

## SPECIAL ISSUE PAPER

# Psychotherapy for depression from the point of view of economically disadvantaged individuals in Chile and Colombia

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## Abstract

*Background:* This article presents a qualitative study, conducted in Chile and Colombia, on mental health care access and experiences with psychotherapy from the perspectives of economically disadvantaged clients. Current epidemiological data show it is important to conduct psychological interventions to address depression in poor populations, given the high prevalence of this disorder in these groups. However, despite efforts made in both countries at the health care policy level, the impact of the available psychological care has been weaker than expected. *Aims:* Based on this observation, this study sought to collect more information for understanding this problem by incorporating patients' views. *Materials & Methods:* To shed light on this issue, 24 participants from Chile and Colombia were interviewed with respect to their opinions on access to psychotherapeutic care and their experience with it. Semi-structured interviews conducted were analysed using Grounded Theory procedures. *Results:* The facilitating and impeding factors that low-income people have regarding access to psychotherapy, in an institutional context, and specific challenges involving changes in their understanding of their problems and their own role in recovery are presented. These changes involve distancing themselves from their original culturally-shaped understanding of psychological disorders. *Discussion:* The influence of psychotherapy as a force capable of shaping culturally determined meanings in clients from economically disadvantaged areas is problematised. *Conclusion:* The results of this research may encourage clinicians to see the client's uniqueness within a certain social order and a social network as different from that of the therapist.

**Keywords:** access to psychotherapy, depression, experience with psychotherapy, poverty

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## Depression and poverty: epidemiological evidence

Research has revealed a link between income levels and depression, with this disorder being more frequent in contexts of poverty (McLeod & Shanahan, 1996; Ohuoha, 2011). Globally, people living in poverty are more likely to suffer from depression (Vöhringer et al., 2013), at a rate 1.5–2 times higher in disadvantaged economic contexts than in advantaged ones (WHO,

2013). As Errázuriz, Valdés, Vöhringer and Calvo (2015) point out the link between poverty and depression constitutes a vicious circle, as the lost productivity and mental health costs affect a person's economic standing as well as that of his/her family, thus maintaining or worsening his/her deficits.

Specific studies conducted both in Colombia and in Chile confirm this connection between poverty and depression (Gómez-Restrepo & Rodríguez, 1997;

MINSAL, 2011). Chilean data show that considering the two extremes of the five income tiers that the population is commonly grouped into, the prevalence of depressive symptomatology in the lowest-income group reaches 25%, versus 8% in the highest-income group (MINSAL, 2011).

Studies conducted in Colombia do not report indexes similar to those presented for Chile. However, data for both countries show an association between socioeconomic level and depression in general (Gómez-Restrepo & Rodríguez, 1997) and for specific populations, such as older adults (Tuesca-Molina et al., 2003). Research in Colombia has also yielded evidence for higher depression rates in populations with a lower educational level (Gómez-Restrepo, Ospina, Castro-Díaz, Gil & Arango Villegas, 2011).

As discussed in the following section, empirical evidence reveals inequality not only in terms of the distribution of this disorder, but also with respect to access to psychotherapeutic treatment and permanence in psychotherapy.

### Access to depression treatment in Chile and Colombia

Chile and Colombia are characterised by the coexistence of private and public health care systems, with most users of the latter belonging to middle and low-income populations (Becerril-Montekio & Reyes, 2010; González et al., 2016; MINSALUD & COLCIENCIAS, 2015). This situation, along with others connected to public funding, coverage and access, maintains inequality in health care in the region. Nevertheless, in both countries, over the last years, legal measures have been adopted to extend the coverage of public mental health care services, including depression treatment as a priority in mental health care.

In Chile, the Plan for Universal Access to Guaranteed Health Care (GES) constituted one of the main steps forward in terms of public health care and equity during the past decade (Law number 19, 996, 2004). This reform included the implementation of National Mental Health and Psychiatry Plans (MINSAL, 2000, 2016a,b), with prioritisation of four mental health problems, one of which is depression (Errázuriz et al., 2015). In the case of severe depression, the GES Plan includes a session with a psychiatrist and treatment with a psychologist and other mental health professionals (Rojas & Pemjean, 2006). To guarantee quality care, clinical guidelines have been produced for interventions and treatment, which differ depending on the patient's type of

depression and age group (adolescents, adults, and older adults) (MINSAL, 2013). However, in practice, the number of depression sufferers who receive treatment is lower than expected (Minoletti, Rojas & Horvitz-Lennon, 2012), especially in low-SES areas (ELSOC-COES, 2018).

