

ORIGINAL ARTICLE ON SOCIAL INEQUALITIES

Change in symptomatic burden and life satisfaction during short-term psychotherapy: Focusing on the role of family incomeAlex J. Behn¹ , Paula A. Errázuriz^{1,*}, Marianne Cottin² & Candice Fischer¹¹ Department of Psychology, Pontificia Universidad Católica de Chile, Santiago, Chile² Faculty of Medicine, Universidad de Chile, Santiago, Chile

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Abstract

Objective: The article examines the role of family income on the relationship between change in symptomatic burden and change in life satisfaction during six sessions of naturalistically delivered individual psychotherapy. *Method:* Five hundred and thirty-two clients receiving psychotherapy were assessed at baseline and on a session-to-session basis with the OQ-30.2 and with a life satisfaction questionnaire. Data were analysed using a bivariate latent class model with structured residuals that included cross-lagged and autoregressive components between residual scores at each time point. Adjusted family income and a binary low versus high-income group variable were added as exogenous baseline covariates at different stages of the analyses. *Results:* Regardless of income level, clients show improvement in psychological distress and life satisfaction as a function of time during treatment. Initial levels and improvement in life satisfaction are related to initial levels and improvement in psychological distress, and lower family income is related to slower decreases in psychological distress. When the whole sample is analysed, psychological distress and life satisfaction show reciprocal prospective relationships at the within-person level. When models are estimated by income group, casual relationships at the within-person level vary as a function of income. *Conclusion:* Family income level appears to play a significant role in the relationship between symptom improvement and life satisfaction during psychotherapy.

Keywords: psychotherapy outcome, income, life satisfaction, happiness, mixed-effects modelling

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Over one hundred years ago, Freud published his ‘Studies in Hysteria’ and commented that the overall purpose of psychoanalysis was to transform ‘... hysterical misery into common unhappiness’ (Breuer & Freud, 1955; p. 305). Freud argued that ‘With a mental life that has been restored to health, you will be better armed against that unhappiness’ (Breuer & Freud, 1955, p. 305). This early conceptualization of psychotherapy introduces the relationship between symptomatic relief during therapy and its potential effects on general happiness. Furthermore, it argues for a specific mechanism: psychotherapy acts primarily on symptom relief which subsequently may produce an improvement in happiness. However,

more than one hundred years have passed since the formulation of this hypothesis and Freud’s proposed mechanism has not yet been empirically tested in psychotherapy studies.

In terms of symptomatic relief, data support the contention that most forms of psychotherapy produce clinically meaningful change in a variety of outcomes across psychiatric diagnoses including depression (Carter et al., 2013), anxiety disorders (Cuijpers, Sijbrandij, et al., 2013) and personality disorders (Bamelis, Evers, Spinhoven & Arntz, 2014).

However, compared to the evidence on the effectiveness of psychotherapy on psychiatric outcomes, much less attention has been devoted to

examining the effects of psychotherapeutic treatments on general happiness. We know that psychotherapy is effective in reducing symptomatology but it remains unclear if this reduction results in an improvement of happiness or life satisfaction. Take the following vignette taken from a recent episode from *The New Yorker Presents series* entitled *Last Session* (Gunther, 2016):

Client: I'm thinking of ending it. . .

Therapist: Ending what?

Client: Therapy. . .

Therapist: Why? I think we are making progress?

Client: I guess I feel that I am better. . .

Therapist: Really?

Client: It's just that I'm, well. . . happy.

Therapist: Happy. . .and you think that's what this is about?

Client: Isn't it?

This exchange raises an interesting point: Is the goal of psychotherapy just symptom reduction or does it also encompass 'happiness'? Globally, there has been increased interest on measuring and examining the concept of 'happiness', which is often operationalized as life satisfaction (Beytía & Calvo, 2011; Diener, 2000). This has led to global efforts to improve levels of happiness, most notably the OECD Better Life Initiative which among other components includes a focused research agenda on happiness entitled *How's life?* (Durand, 2015). This focus on happiness has also been echoed by the United Nations stressing the importance that happiness should have in the context of development and economic progress (United Nations, 2011). In this regard, the apparent dispute between the aforementioned therapist and client is quite relevant. Is psychotherapy an instrument that can lead to an improvement of happiness, perhaps through the improvement of symptomatic burden associated with psychiatric disorders?

