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‘What help can you get talking to somebody?’ Explaining class differences in the use of talking treatments

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Abstract Talking treatments are underused in England by working-class people: their higher rates of common mental disorders compared with their middle-class counterparts are not matched by an increased use of these treatments. Given that, overall, talking treatments are effective in tackling depression and anxiety, understanding their underuse is important. Based upon semi-structured interview data I argue that a framework centred on individuals’ cultural dispositions towards treatment can help with this task. Following Bourdieu, such dispositions can be traced to social structural conditioning factors, together comprising the habitus. Four key dispositions emerge from the data: verbalisation and introspection, impetus for emotional health, relation to medical authority and practical orientation to the future. In turn, these dispositions are rooted in the material, health, occupational and educational characteristics of working-class circumstances. Tracing these circumstances offers suggestions for increasing the use of this service.

Keywords: mental illness, talking treatments, social class, health inequalities, Bourdieu, culture, habitus

Introduction

The role that social class plays in how people access and use health care has been a longstanding concern both in medical sociology (Hart 1971, Stimson and Webb 1975, Blaxter 2010) and the sociology of mental health and illness (Brown and Harris 1978, Hollingshead and Redlich 1958, Horwitz 1977). It has been well-established in this literature that working-class[1] people experience higher rates of mental disorder than their middle-class counterparts, including the common mental disorders which this article focuses on. The strongest recent evidence that this applies in England comes from the adult psychiatric morbidity in England survey carried out in 2007. The survey showed that, controlling for age, rates of neurotic disorder (comprising different types of depression and anxiety) were about twice as high in the lowest income quartile than in the highest (National Health Service Information Centre 2009: 32). The 1999 survey used the Registrar General’s class scheme to show that of those who had a neurotic disorder, 3 per cent were in professional class I, and 7 per cent in the unskilled class V (Department of Health [DoH] 2001a: 89).

At the same time there is underuse by working-class patients of talking treatments for such problems (Ballinger and Wright 2007). This is supported by studies employing the term class (Garfield 1994) or a socioeconomic factor relating to it, such as low income (Anderson *et al.*

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2009) or socioeconomic deprivation (Saxon *et al.* 2007). Yet national survey data indicate that those with low incomes are more likely to have used prescription medication (mostly anti-depressants) (Anderson, Brownlie, and Given 2009) than those with higher incomes. These disparities are a cause for concern when there is good evidence that talking treatments are overall effective (DoH 2001b, Roth and Fonagy 1996, Seligman 1995), while the effectiveness of anti-depressants has been questioned and can be positively harmful and have serious with-drawal effects (see Kirsch et al. 2008). Considering equity in talking treatment use is important at a time when they are espoused more than ever, reflected in the Improving Access to Psychological Therapies (IAPT) programme started in 2008 (DoH 2008) and reiterated in UK government mental health policy at the time of writing (DoH 2011).

Various explanations have been offered for the underuse of talking treatments by working-class patients. In their classic 1958 study Hollingshead and Redlich found that those from the 'lower social classes' had a preference for treatment that provided immediate relief and did not focus on their inner psychological lives. They also tended to be wary of authority, resulting in a lack of trust in health professionals, and fatalistic, so that problems were viewed more as a result of bad luck than as being amenable to treatment (1958: 182). Lorion points to various studies that suggest that low-income patients have different expectations of treatment than higher income patients in terms of duration, attrition, outcome, patient discomfort and partici-pation (1974: 347).

Another approach has been to focus on the culture of talking treatments. Caine and Smail noted that certain types of individuals are more valued by therapists than others: those who:

> Are well educated, articulate and socially responsible … they are members of the middle class, have a considerable measure of 'ego strength', are not deriving excessive secondary gains from their neurotic difficulties via incapacitating somatic illnesses, are anxious, and are eager to do something about their problems. (1969: 142)

Sue and Sue argued that middle-class therapists find it difficult to relate to the circumstances of poverty and when people from such circumstances do use talking treatments, they are much less likely to explore their inner worlds with therapists (2003: 115). Support for this idea comes from Carkhuff and Pierce who found that matching the class (and ethnicity) of therapist and patient had an effect on 'the depth of self-exploration of patients in initial clinical inter-views' (1967: 633). Lorion points to studies that show that therapists often lack rapport with low-income patients and are often unable to understand working-class values (1974: 344). The importance of language to the therapeutic relationship has also been highlighted (Kearney 1996, McLeod 2009). Bernstein's work on elaborated and restricted codes led him to conclude that 'lower working-class' clients require therapists who have a 'sensitive understanding of the predicament of the patient and a willingness to adapt his [sic] technique' (1964: 64).

Although there are no recent studies explicitly focusing on class or socioeconomic factors in relation to talking treatment use, the help-seeking of other hard-to-reach groups has been considered. Appraisal is commonly recognised as an important first step in using services. Biddle *et al.*'s (2007) research on young people with mental distress emphasised the meanings attached to appraisal. They noted that help-seeking is a dynamic process involving cycles of avoidance, whereby increasingly severe symptoms are avoided until a crisis occurs. We would expect class to have a bearing on how this is experienced and when this point is reached, given the interplay between meaning, culture and class (Sayer 2011, Skeggs 2004). In looking at why older people with depression may not present to primary care, Chew-Graham *et al.* (2012) focused on appraisal and the acceptability of services. They found that older people tended to appraise depressive symptoms as common misery caused by life events and therefore

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either do not present symptoms overtly to doctors or present them somatically; a finding echoed by Hollingshead and Redlich (1958) with respect to class.

Horwitz (1977) and others (for example, Birkel and Reppucci 1983, Pescosolido and Boyer 1999) support the idea that help-seeking is a contextual process by considering the role of social networks, which contain knowledge and information about services and offer social support as an alternative to their use. Horwitz argued that social network explanations of working-class service underuse and cultural explanations should be given equal weight. It seems logical to suggest that help-seeking can be explained at both levels, given the relationship between the structure and content of networks. Stigma, for example, is a cultural phenomenon running throughout social networks that has been shown to have a negative effect on help-seeking (Corrigan and Rüsch 2002), observed in relation to ethnic minorities (Gary 2005), adolescent boys (Chandra and Minkovitz 2006) and older people (Palinkas *et al*. 2007), though its influence in relation to class appears to be under-researched. Meta-analyses attest to a range of factors that have a bearing on help-seeking. Analysing 33 transcripts from seven studies, Kovandžić *et al.* (2011) studied hard-to-reach groups in primary mental health care and argued that appraisal, stigma, navigating services, negotiating treatment and the work involved in using services were important. In a review of 22 qualitative and quantitative studies on help-seeking in young people, Gulliver *et al*. (2010) found that stigma, appraisal and self-reliance were key factors. More empirical and theoretical work is needed to explore the interplay of factors involved.