In Colombia, the General Social Security System for Health Care (SGSSS) is included in the Political Constitution (1991) and defined by Law number 100 (December 23, 1993). The SGSSS includes two systems: the contributory system, aimed at people who are able to pay, and the subsidised system, which targets poorer individuals unable to cover the total costs of the care received and are given State subsidies. Mental health, which before this law only included care during crises, was extended after 2015 to cover outpatient psychotherapy for the general population. The law establishes ample coverage for mental health treatments including individual, group, family and couple psychotherapy (MINSALUD, 2015). However, it is important to consider the difference between SGSSS coverage and access to health care in terms of the percentage of people who use these services. Some studies show that despite an increase in the number of beneficiaries of the system, access to health care services has dropped (Ayala, 2014).

Together with the access limitations identified in both countries, data from some service providers show that patients' attendance and adherence to mental health treatments are not very high, and even though the system covers 30 psychotherapy sessions in Colombia and 12 in Chile, very few patients reach those points in their treatments. In a sample of 532 patients of a service provider in Colombia, it was found that 25% of them only attended four psychotherapy sessions, 50% reached session eight, and 75% reached session 14. In this study, conducted between 2014 and 2015, only 10% patients attended more than 30 psychotherapy sessions (Espinosa, Jaramillo & Ocampo, 2017). Chilean studies have also shown that dropout rates are greater in lower income populations than higher income ones (Krause & Winkler, 1995).

In brief, people from economically disadvantaged areas display a higher prevalence of depressive symptomatology, encounter more barriers for accessing psychological treatment and show lower levels of treatment adherence. Given this situation, it is essential to examine users' experiences with a qualitative methodology to detect barriers for accessing treatment and for staying in psychotherapy, which may not have been detected in current research.

### Psychotherapy for depression from the client's point of view

A number of qualitative studies have examined the views of clients belonging to low-income groups regarding access to mental health care and their experience with psychotherapy. A study conducted in Chile in the 1990s, showed that potential patients must complete several steps before receiving help. The first of these steps involves a crisis that often has physical and emotional symptoms (Krause, Uribe, Winkler & Avendaño, 1994). Individuals are referred from the medical care system to a mental health professional and often receive a psychological diagnosis that they find hard to accept, because it does not coincide with their biological-medical definition of their own symptomatology (Krause, 2002). Another barrier they often contend with is the notion in their social surroundings that psychological help means that one is 'crazy', which entails fear of stigmatisation (Krause, 2011).

In Colombia, some qualitative studies have shown that having medical insurance does not guarantee effective access to health care services and that several administrative, geographical, normative and cultural barriers exist (Vargas & Molina, 2009). Similarly, studies of vulnerable populations, such as people in forced migration situations, have revealed that difficulties accessing health care services constitute an additional problem, associated with insufficient funding, unclear public policies and the limitations of medical insurance (Mogollón, Vázquez & García, 2003; Mogollón-Pérez & Vázquez, 2008).

Regarding the psychotherapy experiences of low-income clients, studies conducted in Chile report several issues between patients and therapists (Zalaquett, Manzi, Duque, Krebs & Aninat, 1982), including their definition of the psychological problem, the special challenge of arriving at a shared conceptualisation, and expectations associated with therapeutic actions, where the main challenge is to accept that psychotherapy is 'healing through words'. In psychotherapies which are well evaluated by patients, it is possible to observe a transformation in patients' conceptualisation of their problems and an increase in their perceived ability to deal with them. With respect to bond-related aspects, many patients regard therapy as a type of 'special friendship', in which warm personal interaction is highly valued. For these patients, the effectiveness of psychotherapy goes beyond overcoming symptoms and interpersonal conflicts and is rather a learning process guided by

the therapist (Krause, 2002, 2011; Krause & Winkler, 1995).

These studies also indicate that psychotherapeutic work with low-income populations involves difficulties due to cultural differences, for example, which impede a shared definition of the client's problem (Zalaquett et al., 1982) hindering the therapy process (Winkler, 1993). High dropout rates observed in mental health care centres located in poor neighbourhoods have been ascribed to these difficulties (Krause & Winkler, 1995). Furthermore, research on the social representations of psychological problems in economically handicapped communities has revealed a cultural gap between clients and therapists (Krause, 2002). Whether this gap is still part of clients' experience today, and whether it can be found in two different countries, are topics addressed in this study.

