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Worlds apart: Social inequalities and psychological care

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Social, educational and economic disparities between therapists and clients are often evident. If psychological therapy exerts its restorative influence through communication and guided action, how can effective communication take place when therapists and clients are *worlds apart*? As early as the 1950s, it has been recognised that social inequalities pose serious challenges to the practice of psychotherapy (Imber, Nash, & Stone, 1955). Some early studies, for example, noted that low-income patients were less likely to seek mental healthcare (Riessman & Scribner, 1965), and tended to drop out of talking therapies (Overall & Aronson, 1963). The prevailing attitudes and ideas about this matter were poignantly captured in the title of James Heitler's paper: "Preparatory techniques in initiating expressive psychotherapy with lower-class, unsophisticated patients" (Heitler, 1976). For too long, psychotherapy was seen as a middle-class endeavour for the privileged and educated, where the onus was on the clients to be "psychologically minded" in order to benefit from treatment. In recent decades, however, great strides have been taken to make talking treatments less complicated to explain and to deliver (Bennett-Levy, Richards, & Farrand, 2010). Psychological care is also becoming more culturally sensitive (Bernal & Domenech Rodríguez, 2012), and more accessible to the general population (Clark, 2018). But have we come to understand or address the adverse impact of social inequalities? Today, people living in poverty are still more likely to experience mental health problems (Lund et al., 2010), and are less likely to access therapy (Saxon et al., 2007), and when they do so they are less likely to recover from depression and anxiety problems (Delgadillo, Asaria, Ali, & Gilbody, 2016). Social inequalities continue to be under-researched in our field; rarely acknowledged in clinical training programmes or in the therapy consulting room. It is like an obstacle that is hidden in plain sight; our senses perceive socioeconomic

differences effortlessly, but these perceptions may not register consciously in our therapeutic reflections, formulations and actions.

This special issue of *Counselling and Psychotherapy Research* aims to bring the dimension of social inequalities into the foreground of psychotherapy research and practice, gathering a diverse and international collection of original investigations on this topic. The issue begins by presenting a series of large-scale quantitative studies whose findings fit into a coherent pattern, despite being conducted across three countries with distinctive healthcare systems. Socioeconomically deprived areas tend to have an increased prevalence of common mental disorders and greater demand (numbers of referrals) for publicly funded psychological care, but lower treatment access rates irrespective of local variations in the availability of therapists (Delgadillo, Farnfield, & North, 2018). Compared to favourable periods in the economic cycle, periods of financial recession with high unemployment rates also carry evident consequences for mental healthcare. Even when they are able to access and start counselling, low-income clients tend to have higher distress levels at the start and end of treatment compared to high-income clients (Berzins, Babins-Wagner, & Hyland, 2018). This does not mean that low-income clients cannot benefit from therapy; in fact recent evidence demonstrates that clients tend to show improvements in psychological distress and life satisfaction during therapy regardless of income level (Behn, Errázuriz, Cottin, & Fischer, 2018). However, symptomatic improvements appear to predict subsequent improvements in life satisfaction in high-income clients, whereas for low-income clients symptomatic improvements tend to be slower and preceded by gains in life satisfaction (Behn et al., 2018).

These contemporary findings lend support to *social causation theory* (Dohrenwend, & Dohrenwend, 1996), which posits that socioeconomic and

environmental adversity is associated with the onset and maintenance of psychological problems. Unemployment and low income may, for example, limit access to health-enhancing goods and services, and only modest gains in life satisfaction might be realistic under these circumstances. Hence, one pathway towards psychological distress may be explained by *material deprivation*. It is also plausible that a related pathway to distress may be explained by *adverse life events*. Blackshaw, Evans and Cooper (2018) conducted a systematic review that examined associations between life events, socio-economic status and psychological treatment outcomes for children and adolescents. Starting with a recap on the well-known associations between socioeconomic status and stressful life events (e.g. preventable accidents, abuse, neglect, academic problems), this review synthesises emerging evidence that the relationship between socioeconomic status and treatment outcomes may be partly mediated by the frequency and severity of stressful life events that occur during the course of therapy. Of particular note is their thoughtful observation that, for the individual, stressful life events may lie within a continuum between "no control" and "complete agency". This point suggests interesting possibilities for clinical practice; could different emotion regulation strategies be useful to cope with different stressful life events? And if so, do social inequalities limit our ability as therapists to support patients in adjusting to and coping with adversity?

