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The Psychiatrization of poverty: rethinking the mental health-poverty nexus

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Abstract

The positive association between 'mental illness' and poverty is one of the most well established in psychiatric epidemiology. Yet there is little conclusive evidence about the nature of this relationship. Generally, explanations revolve around the idea of a vicious cycle, where poverty may cause mental ill health, and mental ill health may lead to poverty. Problematically, much of the literature overlooks the historical, social, political, and cultural trajectories of constructions of both poverty and 'mental illness'. Laudable attempts to explore the social determinants of mental health sometimes take recourse to using and reifying psychiatric diagnostic categories that individualize distress and work to psychiatrically reconfigure 'symptoms' of oppression, poverty, and inequality as 'symptoms' of 'mental illness'. This raises the paradoxical issue that the very tools that are used to research the relationship between poverty and mental health may prevent recognition of the complexity of that relationship. Looking at the mental health-poverty nexus through a lens of psychiatrization (intersecting with medicalization, pathologization, and psycholgization), this paper recognises the need for radically different tools to trace the messiness of the multiple relationships between poverty and distress. It also implies radically different interventions into mental health and poverty that recognise the landscapes in which lived realities of poverty are embedded; the political economy of psychiatric diagnostic and prescribing practices; and ultimately to address the systemic causes of poverty and inequality.

Key Words: poverty, emotional distress, mental health, psychiatrization, psychologization, medicalization, psychiatric epidemiology

Introduction

> 'Poverty is pain; it feels like a disease…It eats away one's dignity and drives one into total despair' (Narayan et al., 2000a, p. 2).
> Poverty takes away 'your desire to live' (ATD Fourth World, 2012, p. 40).
> Poverty is when a 'person goes mad and wishes to commit suicide' (Narayan et al., 2000b, p. 258).

When people living in poverty are asked about the lived realities of their experiences it seems some talk about despair, pain, being driven mad and losing the desire to live. People are expressing immense distress at their living conditions. But how useful is it to understand the distress they speak of as constituting something called a 'mental illness' or disorder? Is this distress pathological and in need of psychiatric and/or pharmacological treatments, or might we understand it as a 'normal' expression of sadness at living in a harsh environment?

The positive association between poverty and mental health problems is 'one of the most well established in all of psychiatric epidemiology' (Belle, 1990, p. 385). Yet, there is little conclusive evidence about the nature of this relationship, and much of the literature focuses on the individual psyches of people living in poverty, rather than the politico-economic conditions that sustain poverty. This paper draws upon conceptual work into medicalisation and psychiatrization to trace and tease out the messy and complex relationship between poverty-related distress and the psy-disciplines. This process opens possibilities to explore conclusions that may not be reached through (seemingly) positivist approaches. Specifically, this paper explores whether it may be more relevant to reframe the mental health-poverty nexus as constituting the outcome of the increasing psychiatrization of poverty worldwide. For it sometimes seems that 'society is

much more comfortable dealing with poverty as a mental health problem rather than a social issue' (Furedi, 2004, p. 27).

Mechanisms of the relationship between poverty and mental health

Findings worldwide suggest that for most 'mental disorders 'the association between low socio-economic status and psychiatric morbidity is strong and significant' (Das et al., 2007, p. 467; Kessler et al., 2005; Patel & Kleinman, 2003). Much research has found that a range of 'mental disorders' are associated with poverty (Weich & Lewis, 1998; Butterworth et al., 2009; Jenkins et al., 2008), with depression 1.5-2 times more prevalent (Patel et al., 1999; WHO, 2007), and schizophrenia an eight times greater risk, within low-income groups of a population (Holzer et al., 1986). Furthermore, four out of every ten people suffering from 'mental disorders' are said to live in low- and middle-income countries (LMICs) (Funk, Drew & Knapp, 2012).