### Method

#### Participants

Fourteen Chilean (11 women and three men) and 10 Colombian participants (eight women and two men) were interviewed about their experience of the psychological help they received. All participants were adults, aged 21 – 68, belonging mostly to low-income population groups in both countries.<sup>1</sup> Inclusion criteria involved: suffering from depressive symptoms; being economically disadvantaged and having been clients of usual psychotherapies delivered by the public health care system of their countries. The mean length of psychotherapies was 22 sessions, including dropouts.

#### Procedure and data collection

Interviews conducted in Chile are a subsample of a larger study, whereas the researchers working in Colombia selected interviewees that met the research criteria from a list of medical care recipients (purposive sampling). Participants were contacted through their mental health care centres after completing psychotherapy and interviewed by members of the research team (four of the five authors participated in the interviews). Participants joined the study voluntarily and signed a letter of informed consent. Semi-structured, in-depth interviews were conducted with each patient, which were audio-recorded and transcribed for later analysis. Face-to-face meetings between the researcher and the informants sought to shed light on the latter's experiences in their own words

(Taylor & Bogdan, 1995). In each country, interviews addressed three main topics: the patients' paths towards psychotherapy, their experience with psychotherapy and their evaluation of the results of psychotherapy.

Paths towards psychotherapy included: ways of accessing psychotherapy; factors that impede or facilitate access; referral practices; difficulties linked to patients' socioeconomic status, including general living conditions and work-related aspects; and motivation for psychotherapy.

Experience with psychotherapy included: facilitating and impeding factors in the establishment of the therapeutic relationship and the development of the therapy, taking into account economic, social and cultural conditions; and the influence of the health care system on therapy expectations and goals.

Evaluation of the results of psychotherapy included: evaluation of the effects of psychotherapy, specifically whether any changes occurred, considering the patients' own understanding of the 'problem'; and reasons to terminate psychotherapy.

These topics were addressed in each interview, but not necessarily in the order above. Each interviewee's narrative flow was respected, as is usual for semi-structured interviews (Flick, 2014).

#### Data analysis

Analysis was performed through grounded theory coding procedures (Corbin & Strauss, 2008). The researchers coded and analysed the data by continuously comparing patients' narratives. To do this, they developed concepts by refining them, identifying their properties, exploring their mutual connections, integrating them into a theory and applying the principle of theoretical saturation (Galeano, 2004). This methodology had been employed in previous studies (Krause, 2002, 2011; Krause & Winkler, 1995), which is relevant because it facilitates comparisons between current and historical findings.

First, data from the transcribed interviews were categorised (open coding) and compared considering participants' country of origin. Second, the researchers compared the main categories and their relations for each country (axial and selective coding). To ensure the quality of the results obtained, rater triangulation was used. Identification, interpretation and association of categories were validated through intersubjective agreement. The comparative analysis of Chilean and Colombian data was performed by all five researchers.

#### Results

Qualitative results are presented in two parts: a descriptive analysis of the main findings obtained through interviews with users of the mental health care systems of each country and a relational analysis grouping our findings around central categories that summarise clients' experience regarding access to psychological care and the psychotherapy received.

The descriptive results refer to the clients' experience regarding access to psychotherapy, the treatment process and its results. Said elements include contextual characteristics and aspects of the health care institutions involved, clients' characteristics, motivations, and expectations, and other elements of the treatment process and the results of psychotherapy (Fig. 1).

Some contextual aspects, such as receiving subsidies for covering treatment-related expenses, relate positively to clients' access experience and adherence to treatment. Working conditions also influence clients' ability to access treatment and their experience with it. To attend a psychotherapy session, a person requires support, permission from his/her employer and flexibility to repay the time lost. From a positive point of view, patients narrate: 'In some parts of the service, I managed to get the bosses to help me get treatment; I mean, they changed my shifts, you know? Or I was able to talk to a colleague to substitute me' (CH1222). However, some narrations show the workplace can become a limitation: 'I used to get appointments during the week and that got difficult because I need to pay back the time I miss at work, and I said "no, I need to adapt to this"' (CO63). Workplaces can become a space where clients receive support, but they can also be a source of stigmatisation.