Dovetailing with clinical practice, a series of survey-based and qualitative studies have explored the relevance of social inequalities from the perspectives of trainees, therapists and clients. Using a vignette-based methodology, Kaiser and Prieto (2018) found that trainee counsellors did not have an apparent bias against working-class clients, but trainees who self-identified as being working-class showed a bias towards upper-class

individuals and anticipated having greater difficulties in forming a working alliance with such clients. Trott and Reeves (2018) also examined the relevance of social-class disparities from the viewpoint of qualified therapists who had themselves accessed therapy. Their findings suggest that a lack of awareness and acknowledgement of social-class disparity can damage the therapeutic alliance through inadvertent use of oppressive or classist behaviour; and recognising such disparity can minimise power imbalance and improve rapport. Krause, Espinosa-Duque, Tomicic, Córdoba and Vásquez (2018) also draw attention to the detrimental effect that perceived asymmetry and power imbalance can have on the therapeutic alliance. Furthermore, they pinpoint a series of factors reported by economically disadvantaged clients which act as barriers to effective treatment; geographical and financial impediments to access health centres, culturally-bound prejudices and stigma surrounding mental health problems, and a perceived "clash" of perspectives that may leave clients feeling misunderstood. The theme of cultural diversity is also approached by Moleiro (2018) through a detailed examination of psychotherapists' cultural awareness and competency, where they were interviewed after being presented with two video vignettes of clients from minority social groups (according to migration status, ethnicity and religious affiliation) and two control vignettes of college students presenting the same complaints. With reference to a range of established multicultural competency frameworks, Moleiro concluded that the majority (70.5%) of rated answers from participants reflected low levels of cultural competency across the domains of openness to differences/attitude, awareness, knowledge, and skills. Joining the dots across studies, we can see that the central notion of *social disparity* / asymmetry emerges as a likely obstacle to establishing a supportive therapeutic alliance, which may be a necessary condition to

effectively support clients to cope with adverse financial and social circumstances.

Many obstacles to treatment utilisation and effectiveness were raised across these studies, attesting to the tremendous challenges that social inequalities pose for the advancement of mental healthcare. An obvious step forward is to better integrate the topics of social inequalities, power imbalance and cultural competency into clinical training programmes. However, our discipline has tended to be rather introspective and focused on the internal world of clients and the relational and technical aspects of the therapy process. Though these aspects are important, an overly insular focus may conceal the broader social, cultural and economic context within which human suffering occurs. Under some circumstances, a positive transformation of a person's internal world may require a transformation of their external world too; the psychological and social cannot be seen as *worlds apart*. There are some notable examples that demonstrate this in positive and negative ways. For instance, adjunctive welfare advice yielding financial gains for people with psychological problems improves short-term mental health and well-being (Woodhead, Khondoker, Lomas, & Raine, *in press*). Neighbourhood deterioration is associated with stress and depressive symptoms, and this relationship has been found to be mediated by changes in social contact, social capital, and perceptions of crime (Kruger, Reischl, & Gee, 2007). Living in urban environments with poor housing quality, noise and pollution is also known to be associated with increased rates of depressive mood after adjustment for individual characteristics (Rautio, Filatova, Lehtiniemi, & Miettunen, 2018). Perhaps our ability to improve the equitability and effectiveness of care for disadvantaged communities may improve when

we are better able to integrate insights and evidence from clinical psychology, community psychology and social psychology.

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