Often the wide range of factors the aforementioned studies show to be implicated in help-seeking are all conceived of as, and reduced to, structural 'barriers'. This barriers approach has been particularly apparent in American studies (for example, Steele *et al*. 2007), especially those in clinical psychology and psychiatry (for example Mohr *et al*. 2010, Sareen *et al*. 2007). The problem with it is that it assumes that people are equally willing and able to use services if only the barriers were removed (Biddle *et al.* 2007, Pescosolido and Boyer 1999). This article argues that while certain barriers are real and important, we should focus more attention on the orientations and dispositions of users of talking treatments, so that what a person thinks, feels and perceives becomes of key importance, not least because structural barriers are always tied into and mediated by the culturally and socially generated and situated habitus.

Theoretical groundwork

The sociology of Pierre Bourdieu is well positioned for understanding health service use by class, given his relational understanding of the concept and how it connects with culture. Habitus is the key concept underlying this article. It is best understood, for present purposes, as a system of 'durable, transposable dispositions' (Bourdieu 1990: 53). Elaborating on the term disposition, Bourdieu notes that it:

> Seems particularly suited to express what is covered by the concept of habitus (defined as a system of dispositions). It expresses first the *result of an organizing action*, with a meaning close to that of words such as structure, it also designates a *way of being*, a *habitual state* (especially of the body) and, in particular, a *predisposition*, *tendency*, *propensity*, or *inclination*. (1977: 214, italics in original)

Habitus can then be understood as a wide-ranging concept that denotes ways of thinking, feeling, acting, speaking, perceiving, understanding and knowing; in short, ways of experiencing and being in the social world. Furthermore, habitus is the product of particular 'conditionings of existence' (Bourdieu 1990: 53). Wacquant elaborates, explaining that habitus is acquired via 'the internalization of external constraints and possibilities' (2008: 267), which explains

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why people of the same nationality, class, gender or age 'spontaneously feel 'at home' with one another' (Wacquant 2008: 267). This internalisation, Bourdieu notes, is experienced as personal taste. He argues that 'agents shape their aspirations according to concrete indices of the accessible and inaccessible, of what is and is not 'for us' ' (Bourdieu 1990: 64). Thus an agent's 'practical relation to the future' is determined by the habitus and the 'chances objectively offered to him by the social world' (Bordieu 1990: 64). Ways of experiencing and being in the world, taste, aspirations and orientations to the future, therefore, have roots in the nexus of the social structural conditionings that individuals inhabit.

Bourdieu uses the term social class to describe differing configurations of power-imbued stratifying factors (where there is a clear overlap with the concept of habitus):

> All biological individuals who, being the products of the same objective conditions, have the same *habitus*. A social class (in itself) – a class of identical or similar conditions of existence and conditionings – is at the same time a class of biological individuals having the same *habitus*, understood as a system of dispositions common to all products of the same conditionings. (1990: 59)

In thinking about the key objective conditions and conditionings in a socioeconomic sense, it is clear that in addition to occupation, education and income are key aspects of class, and by extension they will have relatively unique formative effects on the habitus. In interpreting the findings of this study I therefore attempt to evaluate the effect of these factors.

Although habitus is central to my argument, an understanding of the power resources that people have available can also help to explain health service use (Abel 2008). Power is a fundamental property of social structures and is central to Bourdieu's approach. In order to conceptualise power configurations more concretely, Bourdieu delineated different forms of capital. Economic capital is capital as conventionally understood and it can be used to pay for goods and services. To have cultural capital is to have command of one's culture – the knowledge and capacity to act, think, feel, and behave in line with cultural norms (the concept therefore overlaps with habitus) and social capital comprises social connections and relationships. Different forms of capital can be used to gain advantage in different fields (Bourdieu 1986: 47) – the in-flux social spaces of contestation with their own particular laws and mechanisms (Swartz 1997: 122). As noted, working-class people tend not to possess the forms of capital valued in the typically middle-class field of talking treatments.

How have others applied Bourdieu's sociology to health? Williams (1995) argued that the power of Bourdieu's theory was in how it could help explain the durability of health behaviour, highlighting how such behaviour is 'caught up' in struggles for social recognition and distinction (Williams 1995: 599), where symbolic violence is exercised over working-class practices. Similarly, Lawton (2002) considers how the 'unthinking' practices and behaviour the habitus engenders influence the reception of health promotion messages. Lo and Stacey (2008) focus on how the habitus shapes expectations, understanding and relationships with staff in clinical encounters, while Fotaki (2010) uses Bourdieuian theory to problematise the issue of patient choice in the National Health Service. Townsend interviewed 23 people with multi-morbidity, noting how serious illness disrupts the bodily habitus, forcing a 'conscious, deliberate, arduous 'practice' ' (2012: 98) resulting in potential symbolic violence. The need to assert a morally adequate habitus follows, which requires staking one's legitimate position in the field relative to others; a process that is agitated by class norms (McDermott 2006). Emirbayer and Williams (2005) use Bourdieu's sociology to skilfully map out the field of homeless services in New York City with a view to understanding the social work system. They demonstrate how interactions between the habitus of clients and staff and the types of capital they possess and value

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helps to explain the power relations of the field, in turn having effects on access to the field and the nature of relationships within it. These studies have helped to lay the ground by demonstrating how Bourdieu can be applied to help understand health and illness behaviour.

Methods

Recruitment and sample

The data presented here were collected in 2010 as part of a mixed-methods study on social class and the use of talking treatments, which employed the secondary analysis of national survey data, a postal and internet survey and semi-structured interviews. Interview volunteers were recruited via the survey (the topic of which was attitudes towards mental health and talking treatments). Survey respondents had higher rates of mental disorder (measured using the general health questionnaire, 12-item version [Goldberg and Williams 1988]) and more experience with talking treatments than the general population. This followed through into the characteristics of the interview sample. The sample also contained more women than men but nonetheless represented a range of people according to the key characteristics of interest. In total, 18 people were interviewed: four face-to-face and 14 by telephone, depending on their location. I did not perceive any differences between face-to-face and telephone interviews in terms of data collection or analysis, for example, in how candid the interviewees were or the themes that emerged, which tallies with empirical studies on this topic (Sturges and Hanrahan 2004, Novick 2008). The interviews lasted on average 45 minutes to an hour and were recorded with the participants' consent.