Likewise, family environments can have a facilitating or hindering role in people's access to health care, through the perception of mental disease and the usefulness attributed to psychotherapy. Active involvement of the client's family can help improve adherence to the process:

If it hadn't been for my mum, I'd have stayed sleeping in bed, because, you know? If my mum hadn't felt concerned I wouldn't have received that support' (CO10). In contrast: 'My husband's pressure has also made it difficult for me to go to the psychologist because often when you're doing something they tell you "hey, it doesn't matter, you

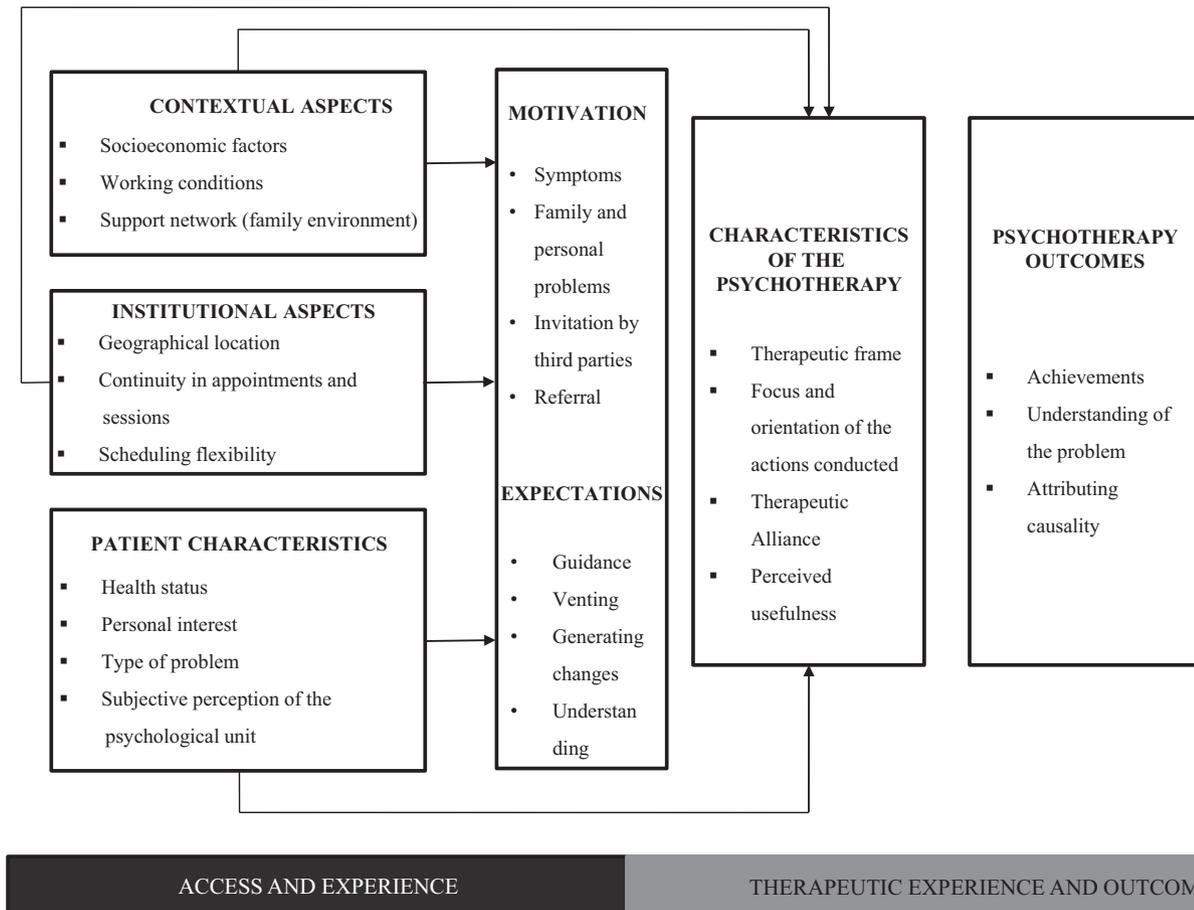


Figure 1: Central contents of the descriptive analysis.

can go there because you say you need it but I don't think it's useful at all" (CO4).

Certain aspects of health care centres, such as their geographical location (closeness and ease of access), the continuity of appointments, and the flexibility of their scheduling can become barriers or facilitating factors that influence clients' access and adherence to the service. Factors such as flexibility when making appointments are positively evaluated: 'Here, they've always been ... they pay a lot of attention to your requests when you make an appointment, they help a lot with that' (CO6). In contrast, appointment limitations are regarded as a barrier to receiving care: 'the therapy finished when I went on holiday, I talked to the therapist, but when I wanted to resume it she said it wasn't possible anymore' (CH122). Factors such as the number of psychologists in each institution, their high turnover rate or barriers to referral can directly affect clients' access to treatment.