Common sense would dictate that indeed, if clients experience clinically significant improvement in symptomatic burden, they should be happier. However, this issue needs to be examined empirically. A recent meta-analysis (Kolovos, Kleiboer & Cuijpers, 2016) is the first systematic effort to clarify this issue, focusing on the effects of psychotherapy for depression on quality of life (which refers to the person's perceived satisfaction with daily activities, likely a proxy of happiness). The study

estimated that the effects of psychotherapy on quality of life were small to moderate. This effect was also identified in another recent study that focuses on psychotherapy, pharmacotherapy and the combination of both on quality of life (Kamenov, Twomey, Cabello, Prina & Ayuso-Mateos, 2017). These studies take into account the idea that above and beyond symptomatic improvement, outcome studies should primarily focus on quality of life, even arguing that it should be considered the 'ultimate outcome measure' (IsHak et al., 2011).

The neglected role of income

These recent studies indicate that the psychotherapy research field has been addressing the question of whether or not psychotherapy is a vehicle that promotes happiness. However, one component has been thus far left out of these scientific efforts: the role of income on the relationship between change in symptomatic burden and life satisfaction. There is ample evidence that suggests that the role of income needs to be taken into account when addressing this issue, including studies showing that people experience higher rates of depression and related psychological symptoms when living in poverty (Smith, 2010). However, the evidence is mixed regarding the particular role of income on life satisfaction (Easterlin, McVey, Switek, Sawangfa & Zweig, 2010). One study suggests that more than actual income, it is income rank (a person's ranked position in society based on his or her income), which leads to happiness (Boyce, Brown & Moore, 2010). Other studies have indicated that income may be stronger related to life satisfaction in poorer countries (Oishi, Diener, Lucas & Suh, 1999), and in the setting of staggering income inequalities, the role of social comparisons may also moderate the relationship between income and happiness (Wolbring, Keuschnigg & Negele, 2011). Thus, particularly in poor and in developing countries and in those countries with high-income inequality, an examination of the relationship between change in symptomatic burden and change in life satisfaction during psychotherapy may benefit from including the central role of client income level.

The present study

The study aims to contribute to the clarification of the role of family income in the relationship between change in symptomatic burden and improvement in life satisfaction using data from longitudinal naturalistic psychotherapy study with session-to-session measurements of symptomatic burden and life satisfaction. The study was conducted in Chile, a

developing country with staggering income inequality levels (Paredes, Iturra & Lufin, 2016). With this in mind, the study aimed to explore two main issues: (1) Does family income have a role in the relationship between symptomatic change and change in quality of life during the first six sessions of therapy? (2) How does family income influence session-to-session temporal relations between symptomatic improvement and life satisfaction in individuals receiving psychotherapy?

Method

Participants

Data were collected at an outpatient mental health clinic in Santiago, Chile, in the context of a feedback Randomized Clinical Trial (Zilcha-Mano & Errázuriz, 2017). Of the invited clients, 547 (57.39%) accepted and participated in this study. Table I presents a summary of demographic and clinical variables to characterise our sample. Finally, 532 clients provided income information, and this group was used for all analyses.

Therapies and therapists

The psychotherapy practised was mostly short-term, from a variety of theoretical orientations. The median length of treatment was six sessions ($SD = 6.5$), with a range between one and 54. Twenty-eight licensed therapists participated in the study. Their average years of clinical experience was 8.38 ($SD 5.33$), mean age was 37.79 ($SD 7.79$) and 68% were women. On a scale from one to five, therapists rated on average their theoretical orientation in the following order: systemic (3.75, $SD = 1.16$), cognitive (3.39, $SD = 1.41$), psychodynamic (3.00, $SD = 1.60$), behavioural: 2.77 ($SD 1.63$) and humanistic/existential (2.00, $SD = 1.65$). The mean number of clients treated by each therapist in this study was 20 ($SD 14.6$; range 1–51). All clients were treated in individual therapy, for weekly sessions of approximately 50 minutes. Treatment length was determined jointly by clients and therapists, as well as by practical concerns (such as clients' financial considerations and health insurance).

