kept confidentially?

Yes, your child's participation in the study and all information about your child will be kept confidentially. Information will be stored in a locked cabinet at the University of Hull.

Only the researcher and other authorised persons (research supervisor) will have access to the information. Once the study has been completed, the information will be kept for 10 years in the locked cabinet before being destroyed.

Confidentiality may be broken, in line with current legislation, only if information is shared that raises concerns for the safety of your child or anyone else. If this happens, information will be shared with only the appropriate people to ensure that your child is safe.

What will happen with the results of the study?

The results will be collected and analysed by the researcher. She will then write up the results and submit them for publication in an appropriate professional journal. If you would like to find out about the results of the study once it has been completed, please contact the researcher on the details provided below and she will feed this back to you. A copy of the finished research, or a summary of this, can be provided for you to keep.

What if there is a problem?

If at any point during the study you or your son/daughter has any questions or concerns you can contact the researcher on the details that are provided below. The researcher will do her best to try to answer any questions you have.

Has anyone reviewed the study?

The study has been reviewed and approved by the Health and Social Care Faculty at the University of Hull.

**Thank you for taking the time to read this information sheet.
If you have any further questions please contact me using the details below:**

XXX

Trainee Clinical Psychologist

Department of Clinical Psychology and Psychological Therapies

Hertford Building

University of Hull

Hull

HU6 7RX

Telephone: XXX

Email: XXX@hotmail.com

Appendix K: Participant Consent Form

Consent Form – Young Person

An exploration of the aspirations of young people who receive free school meals

Please could you circle your answer to each question:

Has somebody explained this project to you? Yes/No

Do you understand what this project is about? Yes/No

Have you asked any questions about anything you don't understand? Yes/No

Have you had your questions answered in a way you understand? Yes/No

Do you understand it's ok to stop taking part at any time? Yes/No

Are you happy to take part? Yes/No

If any answers are "no" or you have decided you don't want to take part, please don't sign your name.

If you do want to take part, please write your name on the line below.

Your Name: _____.

Date: _____.

The person who explained this project to you needs to sign as well:

Print Name: _____.

Sign: _____.

Date: _____.

Thank you for your help.

Appendix L: Parent Consent Form

Parent Consent Form

Participant ID: ***

Title of study: An exploration of the aspirations of children from low-income families.

Researcher: XXX

Please read the statements below carefully and complete your details in the spaces below if you would like to take part.

Please initial the boxes:

- 1. I confirm I have read the information sheet about the above research project and I am happy for my son/daughter to participate .
- 2. I understand what the project is for and what it involves.
- 3. I understand that participation in the project is voluntary and that my son /daughter can withdraw at any time.
- 4. I understand that any information about my son/daughter will be kept confidential.
- 5. I have had the opportunity to ask any questions I had and confirm I have had satisfactory replies to these.
- 6. I have considered all of the information provided and I am happy for my son/daughter to take part in the study.
- 7. Do you live in rented accommodation? Yes/No

Name of parent

Signature of parent

Date

Contact telephone number

Name of researcher.....

Signature of researcher

Date.....

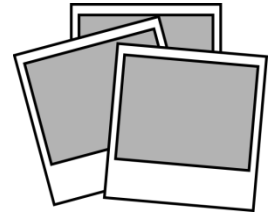
If you have any queries please phone me on – XXX or email me on XXX@hotmail.co.uk

When completed: 1 for participant; 1 for researcher site file.

Appendix M: Instruction Sheet



Instructions Photo Task



What I need to do:

Take photographs of things that show *my ideas for my future*.

I have until (date) to take my photographs.

I can:

- Use the digital camera that XXX has given me to take the photographs
- Get a person's permission first if I want to take a photograph of them or something that belongs to them
- Choose 10 of my photographs to show XXX when we meet on (date) .
- Bring the photographs to XXX on the digital camera
- Decide to quit the task at any time
- Ask questions if I'm not sure about something

I must not:

- Take a photograph of anyone without their permission
- Take a photograph of something that belongs to someone else without their permission
- Put my photographs on any social media sites (such as Facebook or Twitter) before meeting with XXX



XXX will:

- Meet with me on (date) .
- Ask to look at the 10 photographs I have taken and brought to the meeting
- Ask me questions about my photographs
- Take a copy of the photographs to help her with the project
- Keep the photographs private

Appendix N: Demographic Questionnaire

Demographic Questionnaire

Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

1. How old are you?
2. Are you male/female (circle)
3. About how long have you lived in your current home?
4. Are any languages other than English spoken at home? If so, what are they?

Appendix O: Debrief Sheet

Thank you!

Thank you very much for taking part in my study! I really appreciate your help and I hope you have enjoyed it!

If you have any questions for me after the interview you can contact me on:

Telephone: _____

Email: _____

If you are upset or worried about anything you can talk to:

- Your parents
- Your GP
- Someone at school
- Family or friends.

I have also included some numbers of places that you can contact for free for help and support with anything:

Childline – 0800 1111

A free, private and confidential service, where you can talk to a counselor about anything that is bothering you (big or small).