Some client characteristics influence how they access and experience therapy. A personal interest in health can facilitate treatment processes, but there are also a series of hindering aspects, including: self-stigmatising prejudices; doubts regarding the therapeutic usefulness of talking to a stranger; the notion that psychologists treat insane people or shame connected to receiving psychotherapy. Such prejudices appear more explicitly in the narrations of Colombian participants:

I got sad all of a sudden because I said "um, it's just that my problem ... this is like too extreme," I thought, "I mean, I'm not crazy, I'm sort of anxious, but I'm not crazy," but I said nothing, I didn't tell him anything, I just said, "okay doctor" (CO5).

In addition, depressive symptomatology can hinder the identification and use of family and institutional support networks and the motivation to change,

because it leads clients to remain inactive, feel that they lack the energy to attend psychotherapy or refuse to discuss the problem to avoid anxiety.

Patients in the sample all started psychotherapy with depressive symptoms. They are commonly referred by a physician, and thus it is usual for them to expect a similar treatment model. Reasons for receiving psychotherapy included problems with their partner, family issues, parenting difficulties, somatic symptoms, personal problems, invitations by third parties and self-knowledge. Compared with Chilean participants, Colombian clients mention more problems related to their body. Frequent expectations include receiving guidance or advice about what decisions to make and how to behave to solve problems. In addition, clients expect to vent, generate changes, understand themselves and their environment, and work on interpersonal aspects, self-esteem, acceptance and personality:

What did I expect? I wanted the therapist to help me understand many things, many things that maybe I didn't understand, some parts of life, like things that happen to you in everyday life and that sometimes you don't understand (CO1).

During psychotherapy, the patients' experience with the therapeutic setting, the therapeutic alliance, and their evaluation of outcomes is relevant and relates to their adherence to treatment. Therapeutic tasks can produce positive feelings associated with guidance, however, they may also cause anxiety and discomfort in some clients. Clients value therapist traits such as kindness, warmth, tranquillity and professional experience, as well as having a space to talk and vent, where the therapist does not chastise them, exert pressure or display surprise. With respect to guidance, clients stress the relevance of focused discourse, and suggestions, advice or recommendations. Participants also stress the importance of therapist empathy, manifested through his/her interest in and understanding of the client's life events, as well as through emotional support and motivation, leading clients to experience psychotherapy as 'a space of their own':

When I started crying, it's like I ... you know, I felt he ... it's like he entered my sadness, I don't know, it's like he ... it's like he felt sad too. I mean, it's like he understood me (CH79).

In contrast, clients tend to have a negative opinion of short sessions, therapists who only ask questions, sessions with no clear objective, or professionals who do not make any suggestions. Also, they seem to

dislike moments of uncertainty, the repetitiveness of the topics discussed, feeling judged, and exposure to a research context (questionnaires, videos). The fact that clients stay in psychotherapy does not mean that the process is necessarily going smoothly:

She didn't guide me. I didn't feel welcome and I like people to look at me, the way you're looking at me. I want people to look at me so we can have a conversation (...) She was cold, cold (...) She just asked questions, she didn't give me any pointers, she never told me what I could do (CH37).

Regarding psychotherapy outcomes, most participants reported that therapy was useful ( $F = 17$ ), but others regarded it as useless ( $F = 2$ ) or said that it worsened their situation ( $F = 2$ ). Clients highlight positive achievements in the following areas: relationships with family members and with others (partner, children), communication in the family, symptoms, assertiveness, autonomy and independence, coping strategies, decision-making, self-esteem, self-efficacy, self-knowledge, acceptance of life events and the working-through of mourning. In addition, participants noted that they were able to vent and reduce their feelings of guilt:

I feel great, I don't have that weight here on my heart anymore, that thing you feel when ... it's like you want to cry all the time. I feel that weight is going away (CO3).

Also, the psychotherapeutic space allowed patients to increase their understanding of their problems, which entailed identifying links between organic symptoms and psychological problems or recognising relational patterns and the history of their difficulties. This was achieved through a reconceptualisation of the aetiology of their problems, which in many cases involves the convergence of factors belonging to multiple areas. Changes are also observed in the representation of psychotherapy after the treatment, which differs from the views that patients find in their social environment.