Measures

Symptomatology

Psychological dysfunction was assessed at baseline and then weekly through the OQ-30.2 (Lambert,

Table I: Demographic and clinical variables for sample.

	Aggregated sample ($N = 532$)
Demographic variables	
Age	41.33 (12.82)
Female	74.39%
Years of education	14.1 (2.9)
Median income	\$1130 USD
Median income per household member	\$339 USD
Occupational status (%)	
Employed	64.9
Studying	11.3
Homemaker	18.5
Retired	3.5
Marital status (%)	
Married	52.8
Single	27.8
Divorced	17.3
Widowed	2
Sexual identity (%)	
Heterosexual	94.9
Homosexual	3.2
Bisexual	.8
Does not know/report	1.1
Ethnicity (%)	
Indigenous	5
Nonindigenous	95
Clinical variables	
OQ-30.2 at baseline	58.59 (16.67)
On psychiatric medication (%)	89.8
Previous psychiatric hospitalisation (%)	10.6
Psychiatric diagnosis (naturalistic)	
Depression (%)	68.73
Bipolar disorder (%)	5.48
Adjustment disorder (%)	2.2
Dysthymia (%)	1.8
Substance abuse (%)	4.0
Panic disorder (%)	3.7
Generalised anxiety disorder (%)	2.6
Life satisfaction	5.61 (1.95)

Vermeersch & Brown, 2004; Lambert, Morton, et al., 2004). The OQ-30.2 has been found to have good internal consistency (.90), good concurrent validity (with the Depression Anxiety Stress Scales: $r = .82$) and sensitivity to change. The Spanish version of the OQ 30.2 (Errázuriz, Opazo, Behn, Gloger & Ramirez, 2017) preserves adequate psychometric properties.

Life satisfaction

Clients' satisfaction with life was assessed with a one-item self-report measure taken from the World Values Survey (WVS, 2009): *All things considered, how satisfied are you with your life as a whole these days?* The item was

rated by clients on a 10-point Likert scale, with higher scores reflecting higher levels of life satisfaction. The validity of this measure has been demonstrated by several studies (Bjørnskov, 2010; Bjørnskov, Dreher & Fischer, 2010; Diener, 2000; Fleche, Smith & Sorsa, 2012). This measure has been used in Chile in large-scale surveys like the National Socioeconomic Survey – (Encuesta de Caracterización Socioeconómica Nacional – CASEN) by the Ministry of Social Development (Ministerio de Desarrollo Social, 2011).

Patient family income

Patient family income was measured through a demographic interview. Patients were investigated to provide the best estimate they could about their current total family income in Chilean pesos. To provide a more accurate estimate of client's real financial status and capabilities, the estimated family income was divided by the number of household members that rely on the reported income amount. The resulting amount was then transformed into a total US dollars for the analyses and constituted a measure of adjusted family income (AFI). Additionally, and for exploratory purposes, temporal relations between psychological distress and life satisfaction were modelled using a binary covariate of income group membership. Clients in the high-income group were described as having an income equivalent to at least one minimum salary per household member (minimal income in Chile is set by law at USD \$412). Clients in the low-income group fall below one minimum salary per household member. Compared to using AFI as a continuous baseline covariate, this sample segmentation allows for a more straightforward examination of the role of family income on the within-person temporal relations between variables while still preserving real-life pertinence and interpretability.

Procedure

Recruitment started in December of 2011 and lasted until October of 2013. Data were collected throughout recruitment and ended in April of 2014. At the beginning of treatment, clients and therapists completed demographic surveys. The OQ and the Life Satisfaction measure were completed by the clients before every session. All measures were completed in Spanish. All new adult clients were invited to participate in the study, as well as all psychotherapists who work at the mental health centre. All participants signed informed consent before any data

were collected, and the study was approved by the relevant ethical review boards.

Data analysis

All analyses were conducted using only the first six sessions for psychotherapy. Most clients have completed their treatments by the sixth session, and estimating growth parameters including clients who are outliers in terms of their number of sessions (e.g. 54 sessions) would have resulted in biased estimations of growth parameters for the majority of clients who completed in six sessions. As noted by Tasca and Gallop (2009), individuals with more measurements will carry more weight in estimating parameters as the grand mean is used in the estimation process.