Despite the established association between poverty and mental health, there is little conclusive, and sometimes conflicting, evidence about the nature, direction and mechanisms of this relationship (Patel & Kleinman, 2003). Much of the literature is framed around the question: 'does poverty, or social exclusion, cause poor mental health, or does poor mental health lead to poverty and social exclusion' (Payne, 2012, p. 1). Research into the relationship between poverty and mental health tends to posit two hypotheses: social causation and social selection (or drift) (Costello et al., 2003; Das et al., 2007; Dohrenwend et al., 1992; Johnson et al., 1999; Miech et al., 1999; Murali & Oyebode, 2004). Social causation suggests that poverty may lead to 'mental disorders' through pathways of stress or deprivation, or decrease the likelihood of people getting treatment. Whereas social selection 'posits that genetically predisposed persons drift down to or fail to rise out of' poverty, meaning that downward mobility is linked to 'family liability to mental illness' (Costello et al., 2003, p. 2023; Dohrenwend et al., 1992). The World Health Organization

(2001) acknowledges that there has been a 'controversy about which of these two mechanisms accounts for the higher prevalence among the poor' yet concludes that the 'evidence suggests that both are relevant' (p14).

The recognition that poverty leads to distress may be celebrated in that it begins to recognise the social determinants of mental distress (Murali & Oyebode, 2004). Yet, despite this, much of the literature focuses on the ways that 'untreated' 'mental disorder' constitutes an economic burden, is thus detrimental to development in low and middle-income countries (LMICs) (WHO, 2010; Funk, Drew & Knapp, 2012). Here mental health problems are conceived of as 'a brake on development as they cause (and are caused by) poverty. This fuels social failures including poor parenting and school failure' (APPG, 2013, p.5). Here the problematisation of poverty, development and mental health through psy discourse -what might be called the psychologization (Howell, 2011) or psychiatrization of international development -, tends to focus explanations and interventions at the level of the individual psyche, rather than on the structural landscapes that produce and sustain poverty.

This logic prevents us from exploring whether it may be that development itself (led by a logic of limitless growth often enforced by multilateral agencies with allegiances to high-income countries and industry) is detrimental to mental health. It also prevents us from examining whether the diagnostic categories that label distress as 'mental disorder', and the treatments used, may be detrimental to the well-being of people and communities. Furthermore, while appearing to take into account the context in which distress is embedded, such frameworks often do not acknowledge that our very experiences, understandings, and ways of intervening in distress are socially determined within a social, cultural, and historical context, and threaded through with multiple 'isms' (racism, colonialism, capitalism) (Morrow & Weisser, 2012).

The constructs of poverty and 'mental illness'

Before mapping some of the messiness of the mental health-poverty nexus, it is worth pausing for a moment to reflect on definitions. Both poverty and 'mental illness' are constructs that function in particular social contexts at particular historical moments. Often poverty is measured by looking at income and consumption (per capita household expenditure). However, a number of studies have found weak evidence to show a specific association between 'mental disorder' and income (Patel & Kleinman, 2003), leading some to conclude that 'poverty, *per se*, is not a strong determinant of poor mental health' (Das et al., 2007, p. 476). Aware that income alone may not pick up on the many manifestations of poverty, there has been a move to understand poverty as multidimensional (Alkire & Foster, 2011; Sen, 1999). Research in India has found that people with 'severe mental illness' scored higher on all dimensions of multi-dimensional poverty measures (Jadhav et al., 2007). While such studies do important work in exposing the need for more nuanced measures of poverty, they rely (sometimes with little critical reflection) on diagnostic categories of 'mental disorders' that are the products of 'western' high-income countries and are closely tied to the multinational pharmaceutical industry.

This is problematic because what are currently called 'mental disorders' a) have not always been seen as such, b) are not understood as such worldwide because they are the products of specific social, cultural, economic and historical trajectories, and c) are not monolithic, meaning different experiences and manifestations of distress may have different status in relation to poverty and forms of oppression, and d) many mental health diagnoses, and the medications that dominate treatment options, are highly disputed and critiqued (Bracken et al., 2012; Burstow, LeFrançois, & Diamond, 2014; Boyle, 1990/2002; LeFrançois, Menzies, & Reaume, 2013; Moncrieff, 2009). A key critique of psychiatric diagnosis and treatment lies in its decontextualization and

individualization of distress – where 'disorder' is constructed as inside brains, rather than 'outside' within the political economy (McGibbon & MacPherson, 2013).

