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Socioeconomic Status and Psychotherapy: A Cognitive-Affective View

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Abstract

Socioeconomic status (SES) has been in the scope of psychological science for many years, but only in the last decade scholars are starting to grasp its impact on psychological health. The purpose of this mini-review is to address the possible impact of SES on psychotherapy. Previous studies have argued that people of low-SES are more likely to drop out of therapy and that psychotherapy may be of limited effectivity among the poor. Based on recent studies suggesting that poverty impedes cognition, we attempt to provide a cognitive explanation for the limited effectivity and high dropout. Specifically, it is argued that three main cognitive domains impaired by poverty may play a crucial role in psychotherapeutic success; self/emotion regulation, perception, and cognitive flexibility. Relevant literature is briefly reviewed and some points for action are suggested.

Keywords: SES; Poverty; Cognition; Psychotherapy; Emotion Regulation; Cognitive Control

Introduction

In a world with increasing economic inequality, socioeconomic status (SES) have become a major factor affecting one's wellbeing and health [1]. Critically, SES was reported to be a predictor of substance use [2], perceived physical health [3], and with susceptibility to mental illness [4], such that the poor suffer more than middle and high SES. Furthermore, it was recently found that worse financial status was associated with increased perceived pain severity among chronic pain patients, and that this association was mediated by loneliness and anxiety [5]. In this article we wish to raise the concern for the impact patient's SES might have on psychotherapy.

SES involvement in psychotherapy was not overlooked in the literature. Studies found SES to be a determinant of whether the patient would turn to private compared to publicly-provided psychotherapy [4], as well as of dropout rates [6,7], such that patients from low SES are more likely to use the public mental health system but also to dropout of therapy. It is not clear, however, why do low-SES patients tend to dropout of therapy. Some scholars suggested that the high dropout rate among low-SES patients may be related to their low education level (for a review and meta-analysis, see [7]). According to this view, patients of low-SES may not comprehend the importance and advantages of psychotherapy. Other scholars pointed on the association between low-SES and addictive behaviors (for a review, see [6]), thus these patients inability to commit to psychotherapy may be due to maintain adaptive and pro-self behavior. In this article, we wish to suggest a cognitive explanation and argue that the effects of financial constraints on psychotherapy may be mediated through the depletion of cognitive resources, leading to therapy-related irrational decision making (cf. [8]).

The idea that scarcity may impedes cognitive abilities is a rather new notion in psychology. Vohs [9], for example, suggested that poverty should be examined through the perspective of the ego depletion theory, which refers to self-control as a limited-resource cognitive functioning that may be exhausted due to over-control, stress, or negative affect [10-12]. According to this view, people in poverty experience elevated stress and need for self-control, which in turn deplete self-control resources; in the lack of self-control resources, poverty cycle cannot be broken [13]. Because self-control is commonly associated with adaptive behavior and less psychological pathology [14], low-SES may reduce treatment efficiency where patient's self-control is a major key for successful therapy, as in loneliness, depression, anxiety, eating disorders, and post-trauma.

Critically, poverty-induced inefficiencies in self-regulation may be manifested in emotion regulation and its related neural circuitry. Specifically, A longitudinal brain imaging study associated between early childhood poverty and neural circuitry activation during emotion regulation at

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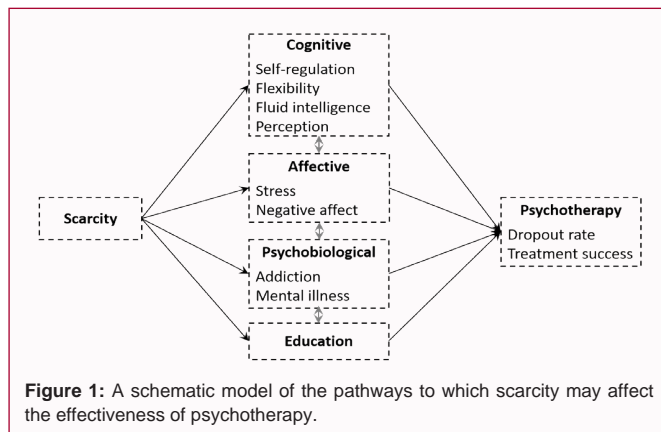
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adulthood; adults who were raised in families with low income at age nine exhibited reduced ventrolateral and dorsolateral prefrontal cortex activity, and failure to suppress amygdala activation during regulation of negative emotion at age 24, indicating weaker cognitive control ([15]; see also Liberzon).

Controlling negative emotions by reconstructing the interpretations of distressful situations is considered an adaptive means of emotion regulation (i.e., reappraisal). Emotion-regulation skills has been found to mediate the effects of stressors on the development of psychopathological symptoms [16,17]; framing emotionally arousing events in a positive light can serve as an effective coping mechanism that enables rapid recovering from stressful experiences [18]. It is not surprising, therefore, that emotion-regulation skills have been found to predict mental health [19] and to play an integral part of therapy success [20-22]. Along with this notion, low SES may limit therapy success in cases where the patient is to endure distressful situations in the therapeutic process or when goal-directed behaviors are promoted [23].

Another cognitive domain impeded by financial constraints is perception. As with the ability to regulate emotions, it seems that the mere perception of emotional facial expression is biased among those who grew up in poverty, independently of their SES at adulthood; such participants showed elevated sensitivity to negative (fearful faces) but not to positive (happy faces) social cues. Similarly, Krosch and colleagues [24,25] showed that thoughts of scarcity yielded strong racial bias, with a shift in the perceptual discrimination point between white and black faces. Because the main course of treatment in cognitive-behavioral therapy is a focus on the manner to which the patient perceives the world, poverty-induced bias in perception may be more resilient to therapy and may be even overlooked due to its inherent nature.

Finally, financial constrains may also affect psychotherapy through increased cognitive load. Shafir and colleagues [26-28] showed that for people in poverty, thoughts about financial constrains are spontaneous and intrusive, hence increasing cognitive load. Considering the notion of depleted self-control resources [9], these thoughts are hard to suppress, thus impairing the poor's decision-making processes. For example, when prompt to think of a large (compared to small) unexpected monetary expanse, performance in Raven's matrices worsen among the poor, but not among the non-poor [26]. Although the authors interpreted their findings in terms of non-verbal decision-making processes, it should be noted that Raven matrices is often considered as a fluid-intelligence test, which reflects

one's ability to solve unspecified non-verbal problems and which requires cognitive flexibility. Cognitive flexibility is a crucial factor in the therapeutic session, enabling the patient to adopt a decentered point of view, to promote behavioral change, and to process and assimilate thoughts, feelings, and insights brought up during therapy [29].

To conclude, psychological treatment dropout and success may be determined by cognitive maladies induced by financial constraints. Critically, such constraints manifest in elevated stress and in poor ability for self-regulation and cognitive flexibility. In turn, these cognitive maladies may limit the patient-in-poverty's ability to carry reflective self-examination, to set and find the agencies to achieve therapeutic goals, and to endorse adaptive behaviors (schematic model is presented in Figure 1). Supporting this notion, it has been recently suggested that psychological treatment for attention deficit may be less effective for low-SES patients, compared to middle or high-SES [8].

Nevertheless, not all is bleak. Simple interventions may be incorporated into treatment in order to reduce the cognitive maladies of poverty. For example, self-affirmation was reported to improve cognitive control and fluid intelligence among the poor [30]. Similarly, a brief mindfulness-based intervention may benefit momentarily with patient's cognitive and affective states [31-33]. This notion is supported by some feasibility studies, which showed that mindfulness may aid people in poverty [34].

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