Because we were primarily interested in examining the bivariate trajectories of psychological functioning and life satisfaction taking into account family income adjusted by number of household members (Adjusted Family Income, AFI), we used a bivariate latent curve model with structured residuals (LCM-SR; Curran, Howard, Bainter, Lane & McGinley, 2014). This analytical strategy allows for the estimation of the joint trajectories of psychological functioning and life satisfaction disaggregating the between-subject and within-subject levels of a longitudinal data set. This differentiation between levels of nesting in the data structure has been argued to be essential in establishing reliable temporal relationships between variables measured longitudinally, particularly when some of the attributes measured may have some trait-like stability for individuals (Falkenström, Finkel, Sandell, Rubel & Holmqvist, 2017; Hamaker, Kuiper & Grasman, 2015). Thus, this type of analysis was pivotal to our secondary objective of understanding potential causal relationships between change in psychological distress and change in life satisfaction. Finally, to better the role of family income on the within-person time-lagged relationships between psychological distress and life satisfaction, we estimated two unconditional bivariate LCM-SR models for each income group using the binary variable described above. All analyses were conducted using SPSS Version 24 and Mplus Version 7.

Results

Unconditional models

Preliminary testing of unconditional univariate LCM-SR models indicates that a linear model with a random intercept and linear slope provides a good fit

of the data for psychological distress, ($\chi^2(16) = 25.89$, $p = .056$, root mean square error of approximation (RMSEA) = .034, comparative fit index (CFI) = .995, Tucker–Lewis Index (TLI) = .995) and for life satisfaction ($\chi^2(16) = 24.32$, $p = .083$, RMSEA = .031, CFI = .964, TLI = .966). Both univariate models also provided statistically significant estimates for the intercept and linear slope factors of psychological distress and life satisfaction. This suggests that our data set clients systematically decrease their psychological distress and improve their levels of life satisfaction as a function of time during psychotherapy, but that there are between-person differences in initial scores and growth trajectories.

Both univariate models were then combined into a bivariate unconditional LCM-SR model. This model provided an adequate fit for the data ($\chi^2(68) = 102.527$, $p = .0043$, RMSEA = .031, CFI = .984, TLI = .982) and included random intercepts and slopes for psychological distress and life satisfaction, covariances between and within growth parameters of psychological distress and life satisfaction, autoregressive paths between residuals at each adjacent time measurement for each variable and covariances between residuals of different variables at each time

point. When psychological distress and life satisfaction are modelled jointly, significant slopes are retained for each variable (slope estimate for psychological distress = -7.615 , $p = .000$; slope estimate for life satisfaction = $.587$, $p = .000$). Variance components also remain significant in the bivariate unconditional model for the intercept and slope of psychological distress and life satisfaction, indicating significant between-person variability in starting pots and growth rates for both variables. Significant negative covariances can be seen in Table II between baseline psychological distress and baseline life satisfaction growth parameters.

Conditional bivariate model with adjusted family income

Results for the conditional bivariate LCM-SR model that includes AFI as a baseline covariate are also presented in Table II. All components of the unconditional bivariate model were retained, with the only difference being the addition of AFI as a baseline covariate into the estimation as well the prospective estimation of the time-lagged relationships between residuals of psychological distress and life satisfaction.

Table II: Growth parameters and variance components for the parallel process model between psychological distress (OQ-30.2) and life satisfaction (LS). Results of the unconditional and conditional (adjusted family income (AFI) is added to the model) models are reported. $N = 532$.