Clients consider that it was beneficial for them to be able to establish a bond with the professional, and to experience extra-therapeutic factors, such as receiving spiritual help, taking medication, making use of support networks, going on holiday, and 'understanding that other people are in a worse situation than them'.

Based on the descriptive results obtained, cross-sectional and interrelated results were generated, addressing the dimensions *access*, *experience* and *therapy outcomes*. Paths for accessing psychotherapy are marked

by the *context* of both health care systems, involving a sequence of referrals that delays access to psychotherapy and generates certain expectations regarding the psychotherapeutic relationship. A second contextual characteristic refers to how familiar the client's culture is with psychotherapy, given the latent threat of stigmatisation. Fear of stigmatisation may dissuade a potential client from attending psychotherapy, or influence the path leading to it through fear of discrimination, for instance in the workplace.

A central element in the therapeutic relationship is the establishment of a close bond, valued by Colombian and Chilean participants, and including the chance to vent and talk to someone who understands. Development of this bond is influenced by structural aspects of the therapeutic setting, such as the asymmetry resulting from the professional and cultural context. Both groups of clients compare the psychotherapeutic relationship with the relationship established with other health care professionals:

... some doctors only talk about what they have to deal with and nothing else, I mean, they don't ask questions, they're over there and you're over here, and you always have that fear, like when you go to school and the teacher is over there and you're over here, there's always a sort of distance (CO3).

In Chilean participants, this type of relationship also affects the start of the psychotherapy: 'I always saw him as a doctor, and I was a patient. I never overcame that barrier' (CH2). In Colombian clients, however, this warm bond is established as soon as the psychotherapeutic relationship starts.

A positive transition often occurs from the more impersonal relationship present in earlier appointments to a warm connection: 'A good thing that happened here (...) is that you feel like a person first, and like a patient second (...). You feel the other person is speaking, or looking, or conversing with a warmer attitude' (CH122). Analogies such as: 'I loved the way she treated me, I mean, she made me feel like she was my friend' (CO1) highlight the therapist as a person, beyond his/her role: 'I felt he wasn't a professional, but a person who wanted to help me' (CH122). Over the course of the psychotherapy, this asymmetry does not fully disappear:

It was reassuring to know that a person with proper training was analysing me (CH79).

Conversely, clients' prior experience shapes their role expectations and thus their wish to receive guidance from the professional. Participants from

both countries value receiving suggestions on how to act regarding their problems and have a negative view of psychotherapies where this does not occur: 'I feel he didn't guide me, and in those moments of pain you want to get some guidelines or a path to follow, some way out of the hole you're in' (CH37). Receiving guidance can also have a favourable effect on the clients' assessment of the psychotherapy:

Well, I was very thorough in the tasks I set for myself, for instance, thinking about other things, writing things that happened to me in a notebook, heavy, sad things, and how to deal with that sadness, and yes, I put into practice all those things and I slowly got out of that situation (CO9).

The interviews reveal a shift in the clients' focus from interpersonal interpretations of their problems and their physical symptoms towards a problematisation of their 'intrapersonal world'. For instance:

My memory loss was related to the fact that I hadn't lived that [mourning] process, so, because I was so, so sad when I went to Dr. P.'s office, I couldn't stop crying, I never stopped, it was constant, so the memory loss was that, because I was shutting my mind so as not to remember anything (CO6).

The first aspect of this shift is the client's engagement with his/her problem:

The support they give you here's very good, but it's also something you have to do yourself; because they say that to you a lot, that's something I won't forget: 'we support you and offer you some solutions (...) but if you don't do your part, if you don't do anything, you won't overcome this' (CO5).

Eventually, there emerges a growing appreciation of the client's 'own space', both within the psychotherapy and outside of it:

It helped me realise that I did matter to myself and that I didn't need to please everyone, I also had to please myself (CO4).

Together with the shift towards the intrapersonal sphere, the clients' self-valuation and behaviour may change, leading to a positive evaluation of the psychotherapy.

However, in some cases the above landmarks are not reached, which results in a negative therapeutic experience; for instance, a Chilean client who, like many interviewees, regarded psychotherapy as a way to 'solve problems', but clashed with the therapist's focus:

It's okay at the beginning, but when you go too deep, that means... I prefer to get some tools to solve what's happening to me, instead of having someone ask me 'How do you feel?' all the time. I don't know if I'm making myself clear: why dig deeper into the pain if you can give me some tools to solve it? If you already know it hurts? (CH15).

