Socioeconomic and sociocultural factors affecting access to psychotherapies: the way forward

Huge progress has been made in the development of evidence-based psychotherapies for a wide array of mental disorders[1]. However, significant socioeconomic and sociocultural divides exist in the access to these interventions. The unavailability of psychotherapies for a large proportion of the world's population presents a major challenge to the future of mental health care.

There are currently both structural and attitudinal barriers to accessing psychotherapies. In relation to structural barriers, a major problem is that, in many countries worldwide, evidence-based psychotherapies are scarcely available in public mental health services, being mostly practiced by psychologists and psychiatrists in their private offices, which creates a socioeconomic divide in accessing them. The introduction of e-mental health was expected to fill some of these gaps in access to psychotherapy. However, digitally and socioculturally disadvantaged and minority groups remain underrepresented in studies of e-mental health and effective uptake of e-health. Indeed, the digital and language skills required for e-mental health engagement are beyond the reach of many, particularly some minority ethnic groups[2].

Attitudinal barriers play an equally, if not more, significant role. The dominant model of psychotherapy is largely pro-rich and pro-highly educated, and therefore is met with suspicion and/or is felt to be out of reach by many. Moreover, psychotherapists are often poorly trained to accommodate the highest level of need, and the ethnic and cultural diversity of mental health professionals rarely reflects the diversity of the population[3]. These problems are exacerbated by the large-scale international migration of families presenting with the consequences of the enduring psychological impact of displacement, uprooting and culture change. Data from the World Mental Health Surveys show that, even in Western countries, reluctance to seek help for mental health problems due to suspicion about the treatments on offer is a far more important barrier than structural barriers to initiating and continuing treatment, and predicts 39% of treatment dropout[4].

The implicit value system behind evidence-based psychotherapies presents a poor fit in relation to some ethnic and cultural groups. For instance, is the prioritization of individual agency implicit in psychotherapy universal or is it a peculiarity of Western cultures? Socioeconomically deprived individuals are underrepresented in clinical trials for most common mental disorders. Our knowledge of the effects of psychotherapies is largely limited to data from so-called "WEIRD" (Western, Educated, Industrialized, Rich and Democratic) individuals, who comprise 90% of study participants in psychological studies, from countries constituting only 12% of the world's population[5]. In this respect, the COVID-19 pandemic currently magnifies underlying social inequalities, with new remote therapy platforms, for instance, often failing to reach those who may need mental health support the most.

What can be done to increase access to psychotherapies, particularly by socioeconomically disadvantaged people and sociocultural minorities? First, the applicability of psychotherapies needs to be broadened to include non-traditional service providers and self-help interventions. Programmes ongoing in low- and middle-income countries to train "barefoot" therapists by creating e-learning platforms represent an important model. These programmes ensure increased reach by trusted and familiar individuals, as well as high levels of fidelity, and direct supervision providing quality control and outcomes reporting[6].

Second, interventions need to be adapted to specific populations. Studies suggest that, when interventions for mental health problems are adapted to make them culturally appropriate, they are typically as effective in minority groups as in the populations for which they were originally created and tested. Likewise, increasing the multicultural competence

of psychotherapists has been associated with improved treatment outcome[7]. This suggests that disadvantage does not rest with the disadvantaged; rather, it results from the unwarranted assumption of psychological universalism, namely that no adjustments need to be made when reaching out to the "hard-to-reach".

Third, the field of mental health needs to actively engage with racial and other issues of inequalities. For example, a history of exploitation of certain racial groups inevitably leaves its psychological mark, and the pervasiveness of racism in many Western societies generates microtrauma which, if not explicitly addressed, leaves psychotherapies to be experienced as irrelevant to the concerns of minoritized groups. Consistent with these assumptions, areas with high density of minority groups are associated with an increased prevalence of mental health problems and poor treatment seeking, but only when combined with low levels of social support and cohesion. Similarly, social deprivation and minority ethnic status have been associated with delays in initiating treatment for mental health problems, but not with continued treatment once engagement is achieved[8].

Early adversity defines a transdiagnostic ecophenotype that has been associated with earlier onset of mental health problems and high service utilization, but poor treatment response and high levels of dropout[9]. Beyond preventing early adversity, increasing social capital – that is, the resources available to individuals through social relationships with an emphasis on reciprocity, trust, collaboration and kindness – may be an important component of countering social inequalities related to unequal access to mental health care. People with a relatively high degree of power tend to focus on themselves as individual agents, while marginalized individuals with low economic power tend to focus on their communities. When that community support is absent, those with low power are, as a result, both more vulnerable to mental health problems and at the same time less inclined to seek help.

Finally, the way the effectiveness of psychotherapies for mental health problems is depicted by the media may have an important impact on their use and perhaps also their effectiveness, decreasing or reinforcing stigma related to mental health problems. Without explicitly addressing issues of stigma and shame, those who feel alienated with mental health needs will remain mistrustful of those perceived as privileged, whilst, at the same time, those offering support will continue to place responsibility on those appearing to be unwilling to accept help.

We need to empower a massive trusted workforce to deliver effective psychotherapies, harvesting the results of over five decades of research, to the large numbers in our societies who need them. This will require not only a significant change in the training of those delivering these treatments, but also an increased willingness on the part of mental health professionals to immerse themselves in the concerns of minority groups. Allyship requires a commitment which is long-term, not just during crises.

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1. Cuijpers P. World Psychiatry 2019;18:276-85.
2. Stone L, Waldron R. Aust J Gen Pract 2019;48:474-9.
3. Singla DR, Raviola G, Patel V. World Psychiatry 2018;17:226-7.
4. Andrade LH, Alonso J, Mneimneh Z et al. Psychol Med 2014;44:1303-17.
5. Henrich J. The WEIRDest people in the world: how the West became psychologically peculiar and particularly prosperous. New York: Farrar, Straus and Giroux, 2020.
6. Kohrt BA, Schafer A, Willhoite A et al. World Psychiatry 2020;19:115-6.
7. Soto A, Smith TB, Griner D, et al. J Clin Psychol 2018;74:1907-23.
8. Lund C, Brooke-Sumner C, Baingana F, et al. Lancet Psychiatry 2018;5:357-69
9. Teicher MH, Samson JA. Am J Psychiatry 2013;170:1114-33