The national statistics socio-economic classification (Rose *et al*. 2005) (NS-SEC) as measured in the survey was used as a basis for operationalising class. I also asked respondents to categorise their parents' occupations according to the NS-SEC categories, and this information was used to designate a socially mobile category for those who were in NS-SEC category 1 or 2 but whose parents did mostly routine jobs or did not work (none were downwardly socially mobile). Given that class background is central to the study, I used parental occupation to classify the young interviewees (Natasha, Sophie, Jessica and Megan). Some cases did not fit neatly into this scheme so other data were used. Jane, who was retired, was classified according to her previous occupation. Fay, despite having an NS-SEC category of 1 when she last worked, was long-term sick/disabled and strongly identified herself as working class. Mike had not worked but was designated as working class as his income and education tallied with this category best. Rob had a NS-SEC category of 5 but nonetheless had just finished a degree and was on a middle-class trajectory. Overall, six interviewees were classified as working class (WC), four as socially mobile (SM) and eight as middle class (MC). The characteristics of the sample are given in Table 1.

Data collection and analysis

An interview guide covered the themes of views of talking treatments (associations with the term, thoughts on what they involve and are for); family background (perceived familial coping with emotional problems growing up); coping with emotional distress (first port of call, coping strategies, social support and other outlets); the use of talking treatments (views on usefulness and potential use, disincentives to use); social relations (the views and experiences of relations) and entering talking treatments/access issues (thoughts on medication, perceived accessibility, potential barriers). I also questioned interviewees about a vignette describing someone with depressive symptoms (adapted from the British Social Attitudes 2007 survey), a particularly suitable approach when researching sensitive topics (Lee 1993).

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Table 1 *Characteristics of the interview sample*

Name, age	*Gender*	*Designated social class*	*NS-SEC category*[a]	*Employment status*	*Mental ill health*[b]	*Had talking treatments?*	*Interview mode*
Jane, 57	Female	WC	4	Retired	No	No	Face-to-face
Natasha, 21	Female	WC	5	Never worked	Yes	No	Telephone
Mike, 58	Male	WC	-	Never worked	Yes	Yes	Telephone
Sophie, 20	Female	WC	2	Employed F/T	Yes	Yes	Telephone
Emma, 48	Female	WC	3	Employed P/T	Yes	No	Face-to-face
Fay, 39	Female	WC	1	Sick/disabled	Yes	Yes	Telephone
Rob, 35	Male	SM	5	Unemployed	No	No	Telephone
Tom, 38	Male	SM	1	Employed F/T	No	Yes	Telephone
Jake, 37	Male	SM	2	Student	No	Yes	Telephone
Dean, 51	Male	SM	2	Employed F/T	Yes	Yes	Telephone
Lee, 31	Male	MC	1	Employed F/T	No	Yes	Telephone
Alex, 39	Female	MC	1	Employed F/T	No	Yes	Telephone
Vicky, 39	Female	MC	1	Employed F/T	No	No	Telephone
Jessica, 21	Female	MC	1	Student	No	Yes	Telephone
Megan, 22	Female	MC	2	Student	Yes	No	Face-to-face
Helen, 37	Female	MC	1	Employed F/T	Yes	Yes	Telephone
Carly, 31	Female	MC	1	Employed F/T	No	Yes	Face-to-face
Katherine, 32	Female	MC	1	Employed F/T	No	Yes	Telephone

[a]1, Managerial and professional; 2, Intermediate; 3, Small employers and own account workers; 4, Lower supervisory and technical; 5, Routine and semi-routine.
[b]According to the general health questionnaire, 12-item version (Goldberg and Williams 1988).

Analysis proceeded after the first interview was carried out, so that the conceptual and theoretical framework was tightened iteratively through further interviews (Srivastava and Hopwood 2009). I listened to recordings many times, noting down the essence of what interviewees said in order to convey their experiences and viewpoints. At the same time, representative quotations were indexed. With repeat listening, coding moved from being fairly descriptive to being theoretically grounded in a Bourdieuian heuristic. I then considered how the themes that emerged from this process were related to each other, consistent with framework analysis (Ritchie *et al*. 2003). Following Corbin and Strauss (1990) I also wrote memos immediately after the interviews to capture my impressions of each interview as a social interaction and of the interviewees' habitus. The validity of the analysis was strengthened by triangulation with the survey data (which was probed in the interviews) and discussing interpretations with my supervisor.

Ethical considerations

The Economic and Social Research Council (2005) research ethics framework was used in designing the research, paying special attention to its six key principles, and ethical approval was gained from the university ethics committee. The main ethical issues related to the sensitive subject matter. Asking questions about emotional problems and treatment could have caused interviewees distress or embarrassment, or they could have revealed existing acute distress or an intention to cause themselves or others harm. I attempted to frame the social interaction as non-clinical by making clear that I was not trained as a therapist or counsellor. I did have a list of contact details for professional agencies to whom I would refer people if I or

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they felt it appropriate but I did not perceive any signs of distress either during the interviews or immediately after.

The subject matter also meant that confidentiality and anonymity were important. Pseudonyms are used in presenting the findings and identifiable information has been removed. An information leaflet and informed consent sheet outlining the main risks and potential benefits were posted to those who were to be interviewed face-to-face (with the informed consent sheet to be collected at the interview) and e-mailed to telephone interviewees, who were asked to consent via e-mail. Participants were told they were free to withdraw at any time.

Findings

Verbalisation and introspection

One of the key factors influencing whether someone is able to benefit from talking treatments is the way in which they talk – how do they talk about and reflect on their feelings and experiences? At a basic level, some of my interviewees were more talkative than others in terms of the quantity of what was said, as others examining the role of class in interview dynamics have found (Charlesworth 2000, McDermott 2004). More importantly, there were also differences in the substance of talk: some talked in a more chatty or gossipy way, while others gave more elaborate and articulate accounts. In addition, the chatty individuals tended to talk more about others' problems in the community, whereas the latter group were more introspective and reflective of their thoughts and feelings. This is in line with the early work of Bernstein (1964), who distinguished between middle-class 'elaborated' and working-class 'restricted' language codes, and Hollingshead and Redlich, who argued that lower class patients 'have not learned to verbalize and symbolize in the same way higher class persons have' (1958: 348).