	Coefficient unconditional model (standard error)	Two-tailed p value	Coefficient conditional model (standard error)	Two-tailed p value
Fixed effects				
OQ-30.2 Intercept	59.830 (.700)	.000	61.005 (1.185)	.000
OQ-30.2 Slope	-2.391 (1.437)	.000	-2.062 (.279)	.000
LS Intercept	5.534 (.081)	.000	5.370 (.139)	.000
LS Slope	-.094 (.025)	.000	.111 (.043)	.010
Random effects				
OQ-30.2 Intercept	212.986 (17.157)	.000	223.336 (16.54)	.000
OQ-30.2 Slope	5.481 (.922)	.000	6.020 (.882)	.000
LS Intercept	1.584 (.296)	.000	1.863 (.275)	.000
LS Slope	.068 (.027)	.012	.091 (.026)	.00
Regression/Covariance				
OQ-30.2 Intercept WITH OQ-30.2 Slope	-8.631 (2.996)	.004	-8.590 (3.009)	.004
LS Intercept WITH LS Slope	-.268 (.071)	.005	-.287 (.073)	.000
OQ-30.2 Intercept WITH LS Intercept	-11.134 (1.451)	.000	-11.047 (1.464)	.000
OQ-30.2 Slope WITH LS Slope	-.480 (.095)	.000	-.499 (.097)	.000
OQ-30.2 Intercept WITH LS Slope	1.186 (.420)	.004	1.231 (.425)	.004
LS Intercept WITH OQ-30.2 Slope	1.385 (.326)	.000	1.482 (.332)	.000
OQ-30.2 Intercept ON AFI	N/E	–	-.002 (.002)	.309
OQ-30.2 Slope ON AFI	N/E	–	-.001	.032
LS Intercept ON Family AFI	N/E	–	.000	.192
LS Slope ON AFI	N/E	–	.000	.830

AFI, adjusted family income; OQ-30.2, psychological distress measure; LS, life satisfaction measure.

In **bold**, significant estimates/coefficients. ON designates regressions of the dependent variable on the independent variable. WITH designates a covariance. N/E indicates the coefficient was not estimated in the model.

This model yielded appropriate fit indices ($\chi^2(70) = 114.133, p = .0007, RMSEA = .034, CFI = .979, TLI = .977$) and all growth factors and variance components continued to have significant means and variances with the exception of the slope and slope variance for life satisfaction.

Between-person effects

The conditional bivariate model retains significant means and variances for all growth components. Clients in our sample show on average significant improvements in psychological distress (slope estimate = $-2.054, p = .000$), but there is significant variability in these rates of improvement between clients (slope variance = $6.000, p = .000$) as well as in baseline levels for psychological distress (intercept variance = $216.800, p = .000$). Similarly, clients tend to progressively improve their life satisfaction as a function of time during the treatment (slope estimate = $.109, p = .011$), with significant variability between clients in the speed of improvement (variance estimate = $.089, p = .000$) and in initial levels of life satisfaction (intercept variance = $1.875, p = .000$). The conditional model continues to show that higher initial levels of psychological distress produce faster decreases in the same variable (covariance = $-8.590, p = .004$) and that higher initial levels of life satisfaction tend to result in slower rates of improvement on the same variable (covariance = $-.287, p = .000$). The model also shows that higher levels of baseline psychological distress are associated with lower levels of life satisfaction reported at baseline (covariance = $-11.047, p = .000$) and that faster rates of reduction in psychological distress are related to faster rates of improvement for life satisfaction during six sessions of psychotherapy (covariance = $-.499, p = .000$). On the other hand, higher levels of psychological distress at baseline are associated with steeper increases in life satisfaction throughout the treatment (covariance = $1.231, p = .004$), likely because higher initial distress produces faster improvement and faster improvement in distress produces steeper climbs in life satisfaction. Perhaps for the same reasons, higher initial scores in baseline life satisfaction are related to slower rates of decrease in psychological distress (covariance = $1.482, p = .000$).

Finally, AFI appears to predict the rate of change in psychological distress so that for every dollar AFI increases, the decrease in psychological distress increases very slightly (estimate = $-.001, p = .032$).

This is, of course, a very small coefficient so that it would require huge increments in AFI to generate clinically significant accelerations of the improvement trajectories of psychological distress for clients.

Within-person effects

An interesting picture emerges when looking at within-person components of the bivariate, time-lagged relationships between psychological distress and life satisfaction. These results are presented in Figure 1. Previous levels of life satisfaction consistently and significantly predict subsequent levels of psychological distress. These relationships are constant over time and suggest that when a person's earlier life satisfaction level goes up, subsequent psychological distress decreases (average estimate across lags = $-.384, p = .028$). Similarly, an individual's previous levels of psychological distress also predict subsequent levels of life satisfaction (average estimate across lags = $.034$, all $ps < .05$), but this relationship appears to decrease slightly over time.