This clash is compounded by a rupture of the therapeutic relationship:

I was talking to him about work, and he was like, 'What are you doing to get a job?' And so the interruption was aggressive, actually, I felt questioned. I didn't feel supported, I don't know, it's not like I need to have someone telling me 'oh, how awful', but I mean I didn't feel like he understood (CH15).

In this case, the asymmetry of the relationship prevented the client from adopting an active role, providing feedback to the therapist about her dissatisfaction with the process. 'So, it was like a vicious circle, you know? I went out of his office crying (...) but because I was angry at myself, because I wasn't helping' (CH15). This sequence eventually resulted in a negative general assessment of the psychotherapy received (and an early drop out):

Generally, in therapies, one solves problems, but I feel that with [the therapist] I didn't solve anything,

actually, more personal issues emerged, like I was angrier about my situation, I felt misunderstood by him. I felt that he was judging me, not helping me (CH15).

Figure 2 summarises the interactions among these phenomena. The results obtained reveal milestones that determine the later development of the psychotherapeutic experience, paving the way for a positive or negative evaluation of it.

### Discussion

In this paper, psychotherapy for depression has been addressed from the point of view of economically disadvantaged clients. Previous research has shown that for this population the disease burden is greater, including a higher depression prevalence (Oluoha, 2011; WHO, 2013), poorer access to psychotherapy (Ayala, 2014; ELSOC-COES, 2018), and specific challenges related to cultural differences between clients and therapists (Winkler, 1993; Zalaquett et al., 1982).

Regarding access to psychological help, one of the aims of our study was to examine the facilitating and impeding factors identified by users. In contrast with the context of previous studies (Krause et al., 1994), nowadays the Chilean and Colombian health care systems have mental health policies in place which in principle ensure that low-income people with depressive symptomatology will get access to

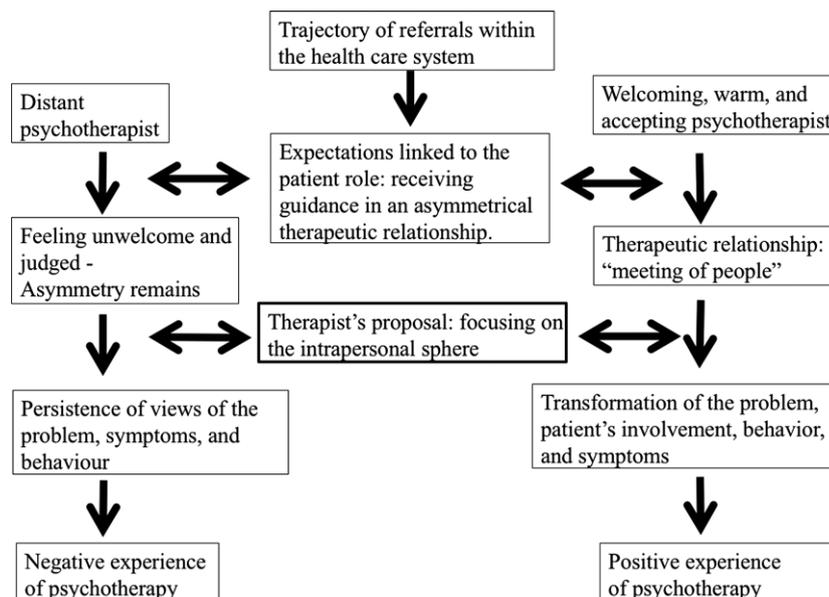


Figure 2: Milestones of the psychotherapeutic experience.

psychotherapy (MINSAL, 2016a; MINSALUD, 2015). Therefore, current beneficiaries could perceive this institutional context as a factor that facilitates their access to help. Furthermore, the institutionalisation of psychotherapy could have a positive impact on the representations potential user have about this type of treatment, shaping their expectations and legitimising its use in depression cases.

However, quantitative evidence suggests that difficulties accessing psychotherapy still exist in both countries (Ayala, 2014; Minoletti et al., 2012). With respect to users' views, our study reveals that the start of the path leading to psychological help has changed little in comparison with the period before health care system reforms were introduced (Krause et al., 1994). In other words – and in both countries – the initial step takes place in the medical system, where the patient is referred to psychological care. Low-income people who are treated in the public health system do not have the chance to select a psychotherapist.