Two working-class interviewees, Natasha (21) and Sophie (20) gave mostly very short answers. Attempts to get them to elaborate were generally unsuccessful. They seemed content that their answers conveyed the essence of what they needed to tell me, with no need to give more detail:

DH: Do you think if you told your family that you had had therapy they would be supportive of you or do you think they would not be keen on the idea?

Sophie: No I don't think they would be too keen.

DH: No? Why do you think that is?

Sophie: It's just the way they come across.

Natasha's answers were similar – short and to the point.

Experienced interviewers will be aware of this situation. It is tempting to assume that it results from shy or introverted interviewees and that the issue is one of personality. Megan's (22) case challenges this assumption. I perceived Megan to be similarly introverted, though she was from a middle-class background. She shows that introversion does not necessarily preclude an elaborate and introspective style of communicating. I queried her response when she indicated she had considered talking treatments but did not end up using them:

> I think it was being put off by the fact that I didn't definitely know I needed it, so, erm … yeah, no, I think I was just … yeah I think that was it and I think also I had a period of I dunno, feeling really crap basically, erm which was kind of partially, erm, hormonal

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> [laughs]. So erm, yeah, I dunno, I think it was kind of external factors that were causing that came to an end so I had a period of 6 months of feeling a bit crap and then it essentially ceased as soon as I stopped being on the wrong kind of pill. So, yeah, it wasn't anything major in any way, so I guess that's why I didn't want to … but then at the same time I think when you suddenly feel different to how you normally feel and you're not quite sure what to do about it, you feel a bit ridiculous so you're not sure who to tell or what to do about it, so …

Megan appeared to be a less confident interviewee than many others, yet she was introspective in talking about her emotions: she attributed external causes to her feelings, noted changes in them over a period of time and evaluated the severity of the disturbance in them. As a contrast, I asked Jake (37, SM) how he came to have talking treatments: 'I went to the university counselling service, I just felt really shit'.

The opposite case, where interviewees were very talkative but the content was not particularly introspective, furthers the argument that personality does not wholly explain differences in verbalisation. Indeed, this carried over into preferences for treatment. Jane (57, WC) talked about how she would be more likely to use counselling if it took the form of community meetings:

> You know, I think a lot of things could be done round people's homes. You know you become friends then, and then perhaps when you're not having meetings you would be talking to people and have phone numbers and, you know, you need other people to talk to that'd been through it. You know, I don't think I would ring up a professional person and say 'I'm not feeling that well' but you might well ring up your mate and say 'Ooh I'm a bit fed up today' and then they could say 'Ooh I've done that what shall we do?' You know, and then you can have a laugh and sort of get on with your bits and pieces that you want to do but I just think things have got to be less formal. You know, you've gotta have sort of smaller groups. And I mean, I could imagine I'd quite like to have another three or four women my age, sitting here, we'd gossip all day [laughs]. And I think sometimes you can have a laugh and a gossip you know.

The focus here is on others' experiences and gossiping, which is in some ways the opposite of personal introspection. Similarly Emma (48, WC) had taken a counselling course and worked part-time in a counselling service. She was a talkative interviewee but despite her involvement with counselling much of her interview was about others' problems in the local community and steps that could be taken to address them. When I did probe her own experiences with depression, she talked briefly about them but soon stood back and related them to why others might or might not seek treatment.

Impetus for emotional health

Given that talking treatments aim to effect emotional health gain, their users must be interested in and concerned with aiming for this goal. In other words, they must have an impetus for emotional health. Middle-class interviewees tended to say that they sought treatment because they felt they had to get better. For example, I asked Helen (37) when she sought counselling:

> I wasn't eating because I was so anxious at the time. I just thought – I was getting skinnier and skinnier, and I just thought – something's got to help. I need to find some form of help.

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Alex (39) noted how the feeling of needing to get better can be so prominent that serious concerns about treatment are allayed:

Alex: I was pretty confident they were gonna put me in a padded cell. And there was going to be an analysis of my mental state, and they were going to decide that I was mentally unhinged, and they were potentially going to keep me, and that was absolutely terrifying.

DH: But nevertheless you still agreed to it with your doctor? Maybe he dispelled some of that?

Alex: I persuaded a very good friend to come with me to the first session, for moral support and possible escape!

Similarly Lee (31) followed through with talking treatments, despite concerns:

> [My GP] called it something like 'the mental health team', which conjured up strong images in my mind. So initially I thought 'Hang on, hang on, what's this?' Because I hadn't been to anything like that before I was apprehensive to start with but I was at quite a low point at that stage so I thought I'd fill in the form and see what happens.

An interesting point is being made here. Stigma is a recurring theme in the help-seeking literature. Yet when a desire for treatment exists fears can soon be cast aside, even when they are particularly strong. Stigma is no doubt important but should not be treated as a separate, abstract barrier without understanding how it ties into individual orientations towards mental health and services. Carly (31, MC) demonstrates how her impetus to achieve emotional health is related to how she reflects on her emotional state:

> I noticed the signs … I know those … I call it my scales. If my scales are tipping I know something has got to be done … I recognise it and I think 'I'm not going down that road again'.

Seeking, and being able to effectively use talking treatments results from being attuned to and concerned about emotional health and being able to verbalise emotions. Working-class interviewees differed in that they tended to be referred for treatment, as in Sophie's case (20):

> I was at college and they just said, because I wouldn't talk about anything, they put me down for having it … I was talking to my tutor and she recommended having it.

Similarly Tom (38, SM) was influenced by his wife in seeking talking treatments:

> Oh God, if it hadn't been for Katrina I wouldn't have gone and God knows what state I'd have been in, and if I hadn't actually gone she would have probably left me in the first place [laughs]. So for once I did actually listen to her and took her advice and went to see somebody.

In Tom's case his social capital facilitated seeking treatment. It is interesting to ponder whether he would have used talking treatments were it not for his wife's influence.

Relation to medical authority

In the UK talking treatments on the NHS can generally only be accessed through general practitioner (GP) referral, though this is beginning to change with the IAPT programme. Since NHS provision accounts for the bulk of services, GPs are the main gatekeepers of talking treatments. Referral is a collaborative process, dependent not only on the approach of individual GPs but

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on their relationship with the patient and patient preferences (Goldberg and Huxley 1992: 44, Stimson and Web 1975: 58). Indeed, the National Institute for Clinical Excellence (2009: 7) state that patient preference should be a deciding factor in what treatment is prescribed for depression. What individuals bring to the GP encounter is therefore likely to be pivotal in deciding who gets what treatment. In Alex's (39, MC) case, the decision was made mutually:

Alex: We [she and her GP] both begged for it independently! … It was patently obvious that that was a suitable treatment.
DH: So before you went to the doctors, you had a preference for that anyway?
Alex: Yes … well, not necessarily a preference, but I knew it was available.

