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Treatment Compliance in Underserved Populations

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Opinion

Of late, there has been an increasing concern as to mental health care provision for those living either in severe financial constraint and/or social deprivation and seclusion, often due to migration. Psychotherapy as we know it and habitually practise it - whichever the school- has been developed upon assumptions which are not suitable for these vast groups of people in need of our help. Issues taken for granted such as verbal communication, continuity and a fixed setting, as well as willingness to explore one's past, are not applicable to those living under harsh life conditions. For these persons and families, continuity is incongruent with their life styles, in which permanent transitions are the rule. Furthermore, their past lives are often too painful and shameful to be explored, remembered and told. Many early traumatic experiences –which are adamant to adult-life difficulties and limitations- are too primitive to be transmitted in explanatory words, specially when words have been often absent in their upbringing.

Another central issue in our regular practice of psychotherapy is trying to "dismantle" what we consider inadequate, immature or even pathological ways of living, acting, thinking and bonding. However, given the unlikelihood of continuity in a therapeutic process, this early preparatory steps for later work may end in simply dismantling whatever little, inappropriate (in our view) or primary ways this person has found to deal with the stresses and strains of their lives, often with very little external help or permanent presence of caring others. Another issue we take for granted in any form of psychotherapy is that presenting complaints and/or observed difficulties are assumed to stem from the person's actions or attitudes, which we set out to modify. However, we should review our assumption that life situations like abuse, abandonment of caring others or street dwelling are merely due to the person's actions or attitudes.

What to change, then? As an initial step, us therapists should reflect upon our implicit beliefs on what we consider mental health and psychotherapy, which we habitually take for granted as suitable for all. A second step is to take a stance of what has been called "cultural humility" and consider the need for therapeutic approaches which are culturally sensitive, competent and respectful, offering help which is relevant to the other, not to us providers. This requires a careful and respectful effort to explore and strive to understand what help is expected from us (often to discover it is totally unrelated to our initial intentions). Participative research (under the motto "nothing about us without us") is no doubt a tool to better understand lives and contexts so different to ours and grasp what the "patient" or "client" really has in mind. Some therapeutic approaches have been developed and have proven specially adequate, such as Barreto's "Integrative Community Therapy" (backed up by WHO), and "Therapeutic Consultation", initially developed by D. Winnicott, in which each therapeutic encounter is unique and encloses both diagnostic and intervention stances.

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