To further understand the influence of family income on the within-person prospective relationships between psychological distress and life satisfaction, we estimated two unconditional bivariate LCM-SR models, one for each income group. Results of the within-person prospective relationships between residuals of the variables show that for clients belonging to the high-income group, previous levels of psychological distress predict subsequent levels of life satisfaction and the adjacent time point (average estimate = $.046$, all $ps < .05$), but previous levels of happiness do not predict subsequent psychological distress. The exact opposite is true for clients in the low-income group, where previous levels of life satisfaction consistently predict subsequent levels of psychological distress (estimate = $-.453$, all $ps = .037$), but not the other way around.

Discussion

This is the first study that uses a mixed-effects analytical framework to examine the session-to-session relationship between psychological distress and life satisfaction focusing on the role of family income during six sessions of naturalistically delivered psychotherapy. Additionally, our analytical strategy uses well-developed current estimation procedures that disaggregate between-person and within-person levels to establish perspective relationships between psychological distress and life satisfaction.

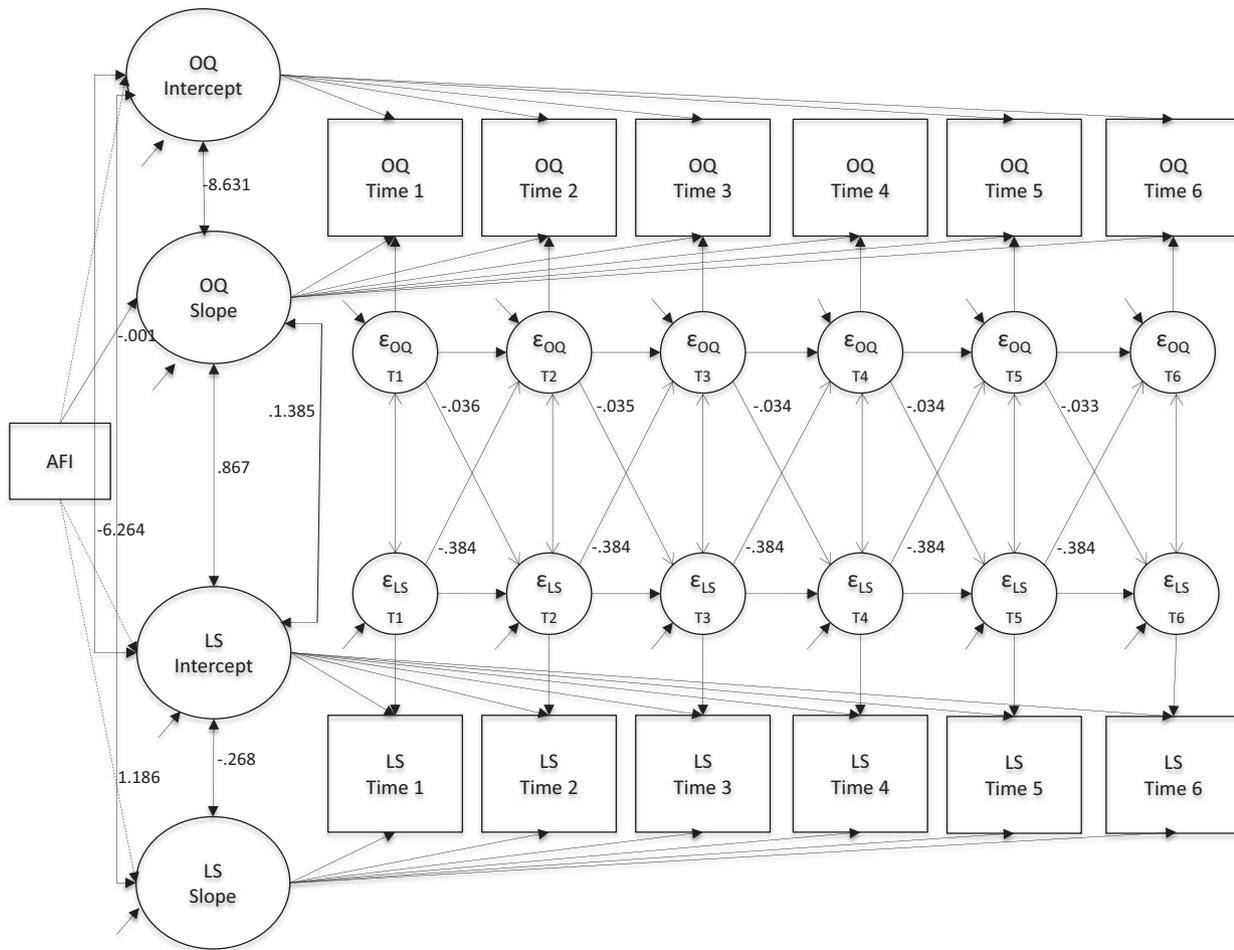


Figure 1: Final results for conditional bivariate model for psychological distress (OQ) and life satisfaction (LS) with adjusted family income (AFI) as an exogenous baseline covariate. All numerical values reported are significant at $p < .05$. Dashed lines are estimated in the modeling but nonsignificant.

Overall, results of our study show that psychological distress and life satisfaction display stable mutual relationships. First, both variables improve as a function of time during treatment and at a between-person level, all growth parameters covariate among each other. In other words, initial levels and improvement in life satisfaction are related to initial levels and improvement in psychological distress. To this extent, Freud’s prediction that psychotherapy does impact life satisfaction seems to be warranted – even if it is only to move a client to ‘common unhappiness’. All growth parameters also show significant variances, indicating that there is variability in initial levels as well as in growth for both variables. The introduction of adjusted family income as an exogenous baseline covariate does not explain away this variability and in fact, at the between-person level, the role of adjusted family income on baseline levels and rates of improvement of

psychological distress and life satisfaction seem to be quite modest, with a very small effect of AFI predicting rates of decline in psychological distress. Indeed, the effect of family income on the relationship between psychological distress and life satisfaction becomes visible mainly at the within-person effects in the prospective relationship between psychological distress and life satisfaction emerge. At this level of analysis, opposite causal relationships between the variables emerge. For high-income clients, situational improvements in psychological distress appear to produce prospective improvements in life satisfaction and not the other way around. For low-income clients, however, the opposite is true and only previous situational levels of life satisfaction predict subsequent effects on psychological distress. This may mean that particularly for low-income clients, psychotherapy may benefit from fostering situational improvements in life satisfaction to