Alex notes that a prerequisite to having a preference for talking treatments is knowledge that they are available. Middle-class interviewees tended to be aware of the variability of GP services. I asked Dean (51, SM) about what the person in the depression vignette should do:

> He needs to speak to someone about it. He needs to go to his GP first of all and not get fobbed off with something like, 'Oh you've just got seasonally affective disorder, it will go away, get yourself a hobby'… You get different reactions from different GPs … I mean initially, they're probably going to prescribe anti-depressants, but I would hope that the GP would be able to intervene in some other way and say, 'Look, we can offer counselling here as well if you want to come and discuss your problems with a counsellor'.

Some middle-class interviewees took a more critical approach to GPs, such as Vicky (39):

> I would rather pay for it than go to my GP … my GPs are pretty useless, to be honest. Not that I've ever been to them for a problem like that, but when I've been to them for other problems – like when the children weren't very well – they were just rubbish.

The critical, conscious engagement with health services requires a certain amount of cultural capital (there are parallels here with Ball *et al.*'s [1995] research on how middle-class parents' cultural capital enabled them to evaluate which schools they felt were most suitable for their children). Working-class interviewees, on the other hand demonstrated a certain deference to the authority of the GP and adherence to their recommendations. Emma (48) provides an example. She unquestioningly accepted her GP's diagnosis of the problem:

> I had undiagnosed chronic postnatal depression and didn't know, I just thought I was a grumpy sod dealing with loads of small children. Eventually [I found out that according to my GP] it was an imbalance in the serotonin in my brain and I needed medication, basically.

I asked Fay (39) whether she expected her GP to refer her for counselling:

> I thought he might have done. But it was up to him, obviously, what he thought. He thought it was a good idea for me.

She also displayed how deference can carry over into expectations of the counselling process. She told me that when her friend had counselling:

> She would go into the room and just sit and look at him [the therapist]. And waiting for her to say something when it was him that should have been saying something. And a couple of appointments absolutely nothing was said until he told her that was her time up.

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There are echoes here of Hollingshead and Redlich's point that instead of seeking insight into their problems, working-class patients tend to want 'advice and some tangible intervention, such as pills, shots, warmth, or radiation' (1958: 348). Fay implies she is disappointed that the therapist was not doing something. It makes sense that a preference for insight follows from having the impetus for emotional health, and being able to verbalise and introspect about it, and a preference for something tangible is associated with a more practical orientation to the world. It is this disposition to which I now turn.

Practical orientation to the future

People engage in a wide range of coping strategies for mental distress, with some of these being very much practically oriented, that is, focused on what can be done in the here and now to tackle the problem. In some ways this orientation runs counter to the ethos of talking treatments. As in Fay's case, working-class respondents appeared to be more attuned to practical solutions. I asked Tom (38, SM) whether he was aware of counselling and what his ideas were about it before his wife recommended it to him:

> I knew it was out there, but I was always of the opinion that *it wasn't for me*. I'm too strong to go for that, I'm weak going for help … what help can you get talking to somebody? You basically know all the answers anyway … it's for people a lot more ill than myself.

The phrase in italics is one Bourdieu uses to describe a key aspect of habitus: the feeling that something is or is not for oneself, which arises out of the 'chances objectively offered' by the social world. Tom went on to talk about his workplace, where he said there is an 'old school train of thought' attitude, along the lines of 'What's up with ya? Get a pint down your neck, you'll feel better'.

I asked Dean (51, SM) about his thoughts on use of therapy by working-class people, and he expressed something very similar:

> A working-class person who had not had the opportunities and had left school semi-literate even, perhaps may have felt that it was something that wasn't for them, that people wouldn't understand.

Like Tom, Dean discusses drinking as a culturally normative coping strategy when there is a lack of insight into the origin of emotional distress:

> I started, very slow at first and very gradually, to drink problematically, as a way of dealing with my feelings. Still, at that time, there wasn't any inclination that it was to do with my childhood and upbringing. I mean, my doctors prescribed me anti-depressants and he said, 'You know, we all get low at times' and so on and so on and so on. So it's been a long, long process of learning and understanding.

Drinking and taking anti-depressants represent a short-term orientation to 'fixing the problem' in the moment. It is telling that in both Tom's and Dean's cases, the way they tackle emotional problems has changed from being typically working class to typically middle-class as their class status has changed.

Using talking treatments also requires the economic capital to do so, whether this is in the form of money for more accessible private services or time. Both Tom and Dean had used

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private services and conveyed the view that they were affordable. For others, time constraints made talking treatments untenable, as in the case of Emma (48, MC):

> I wouldn't have been able to find the time. I'd got a 4-year old and newborn twins – there was no way I could have found the time or the strength to go to counselling once a week … when you've got small children it's hard enough to negotiate half hour to do the washing up or cleaning.

Jane (57, WC) similarly emphasised that practical tasks are often prioritised in working-class households. She talked about her inability to get on with these as a central aspect of her experience of depression:

> I didn't do anything. I didn't shop, I didn't do the washing, I didn't do the cleaning, I didn't do anything. It was really weird.

Jane was prescribed anti-depressants by her GP, and found comfort in her GP telling her that 'it's an imbalance in your brain … it's like a physical illness, we can make you better' [Jane's words]. Katherine (32, MC) was astute about her use of talking treatments in relation to class:

> If I'd been a working-class person throughout most of the history of counselling – for example, breaking my back in a factory, dealing with the premature death of my child due to malnutrition or something, while the upper classes floated around and talked about their dreams on Freud's couch – I'd have been a bit down on the whole idea of therapy!

Priorities, preferences and motivations are ultimately traceable, at least to a large extent, to social structural conditioning factors.