In fact, the survey tools of psychiatric epidemiology (based on 'western' diagnostic classifications) and the methods used for calculating who counts as poor, could both be read as operating as tools that decontextualize and dis-embed people's lives from their meaningfulness within culturally defined vernacular spaces. The construction of poverty as a 'single pathological phenomenon of universal character' which can be treated by an 'acultural recipe for abstract "patients"' (Rahnema, 1992, p. 161-162) holds similarities with World Health Organization constructions of 'mental disorders' as having 'a physical basis in the brain….they can affect everyone, everywhere' and are 'truly universal' (WHO, 2001, p. x & 22).

Laudable attempts to explore the social determinants of mental health sometimes take recourse to using and reifying psychiatric diagnostic categories that individualise distress and work to psychiatrically reconfigure 'symptoms' of oppression, poverty, and inequality as 'symptoms' of 'neuropsychiatric disorder'. There is thus, as McGibbon & MacPherson (2013) point out, 'an inherent paradox when one is gathering evidence to expose the mental health impacts of oppression: in order to make a case for the impact of oppression, one must consider evidence related to psychiatric diagnostic categories' (p. 72), when for many women, and particularly low-income racialized women, 'these categories play a central role in locating the "problem" in individual women, rather than in misogynist social systems' (p. 72). Therefore, to use these categories to explore the relationship between social determinants such as poverty and mental health may be problematic: a) because it transposes particular worldviews universally, and b) because these categories work to locate distress within individuals. This reductionism could be said to immediately bias any findings towards individualised instead of systematic understandings of distress and poverty.

'Poverty is pain; it feels like a disease'

There is, however, literature that utilises approaches other than psychiatric classifications to document people's (emotional) responses to poverty. For example, the quotes at the beginning of this paper, from participatory studies into poverty, highlight the 'pain' of poverty, that it can drive people into despair and take away people's desire to live. Such research is a testament to the need to take seriously the pain and distress that some people speak of in their accounts of the lived realities of poverty. However, the question arises as to whether this pain and distress should be classified as constituting 'mental illness'. From such studies we can see that people living in poverty may well be experiencing levels of distress diagnosable as depression but the reason they attribute to their sadness is poverty. Poverty may well be so acutely or chronically distressing that it leads to 'symptoms' that might fit psychiatric diagnostic categories, however, this does not mean that these 'symptoms' are 'symptoms' of such disorders, rather than 'normal' reactions to longstanding conditions of poverty or inequality (Horwitz & Wakefield, 2006, p. 22).

However, the use of diagnostic classificatory systems, such as the *Diagnostic and Statistical Manual* (DSM) and the WHO's *International Classification of Diseases* (ICD), to formulate questions for use within surveys that seek to calculate the prevalence of 'mental disorder' nationally and internationally, and particularly in contexts of poverty (used by many of the studies cited in this paper), often ignore the context in which 'symptoms' arise. They also overlook the wider issue of whether disorders from one country can or should be transposed onto other cultures. For Horwitz and Wakefield, the use of such surveys within epidemiological studies enable a 'massive pathologization of normal sadness' (2007, p. 103), and furthermore, present people's experiences of poverty as 'discreet and apolitical' psychiatric diagnoses (McGibbon and MacPherson, 2013, p. 74).

Therefore, while research into the covariates of 'mental illness' and poverty can be useful in that it draws attention to the potentially psychologically distressing effects of living in poverty, such research is psychologically and behaviourally oriented - locating the causes of poverty in individual pathology, meaning that interventions to overcome poverty centre on changing the behaviour of poor people (Schram, 1995). This reinscribes the old 'blame-the-poor, personal-pathology paradigm' (Gunewadena, 2009, online) embedded in culture of poverty frameworks (Lewis, 1967) that see poor people, neighbourhoods, and whole countries as deficient and in need of 'treatment'.

Similarly, the current emphasis on gene-environment interaction and genetic vulnerability to explain the mental health-poverty nexus (Costello et al., 2003; Murali & Oyebode, 2004) may work to relocate blame from culture to genes. This does little to combat the 'pervasive individualism' that dominates public opinion about poverty (Harper, 2003, p. 186), and creates a 'double bind' that masks intersecting axes of oppression; that may undermine community and self-determination (Schram, 2000); and prevents acknowledgment of the role that the 'west' plays in creating and sustaining poverty (Hayter, 1981).