promote a reduction in psychological distress. For high-income clients, it appears that a standard therapeutic focus on reduction in psychological distress may be enough to improve life satisfaction.

Is, – as Freud suggested over a century ago – the goal of therapy to turn symptomatic misery into common unhappiness? The answer to the question seems to be *well, it depends on how much money a family makes*. Perhaps, Freud's prediction applies mainly to high-income clients, but for low-income clients, the goal may be to reduce unhappiness to reduce symptomatic misery,

Our study has several limitations that need to be noted. First, we measured life satisfaction with a one-item measure. Future research should look at whether our results hold true when measuring life satisfaction with more comprehensive measures. Second, this measure may not be sensitive enough to measure week-to-week changes in life satisfaction, thus making it less sensitive to change than our symptomatology measure (the OQ-30.2), which was designed to be sensitive to session-to-session changes in symptoms. Third, our sample was mostly a low-middle and high income, without extreme poverty or wealth. Future studies could try to replicate these findings examining a wider range of income status to model different relationships between income, life satisfaction and symptomatology burden.

Our study sheds some light into an issue of growing importance: the role of income on the effects of psychotherapy not only on symptomatic improvement but also in levels of life satisfaction. We should not only concentrate efforts in securing mental health treatment for low-income clients, but our results suggest that typical treatments should be modified, perhaps adding a focus on improving situational life satisfaction (such as problem-solving strategies, support-network building and responsive case management), to help low-income clients with session-to-session symptom improvement. This may be an interesting finding to rethink the issue of higher dropout rates in low-income clients even in the face of significant clinical effects of treatments (Santiago, Kaltman & Miranda, 2013). In our view, these findings suggest that therapists working with low-income clients in individual psychotherapy should monitor levels of life satisfaction. This may help towards improved client retention as well as with client experience of the treatment, which is in line with evidence suggesting that particularly low-income women (the majority of our sample is female) tend to experience their therapists as more helpful

when they are aware of the struggles related to poverty and provide direct instrumental support related to those difficulties (Kim & Cardemil, 2012; Pugach & Goodman, 2015). Thus, when working with low-income clients, therapists should work proactively to secure the buffering effect of psychotherapy on decreasing trends of life satisfaction.

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