Discussion

Four key dispositions helping to explain the underuse by working-class patients of talking treatments have been outlined: verbalisation and introspection, impetus for emotional health, relation to medical authority, and practical orientation to the future. In line with Bourdieu's theory of practice, such dispositions are best understood not as conscious opinions or considered positions, but as 'unthinking and routine' (Williams 1995: 582). They are likely to be thrown into relief in clinical encounters, where institutionally sanctioned ways of talking, thinking and feeling are especially apparent. Because dispositions tend to be experienced as taste (for example 'I like to live each day as it comes'), what Bourdieu has described as socially constituted agoraphobia can result, whereby the extreme tensions created by confrontation with a social practice from which one is structurally excluded leads to self-exclusion (Bourdieu and Wacquant 1992: 72). Sayer suggests that shame is a key psychosocial mechanism in this process, which results from and can lead to a feeling of being negatively judged as inadequate and disempowered (2005: 157). Given that, in effect, talking treatments challenge the habitus in typically more middle-class terms, it might be argued that they constitute a form of symbolic violence over working-class lives. Although there is merit in this argument, adopting it wholesale would be tantamount to denying that working-class people ever benefit from talking treatments. It is, however, fruitful to consider how disparities and inequalities in service use can be minimised. One task that can help with this is tracing the structural factors that give rise to cultural dispositions in order to suggest ways in to affect these factors.

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As suggested earlier, a practical or pragmatic habitus – which stands in contrast to an aesthetic, detached or casual habitus – arises out of a lack of 'distance from necessity' (Brubaker 1985: 765). A working-class habitus allows no escape from 'ordinary interests and urgencies' (Bourdieu 1984: 56) because material needs are never far away, a point demonstrated by MacDonald *et al*. (2005) with reference to social exclusion on working-class estates. Working-class lives have historically been tough and short (Engels (1987 [1892]. In such circumstances, it makes sense to seek instant gratification wherever it is available, a propensity that might help to explain coping with emotional health problems by drinking or taking illicit drugs, using medication or ignoring the problem versus using talking treatments. Although, since the epidemiological transition (that is, when the main causes of death shifted from being infectious to non-communicable), the mechanisms of health inequalities have arguably become more psychosocial in nature (Wilkinson 2005: 9) and working-class lives are no longer as short and harsh, the habitus lags behind the circumstances that shape it (Bourdieu 1977: 83). Taylor and Seeman (1999) postulate some of the psychosocial mechanisms that help to explain links between social class and mental health. Optimism, coping style, a sense of mastery or personal control and social support and social conflict are associated with both socioeconomic status and mental health. They argue that those in lower socioeconomic environments tend to have less time and money, experience more chronically stressful conditions, have less control over their work and experience more damaging social stressors ('residential crowding, fear of crime, financial strain'), which in addition may foster distrust of others (Taylor and Seeman 1999: 215). Thus, what at first seem to be individual coping strategies determined by personality traits can be viewed upon further examination as 'farther downstream' than psychosocial and dispositional factors (Taylor and Seeman 1999: 217). These aspects of mental health – a sense of control, optimism and trust – are central to the therapeutic relationship.

Working-class occupations offer few opportunities to build the verbalising and introspecting skills required for talking treatments. In addition, those with physically demanding jobs are more likely to value physical over emotional health, whereas professional roles entail responsibilities involving others whereby some level of emotional health must be maintained. Carly, for example, locked herself away when she experienced depression while she was a student, but sought help for it once she was in a professional role. She also showed how a person's occupation can bring them into contact with others who have experienced treatment. Working-class occupations also engender low levels of control and autonomy, which can lead to feelings of powerlessness such that emotional problems seem like 'bad luck' or just 'life' and so 'the goal of coping becomes ambiguous' (Wheaton 1980: 106). Subsequently, some question the extent to which people can benefit from talking treatments if the main drivers of their problems stem from work. I think, however, that this is a defeatist position. Talking treatments can also help people remove themselves from unfavourable circumstances or learn to cope with them better. As Sayer notes, it is possible (though difficult) to consciously override the habitus (2005: 25). The same point applies in considering how the therapeutic enterprise can adapt to ensure a greater level of cultural compatibility with its diverse range of potential users.

Finally, education is also associated with certain orientations to the world, inculcating active thought and enquiry and the ability to read, write, speak about and solve problems. In turn, this is likely to influence how those with higher levels of education cope with emotional problems. Education facilitates researching effective ways to cope with problems using formal treatment (Hollingshead and Redlich 1958: 173) or informally by utilising social support or

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individual coping strategies. Those with higher levels of literacy are generally more able to digest self-help books or write (for example, a diary) as a means of coping.

Increasing the use of talking treatments

Tracing dispositional factors suggests that they are deeply entrenched and difficult to affect, which presents a tough problem for mental health policy. For example, the way we use language is an essential part of who we are. However, the notion that those who use more restricted forms of language cannot benefit from talking treatments as readily as those who speak in an elaborated code does not mean that they are inherently incompatible with them. Some working-class individuals are receptive to talking treatments and respond to encouragement to verbalise their thoughts and feelings. For others, admittedly, differences in the use of language between themselves and therapists may be too much of an obstacle. One solution would be to train more therapists from working-class backgrounds so that users and therapists are more likely to speak the same language, in both the linguistic and figurative sense. Those who might find the therapist encounter too alien may feel interventions like peer support more suitable (Jane's preference for chatting with friends springs to mind).

Other policy efforts might focus on increasing therapists' awareness of cultural and social factors through training programmes. Ideally, therapists should be aware of how they themselves and those from different backgrounds tend to relate to and experience the world. Hollingshead and Redlich argue that therapists should understand the communities they work in – its organisations, cultures, stocks of ethnicities and classes and general history, and should also evaluate their own and their patients' social class and social class mobility, through objective indicators and subjective impressions (Hollingshead and Redlich 1958: 371). Relatedly, therapists could also be made aware of the kind of problems with which people from different backgrounds tend to be concerned. Sue and Sue suggest that talking treatments should be carried out on users' rather than the therapists' terms:

> Many minority group individuals find the one-to-one/in-office type of counseling very formal, removed, and alien. When counselors move out of their offices into the environments of their clients, it again indicates commitment and interest in the individual. (2003: 100)

Similarly, group therapy might make talking treatments more accessible to a wider range of people. Finally, equitable use could also be encouraged by informing people about the existence of services and how to access them (including the point that their preferences to some extent determine what treatment they get), how widespread their use is, what they are for, how effective they are and side/withdrawal effects compared to other treatments, given that the data indicate that there may be class disparities in this type of knowledge.

Limitations

Social class intersects with other socio-demographic factors such as age, gender and ethnicity. There has not been space to discuss the influence of these factors on the findings. More work needs to be done to disentangle the structured space of cultural dispositions that influence the use of the mental health and health service use more generally. Methodologically, the sample would have benefitted from including a wider range of interviewees, especially those who had never had contact with talking treatments.