Psychiatrizing Poverty

Tracing the messiness of the relationship between poverty and mental health allows us to explore outside of the 'vicious cycle' argument of whether poverty causes 'mental disorder' or 'mental disorder' leads to poverty. It enables exploration of the politico-economic context of diagnosis, shofting the question from why higher numbers of people living in poverty may *have* mental health problems, to the question of whether poor people are more likely than people from higher socioeconomic groups *to be diagnosed* with 'mental disorder', and *why*? (Howell, 2011, p. 94).

Similarly, research into institutional racism, sexism and patriarchy within psychiatry (Metzyl, 2009; Bullock, 2004) allow questions of whether specific groups, such as racialized peoples and women (and perhaps particularly racialized women), are experience an increased likelihood of both living in poverty and being *diagnosed* with "mental disorder"?'

Crystal et al.'s (2009) findings that children from low-income backgrounds in the USA are significantly more likely to be psychiatrically diagnosed and to be prescribed anti-psychotics than youth from high-income homes lend empirical support to the relevance of the lens of psychiatrization. This raises the question of whether we are witnessing the reconfiguration of poverty from 'an economic problem to a medicalized [or psychiatric] one' (Schram, 2000, p. 92), paving the way for increasingly clinical and therapeutic approaches to poverty, and resulting in psy interventions being positioned as '(technical and medical) solutions to (political) "problems"' (Howell, 2011, p. 20).

There is a solid body of literature that discusses the medicalization of distress and madness (McGruder, 2001; Scull, 1975), and of poverty (Arnold, 2012; Blackwell, 1999; Schram, 2000). Medicalization is the process by which ever increasing life experiences come to be defined and treated within medical terms (Conrad, 1992), often made possible through a series of other 'izations': individualization, biologization and pathologization. Furthermore, there are genres of medicalization, for example, psychologization (Gordo Lopez and De Vos, 2010), and psychiatrization (Foucault, 1975/2003). Psychiatrization is the process by which more and more of our lives come to seen, globally, as concerns for psychiatry (Rose, 2006; Mills, 2014). Examples within the literature include, the psychiatrization of: children (LeFrançois, 2013); trans people's bodies (Tosh, 2013); farmer suicides in India (Mills, 2014); incarcerated women (Kilty, 2008); and the oppression of women, including the intergenerational trauma of colonialism (McGibbon & MacPherson, 2013).

While there is some work on the medicalization and pathologization of poverty, there is little in the literature on the psychiatrization of people living in poverty, of poverty itself, or of the relationship between psychiatrization and the structural and social determinants of mental health. In fact, we might not be surprised by the psychiatrization of poverty when much research has documented the historical emergence of the psy-disciplines as a means to 'classify, measure and regulate…those populations deemed a social threat to the prevailing order' (Burman, 1994, p. 18; Kilty, 2008). Thus, just as women who challenge patriarchal norms of a 'good woman' may be diagnosed as 'mentally ill', so might people living poverty who challenge (and yet are essential for) the liberal individualist capitalist economy.

While much research has documented a link between poverty and 'mental disorder', historically 'mental illness' has been understood as a disease of 'civilization' (Ernst, 1997), and of affluence (James, 2007). Racist and colonial assumptions that emotional distress is not relevant or is a luxury to poor people have, according to Moreira (2003), been displaced by the idea that '"poverty is a disease," the symptoms of which can be treated with medicine' (p69), meaning that 'poverty becomes a mental illness'…and therefore, a 'problem that is principally social and political is treated as a psychiatric symptom' (p. 70). Thus, approaches that emphasise the universality of 'mental disorder', often through locating it within brains, can also be used as part of racialized and colonial projects to transpose a universal (read 'western') approach globally (Mills, 2014).

Side-effects of psychiatrization

For Schram, 'there are real dangers in characterizing the poverty population as primarily a population of people who are psychologically disabled' (2000, p. 92). One of these dangers is the disabling iatrogenic effects of medicalization (and psychiatrization) within a system where the