Interviewees' narratives show that the beginning of their trajectory in the medical system causes them to adjust their expectations when starting the psychotherapeutic process, especially with regard to the type of relationship established with the psychotherapist. What indeed differs from previous findings (Krause, 2002) is that psychotherapy appears to be regarded as a valid resource for dealing with a disorder like depression. Some Colombian clients still associate psychotherapy with 'craziness' or being perceived as insane by their social environment, but in general this association is less central than in prior studies (Krause, 2002).

In our study, clients from both countries explicitly refer to some of the social, cultural and contextual determinants that may hinder access to health care and keep them from benefiting from psychotherapy. These include the economic and geographical limitations hindering access to centres that provide subsidised or low-cost mental health services, the negative views and stigmas linked to depression and the need for psychological help, and the lack of a 'psychotherapeutic' culture, which means that clients may display low initial levels of involvement in their change process.

For participants in this study, the therapeutic relationship is central as it is across all psychotherapy research, specifically in the literature on the therapeutic alliance (Horvath, 2016). Our participants value a close, warm and trust-based relationship with the therapist, ascribing importance to his/her validation of their experience, his/her commitment to

making them feel understood and his/her affective resonance with their emotions. This finding is consistent with qualitative studies that examined clients who differed in terms of SES (Altimir, Capella, Núñez, Abarzúa & Krause, 2017). Nevertheless, some clients interviewed for our study problematise the way, in which professionals treat them. Considering the sociocultural distance between clients and therapists, the decision to establish a distant and cold relationship or a close and warm one is particularly relevant. Psychotherapy, for most interviewees, seems to dissolve this choice, as an empathic relationship allows them to experience a reduction in asymmetry. However, this is not possible when a 'clash of values' related to sociocultural differences between both, makes the client feel misunderstood and rejected; a situation that has also been addressed in previous studies (Zalaquett et al., 1982).

Regarding therapeutic procedures, 'talking' seems to be more validated nowadays than in previous studies (Krause & Winkler, 1995). What remained relatively unchanged – and applies to both the Chilean and the Colombian samples – is that 'guidance' from the therapist seems highly valued. Based on results of studies that include a wider range of income groups (Krause, 2011), we could hypothesise that this expectation is specific to our income group and culturally shaped.

Regarding what is valued in terms of outcomes, our interviewees stress the importance of 'problem solving', which is in line with previous studies (Krause & Winkler, 1995); however, the range of expected outcomes has broadened to include dimensions more typical of a psychological definition of the problem, such as changing, understanding oneself, improving one's self-esteem or transforming one's interpersonal relationships.

Overall, the results reflect clients who are more empowered than those in previous research, being confident enough to make certain demands regarding the type of relationship they wish to establish with the therapist and what they expect from the therapy. However, some interviewees still display a certain degree of submission, marked by a perception of extreme asymmetry, which can even lead them to continue in therapy against their own wishes to avoid displeasing the therapist.

At another level of analysis, it is also relevant to problematise the influence of psychotherapy as a force capable of shaping (maybe unintentionally) certain culturally determined patterns of clients from economically disadvantaged areas. Highlighting the

person's individuality can be effective in terms of producing subjective change (Krause, 2011), but the clients sociocultural conditions may be maintained invisible. In consequence, culturally-competent notions of therapy, that is, those that involve 'seeing and looking at oneself in context' (Sue, Zane, Nagayama Hall & Berger, 2009) may not be addressed. By doing this, therapy may lose part of its potential effectiveness, because including the social and cultural context in the therapeutic conversation could help overcome the internal-external polarity and pave the way for a reflexive approach that could lead to better therapeutic outcomes (Banham & Schweitzer, 2015).

This reflection may encourage clinicians to identify ways, in which their relationship with the client could include sociocultural determinants of distress in psychotherapy for depression: seeing the client's uniqueness within a certain social order and a social network as different from that of the therapist.

Continuing to study the necessary conditions for providing effective treatment to clients from economically disadvantaged areas may have an impact on mental health policies. In future studies, samples could be expanded by incorporating the perspectives of psychotherapists. In addition, analysis of the impact that the context can have on therapy, taking into account other cultural variables that add complexity to the study of factors leading to inequality in mental health, could prove valuable.

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### Notes

<sup>1</sup> During the analysis, it was observed that three Colombian patients did not fully meet the inclusion criterion of being economically disadvantaged. This mistake was due to the inaccuracy of the data provided at the start of the process, but the information derived from the interviews served to

enrich the analysis categories thanks to the comparison and contrast possibilities that they afforded

<sup>2</sup> CH2 = Chile, interviewee 2.

<sup>3</sup> CO3 = Colombia, interviewee 3.

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