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Conclusions

The contention of this article is that a large part of why people act in the way they do is rooted in their cultural dispositions – their ways of feeling, thinking, talking, acting, moving, perceiving, and so on. We should try to avoid a situation where the literature on help-seeking and service use focuses on the same recurring themes without a theoretically grounded understanding. What are traditionally conceived of as barriers to service use should not be thought of as detached entities but as tied into and mediated by habitus (how stigma interacts with the impetus for emotional health is one example). Given that talking treatments involve certain ways of talking, thinking and feeling about the social world, paying attention to how users engage with such treatments (and the process of accessing them) by virtue of the social and cultural circumstances they inhabit suggests useful avenues for increasing their use. Subsequently, mental health policy needs to consider how treatments can be made appropriate to the local context. Future research in this area should explore the dispositions that other key social structuring variables, such as gender, age and ethnicity, give rise to.

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Note

1 I follow the general trend in the literature (for example, Charlesworth 2000, Sayer 2005) of using the term 'working class' to refer to a group that are hierarchically lower in the class structure in terms of their socioeconomic characteristics, especially with respect to occupation. In this sense, the term working class is used as a 'wide-ranging discursive and symbolic construction aiming to represent [a certain] sector of the class structure' (Atkinson 2010). In reviewing the literature I include studies that use socioeconomic concepts (for example income) that relate to or approximate class.

References

Abel, T. (2008) Cultural capital and social inequality in health, *Journal of Epidemiology and Community Health*, 62, 7, e13 doi:x10.1136/jech.2007.066159.

Anderson, S., Brownlie, J. and Given, L. (2009) Therapy culture? Attitudes towards emotional support in Britain, In Park A., Curtis J., Thomson, K. Phillips, M. *et al*. (eds) *British Social Attitudes: the 25th Report*. London: Sage.

Atkinson, W. (2010) Class, individualisation and perceived (dis)advantages: not either/or but both/and? *Sociological Research Online*, 15, 4.

Ball, S.J., Bowe, R. and Gewirtz, S. (1995) Circuits of schooling: a sociological exploration of parental choice in social class contexts, *Sociological Review*, 43, 1, 52–78.

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Ballinger, L. and Wright, J. (2007) 'Does class count?': social class and counselling, *Counselling and Psychotherapy Research*, 7, 3, 157–63.

Bernstein, B. (1964) Social class, speech systems and psycho-therapy, *British Journal of Sociology*, 15, 1, 54–64.

Biddle, L., Donovan, J., Sharp, D. and Gunnell, D. (2007) Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour, *Sociology of Health & Illness*, 29, 7, 983–1002.

Birkel, R.C. and Reppucci, N.D. (1983) Social networks, information-seeking, and the utilization of services, *American Journal of Community Psychology*, 11, 2, 185–205.

Blaxter, M. (2010) *Health*, 2nd edn. Cambridge: Polity.

Bourdieu, P. (1977) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgment of Taste* (trans. Nice, R.). Cambridge: Harvard University Press.

Bourdieu, P. (1986) The forms of capital. In Richardson, J.G. (ed.) *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood.

Bourdieu, P. (1990) *The Logic of Practice*. Cambridge: Polity.

Bourdieu, P. and Wacquant, L.J.D. (1992) *An Invitation to Reflexive Sociology*. Chicago: University of Chicago Press.

Brown, G.W. and Harris, T. (1978) *Social Origins of Depression*. London: Routledge.

Brubaker, R. (1985) Rethinking classical theory: the sociological vision of Pierre Bourdieu, *Theory and Society*, 14, 6, 745–75.

Caine, T.M. and Smail, D.J. (1969) *The Treatment of Mental Illness*. New York: International Universities Press.

Carkhuff, R.R. and Pierce, R. (1967) Differential effects of therapist race and social class upon patient depth of self-exploration in the initial clinical interview, *Journal of Consulting Psychology*, 31, 6, 632–34.

Chandra, A. and Minkovitz, C.S. (2006) Stigma starts early: gender differences in teen willingness to use mental health services, *Journal of Adolescent Health*, 38, 6, 754, e1–8.

Charlesworth, S.J. (2000) *A Phenomenology of Working Class Experience*. Cambridge: Cambridge University Press.

Chew-Graham, C., Kovandžić, M., Gask, L., Burroughs, H., *et al*. (2012) Why may older people with depression not present to primary care? Messages from secondary analysis of qualitative data, *Health and Social Care in the Community*. 20, 1 52–60.

Corbin, J. and Strauss, A. (1990) Grounded theory research: procedures, canons, and evaluative criteria, *Qualitative Sociology*, 13, 1, 3–21.

Corrigan, P.W. and Rüsch, N. (2002) Mental illness stereotypes and clinical care: do people avoid treatment because of stigma? *Psychiatric Rehabilitation Skills*, 6, 3, 312–34.

Department of Health (DoH) (2001a) *Psychiatric Morbidity Among Adults Living in Private Households, 2000*. London: HMSO.

DoH (2001b) *Treatment Choice in Psychological Therapies and Counselling*. London: Department of Health.

DoH (2008) *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit*. London: Department of Health.

DoH (2011) *Talking Therapies: A Four Year Plan of Action*. London: Department of Health.

Economic and Social Research Council (2005) *Research ethics framework*. Swindon: ESRC.

Emirbayer, M. and Williams, E.M. (2005) Bourdieu and social work, *Social Service Review*, 79, 4, 689–724.

Engels, F. (1987 [1892]) *The Condition of the Working Class in England*. Harmondsworth: Penguin.

Fotaki, M. (2010) Patient choice and equity in the British National Health Service: towards developing an alternative framework, *Sociology of Health & Illness*, 32, 6, 898–913.

Garfield, S.L. (1994) Research on client variables in psychotherapy. In Bergin, A.E. and Garfield, S.L. (eds) *Handbook of Psychotherapy and Beh aviour Change*, 4th edn. Hoboken: Wiley.

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Gary, F.A. (2005) Stigma: barrier to mental health care among ethnic minorities, *Issues in Mental Health Nursing*, 26, 10, 979–99.

Goldberg, D.P.B. and Huxley, P. (1992) *Common Mental Disorders*. London: Routledge.

Goldberg, D.P. and Williams, P. (1988) *A User's Guide to the General Health Questionnaire*. Slough: Nfer-Nelson.