Samaritans – 0845 790 9090

Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts.

Wilberforce Health Centre – 01482 336 336

For free help and advice around sexual health. They also have a free drop-in service.

Relate – 0800 100 1234

For counselling, support and information about relationships.

ReFresh – 01482 300 300

Offers information, advice and support about drugs, solvents and alcohol. ReFresh is part of the young people's support service (YPSS).

YPSS Counselling and Therapeutic Service – 01482 300 300

Provide a safe and private space for young people aged 13-21 to talk about any worries or problems they may have.

Appendix P: Coding Example

Code:

Yellow – Descriptive codes

Green – Linguistic codes

Purple – Interpretative codes

R: So I'll just start with some questions about school, if that's alright?	
Pt: Yea	
R: So do you enjoy school?	
Pt: Yea. I enjoy school.	
R: Yea. Have you, what are your favourite subjects?	
Pt: Ergh. My GCSE subject is (.) one of my favourites, along with English, I really, English.	
R: Yea. And why is it those subjects d'you think?	
Pt: I don't know its because erm, obviously my GCSE subject I got to pick my own, and everything, so I got to pick what I wanted to do. I just do erm, art, cos we haven't done it since (.) I think the end of year 8, or something like that was eh, when we stopped doing art, and I really wanted to do it again because it's like, one of my favourite things to do is to be creative with art and things like that.	'What I wanted to do' Following own interests.
R: Yea. Brilliant. And, what sort of things do you like to do outside of school?	
Pt: I like to do all sorts. Erm, I like to go out with my friends and stuff, I like to, play guitar (.) draw a lot, play a lot of games and everything, with my friends and stuff so. And I like doing all sorts.	
R: Yea. So you're quite busy?	
Pt: Yea.	
R: Yea. And what's it like where you live now? The area.	
Pt: It's alright.	
R: Yea. Is there much to do around?	
Pt: Not really. I mean my friends don't live to far away so I can easily get to them if I want to see one of them or something. But erm, there's nowt really in the area, that I'm interested in.	
R: Yea. Ok. SO, do you think you would be able to just run me through what you can	

remember of the pictures that you've taken, and why you might have taken them?	
Pt: Yea, erm. Well cos the topic was like erm where you want to be in ten years and stuff, so, I took a couple of photos of the erm, music shop I go to, Hessle Music Centre, because (.) erm (.) one job I want to do in the future at one point is erm (.) work in a guitar shop, or a music shop or something well, even maybe become a guitar teacher or something like that, that would be ergh, quite good.	Possibilities. 'At one point' – acknowledgement of change in job roles over time.
R: Yea.	
Pt: And I erm, I took a (.) couple of photos of my cat weirdly enough cos I really like animals and stuff, so.	
R: Yea.	
Pt: I thought (.) that might be something interesting.	
R: That's good. Any more, or is it those ones?	
Pt: Erm, I can remember taking a couple of other photos, but I can't remember what they're of.	
R: Yea. Ok. Great, thank you.	
Pt: So you already (.) said a bit about what job you might want to do in the future, so you think it might be something to do with music?	
Pt: Yea. Definitely.	
R: Yea. So, do you think (.) you'll decide exactly what sort of job it will be yet, or is it	
Pt: I mean like, dream job, I'd want to be in a band	'Dream job', not achievable/realistic? Plan B.
R: Yea	
Pt: Erm, but (.) I mean there's all sorts of different paths you can go with music and everything. I'm doing ergh, two music courses when I get to Wilberforce hopefully and stuff, so. I, I don't know. I, really (.) feel quite passionate about music and stuff, and it's one of my favourite things.	Hopefulness
R: Yea. So if you didn't manage to make it into a band what do you think you'd do instead, music.	
Pt: Erghh. Try and work in a guitar shop or, something like that, or maybe even try and write music for, I don't know, maybe a TV show or something like that or anything.	
R: Yea. Lots of choices like you said. Yea. Great. Erm. And is there anyone else you know that does that kind of work? Or is involved in music?	

Pt: Erm (.) Not, none of my friends are really (.) that interested in like, doing music professionally, I mean a lot of my friends like music and everything but none of them are really (.) into doing music	
R: Yea. And what about in your family?	
Pt: My family erm (pause) no, no one really does music (pause) I mean I think my Dad's been in a band before but, I don't really know much to be honest.	
R: That's ok. Erm, and do you know what you would need to do (.) to get to where you want to be with music?	
Pt: Not really, if I'm honest. I mean, I thought all it takes to make a band is get a couple of friends and	Achievement of dream job less in own control? More to do with luck?
R: Yea, yea	
Pt: Stuff like that so, I don't know	
R: Yea. Ok. Erm (.) and who do you think will be the main people that will help you?	
Pt: My mum's very supportive, as well as like erm. My guitar teacher, he's really supportive, and he really believes in me and that so. Erm, there's quite a lot of people (.) who sort of, support me and everything. So I've got quite a lot of people supporting me and everything in what I want to do.	Being 'believed in'/supported