pathologization of poverty is increasingly achieved through psychiatric diagnosis and prescriptions of psychotropic drugs. Hansen, Bourgois & Drucker (2014) discuss how the retraction of welfare provisions for low-income groups in the USA has led to a dramatic increase in medicalized support in the form of disability benefits justified by a psychiatric diagnosis (now the largest diagnostic category qualifying people for payments). Here there is a shift in the labelling of poor people - from racial weakness, to culture of poverty, to medical pathology (and increasingly biochemical imbalance and genetic predisposition) – where a psychiatric diagnosis and compliance with psychotropic drugs (despite sometimes harmful side-effects), as well as mental health screening, are requirements for eligibility to receive welfare provisions (Hansen, Bourgois & Drucker, 2014; Schram, 2000). This is one instance of the 'pathologization of poverty' (and arguably also its psychiatrization), whereby seeking psychiatric diagnoses and taking potentially harmful medicines has come to be one of the remaining survival strategies for poor people (Angell, 2011; Wen, 2002) in an 'era of medicalized poverty' (Hansen, Bourgois & Drucker, 2014, p. 81).

There may be huge socio-political 'side-effects' in promoting psychiatric and pharmaceutical understandings of and interventions into poverty: 'Allopathic, individualized, medicalized, approaches to poverty reinforce the isolation, marginalization, and pacification of low-income persons and communities' and subordinate people to expert discourse (Schram, 2000, p. 98). Here both people living in poverty and those diagnosed as 'mentally ill' (and those who occupy both of these categories) are constructed as incompetent and as reliant on experts acting in their 'best interests' (Rahnema, 1992).

The psychiatric reconfiguration of poverty encourages people to see and act on themselves as if they were psychologically unwell and biochemically impaired, and in need of medication. This, according to Parker (1997, p. 27), 'constructs a place for people to experience their economic

distress as a *psychological* problem and to look into themselves as if *they* were the cause of social ills'. In such conditions, many anti-poverty campaigns have shifted their focus from addressing the structural architecture of poverty to addressing the effects of poverty on individuals' self-esteem, essentially working to normalise poverty through psychological intervention (Furedi, 2004).

Thus, a grave danger in the medicalization and psychiatrization of poverty is the confusion of cause and effect - for while poverty may lead to psychological distress, correcting only the psychological issues will not necessarily correct the conditions of poverty that lead to the distress in the first place, or the political-economic forces that produce and sustain poverty and economic marginalization. Thus, not only does such psychiatrization overlook the conditions of inequality and poverty that may lead to distress initially, it may actually allow such conditions to persist, or worsen.

The psychiatrization-poverty nexus

Looking at the mental health-poverty nexus through the lens of psychiatrization may enable a number of moves to be made. Firstly, it moves away from the tendency reconfigure structural problems as individual pathology. Secondly, it allows us to take seriously 'the poverty of psychology' and psychiatry (Pearl, 1970, p.348), and the impoverishment of social scientific research into poverty and distress that remains unable to provide structural or poststructural critique (Schram, 1995: xxvi). Thirdly, the lens of psychiatrization enables examination of the ways that the psy-disciplines are constituted through, and themselves operate, systems of discrimination and oppression. These intersect with hegemonic systems of capitalism, ableism, (neo)colonialism, patriarchy (and more) and produce different effects among differently oppressed groups (Caplan and Cosgrove, 2004; Diamond, 2014).

There needs to be an awareness of how forms of oppression 'combine in a deadly synergy' for oppressed peoples, and how 'poverty is deepened when oppressions intersect' (McGibbon & MacPherson, 2014, p. 64&67). And thus, psychiatrization and poverty may be one such oppressive synergy. Furthermore, if indeed poverty is increasingly being psychiatrized (and is already racialized) then this has enormous implications not only for low-income groups in high-income countries, but for poor people in low and middle-income countries, where there is currently a strong push (mainly from the global north) to scale up access to mental health services and psychotropic medications (Lancet, 2007).

Looking at poverty through the lens of psychiatrization also makes apparent the need for more work on the mechanisms by which oppression is inscribed on 'bodies, minds, and spirits over time and intergenerationally', locating distress within 'the context of oppressive societal structures', geopolitical relations and political economy that create and sustain poverty (McGibbon and MacPherson, 2014, p. 63). This implies the need for radically different tools to trace the messiness of the relationships between poverty and distress. It also implies radically different interventions into mental health and poverty - zooming out from the genetic makeup and so-called 'biochemical imbalances' of individuals living in poverty; out again from behaviour and psychology; and finally coming to recognise the landscape in which lived realities of poverty are embedded; the political economy of psychiatric diagnostic and prescribing practices; and ultimately to the systemic root causes of poverty and inequality.

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