Gulliver, A., Griffiths, K.M. and Christensen, H. (2010) Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review, *British Medical Council Psychiatry*, 10, 113, doi:x10.1186/1471-244X-10-113.

Hart, J.T. (1971) The inverse care law, *The Lancet*, 297, 7700, 648–49.

Hollingshead, A.B. and Redlich, F.C. (1958) *Social Class and Mental Illness*. Hoboken: Wiley.

Horwitz, A. (1977) Social networks and pathways to psychiatric treatment, *Social Forces.* 56, 1, 86–105.

Kearney, A. (1996) *Counselling, Class & Politics: Undeclared Influences in Therapy*. Manchester: PCCS Books.

Kirsch, I., Deacon, B.J., Huedo-Medina, T.B., Scoboria *et al*. (2008) Initial severity and antidepressant benefits: A meta-analysis of data submitted to the food and drug administration, *PLOS Medicine*. 5, 2, 260–68.

Kovandžić, M., Chew-Graham, C., Reeve, J., Edwards, S. *et al*. (2011) Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work, *Social Science & Medicine*, 62, 5, 763–72.

Lawton, J. (2002) Colonising the future: temporal perceptions and health-relevant behaviours across the adult lifecourse, *Sociology of Health & Illness*. 24, 6, 714–33.

Lee, R.M. (1993) *Doing Research on Sensitive Topics*. London: Sage.

Lo, M.M. and Stacey, C.L. (2008) Beyond cultural competency: Bourdieu, patients and clinical encounters, *Sociology of Health & Illness*, 30, 5, 741–55.

Lorion, R.P. (1974) Patient and therapist variables in the treatment of low-income patients, *Psychological Bulletin*, 81, 6, 344–54.

McDermott, E. (2004) Telling lesbian stories: Interviewing and the class dynamics of 'talk', *Women's Studies International Forum*, 27, 3, 177–87.

McDermott, E. (2006) Surviving in dangerous places: lesbian identity performances in the workplace, social class and psychological health, *Feminism & Psychology*, 16, 2, 193–211.

MacDonald, R., Shildrick, T., Webster, C. and Simpson, D. (2005) Growing up in poor neighbourhoods: the significance of class and place in the extended transitions of 'socially excluded' young adults, *Sociology*, 39, 5, 873–91.

McLeod, J. (2009) *An Introduction to Counselling*, 4th edn. Maidenhead: Open University Press.

Mohr, D.C., Ho, J., Duffecy, J., Baron, K.G. *et al*. (2010) Perceived barriers to psychological treatments and their relationship to depression, *Journal of Clinical Psychology*, 66, 4, 394–409.

National Health Service Information Centre (2009) *Adult Psychiatric Morbidity in England, 2007*. London: NHSIC.

National Institute for Clinical Excellence (2009) *Depression (clinical guideline 90)*. London: NICE.

Novick, G. (2008) Is there a bias against telephone interviews in qualitative research? *Research in Nursing and Health*, 31, 4, 391–98.

Palinkas, L.A., Criado, V., Fuentes, D., Shepherd, S. *et al*. (2007) Unmet needs for services for older adults with mental illness: comparison of views of different stakeholder groups, *American Journal of Geriatric Psychiatry*, 15, 6, 530–40.

Pescosolido, B.A. and Boyer, C.A. (1999) How do people come to use mental health services? Current knowledge and changing perspectives. In Horwitz, A.V. and Scheid, T.L. (eds) *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems*. Cambridge: Cambridge University Press.

Ritchie, J., Spencer, L. and O'Connor, W. (2003) Carrying out qualitative analysis, In Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage.

Rose, D., Pevalin, D.J. and O'Reilly, K. (2005) *The National Statistics Socio-economic Classification: Origins, Development and Use*. Basingstoke: Palgrave Macmillan.

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Roth, A. and Fonagy, P. (1996) *What Works for Whom? A Critical Review of Psychotherapy Research*. New York: Guilford.

Sareen, J., Jagdeo, A., Cox, B.J., Clara, I. *et al*. (2007) Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands, *Psychiatric Services*, 58, 3, 357–64.

Saxon, D., Fitzgerald, G., Houghton, S., Lemme, F. *et al*. (2007) Psychotherapy provision, socioeconomic deprivation, and the inverse care law, *Psychotherapy Research*. 17, 5, 515–21.

Sayer, A. (2005) *The Moral Significance of Class*. Cambridge: Cambridge University Press.

Sayer, A. (2011) *Why Things Matter to People*. Cambridge: Cambridge University Press.

Seligman, M.E.P. (1995) The effectiveness of psychotherapy, *American Psychologist*, 50, 12, 965–74.

Skeggs, B. (2004) *Class, Self, Culture*. London: Routledge.

Srivastava, P. and Hopwood, N. (2009) A practical iterative framework for qualitative data analysis, *International Journal of Qualitative Methods*, 8, 1, 76–84.

Steele, L., Dewa, C. and Lee, K. (2007) Socioeconomic status and self-reported barriers to mental health service use, *Canadian Journal of Psychiatry*, 52, 3, 201–06.

Stimson, G. and Webb, B. (1975) *Going to See the Doctor*. London: Routledge and Kegan Paul.

Sturges, J.E. and Hanrahan, K.J. (2004) Comparing telephone and face-to-face qualitative interviewing: a research note, *Qualitative Research*, 4, 1, 107–18.

Sue, D.W. and Sue, D. (2003) *Counseling the Culturally Diverse: Theory and Practice*, 4th edn. Hoboken: Wiley.

Swartz, D. (1997) *Culture and Power: The Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.

Taylor, S.E. and Seeman, T.E. (1999) Psychosocial resources and the SES-health relationship, *Annals of the New York Academy of Sciences*, 896, 1, 210–25.

Townsend, A. (2012) Applying Bourdieu's theory to accounts of living with multimorbidity, *Chronic Illness*, 8, 2, 89–101.

Wacquant, L.J.D. (2008) Pierre Bourdieu. In Stones, R. (ed.) *Key Sociological Thinkers*, 2nd edn. Basingstoke: Palgrave.

Wheaton, B. (1980) The sociogenesis of psychological disorder: an attributional theory, *Journal and Health and Social Behavior*. 21, 2, 100–24.

Wilkinson, R.G. (2005) *The Impact of Inequality*. Abingdon: Routledge.

Williams, S.J. (1995) Theorising class, health and lifestyles: Can Bourdieu help us? *Sociology of Health & Illness*, 17, 5, 577–604.

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