More equal societies have less mental illness: what should therapists do on Monday morning?

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(This article was published in the International Journal of Social Psychiatry in August, 2014 (Volume 60(5) 436-44). Sage Publications has given permission for this pre-publication version to be posted on "any non-commercial repository or website." one year after publication.
D.W. 12/1/15)

Abstract

Background

Therapists seeing poor clients may ask if countries with greater income equality have less mental illness. If so, how should therapists respond?

Material
A review of epidemiological studies, theories of inequality and democratic reform movements in psychiatry and psychology leads to four arguments.

Discussion
1) Increasing income equality improves the health of societies.

2) An elite opposes greater equality, partly by persuading the majority to consent to the existing order.

3) Therapists may inadvertently help in this persuasive effort.

4) However, therapists in democratic traditions create systems of care that support movements for greater income equality.

Keywords
Income inequality, shame, capitalism, ideology, Italian democratic psychiatry, liberation psychology, critical psychiatry

Introduction

Dawn M. had not paid her rent for several months. On a spring day in Brooklyn, a sheriff knocked on her door. He told her to leave her home and not come back. She walked for hours. She felt as if a force from another world had come into her. She bought a bottle of bleach and drank from it. Months later, I spoke with her at a clinic. A slender lively African American woman with neatly trimmed hair and earrings, she joked about her failure to kill herself, saying, "At least my teeth are whiter." Many therapists have seen people like Dawn M., made ill by poverty. Therapists might then infer that societies with less poverty-less income inequality-would be likely to have less mental illness.

While perhaps agreeing on this general conclusion, therapists differ in their response. Some take extreme income inequality as a given and help their clients adapt to it. Others would say that income inequality varies among countries,

depending on the actions of citizens. They would then ask about the actual benefits of increasing income equality, the obstacles to achieving it, including their own actions as therapists. They then would ask if they should change what they do, on a Monday morning.

As a psychiatrist who has worked in emergency rooms and mental health centers, I will attempt to answer these questions by making four points.

1) There is strong evidence that increasing income equality decreases the rate of mental disorders and other health and social problems. Thus increased income equality should be a primary social goal.

2) One obstacle to achieving this goal is the actions of a small wealthy group. In addition to using force on its behalf, this group attempts to persuade the majority that great income inequality is a given.

3) As one of many groups who define social experiences, therapists often inadvertently help in this persuasive effort.

4) Some therapists instead have fostered greater income equality, by practicing in traditions such as liberation psychology, and democratic psychiatry. Guided by these traditions, therapists can do two things on a Monday morning. They can organize to create a mental health care system that supports the movement towards a more equal world. And they can change their own practice.

I The benefits of increasing income equality

When citizens bring about greater equality of income, two types of benefits occur. First, more people enjoy adequate food, shelter and education. Second, a smaller gap between the rich and the poor-the smaller gap itself- has many benefits.

Epidemiologists Roger Wilkinson and Kate Pickett define this gap as the ratio of the income of the top 20% to that of the bottom 20% (2009). This smaller gap improves health and well-being. For example, life expectancy and educational attainment increase, even for the upper middle class. This smaller income gap decreases the rate of many other health and social problems. These include infant mortality, obesity, teenage births, homicides, imprisonments, substance abuse and, our subject here, mental illness. Wilkinson and Pickett soberly review the evidence and reach an astonishing conclusion. If over the next fifty years the extremely unequal United States were to change its income distribution to that of more equal Japan or Spain, the rate of mental disorders would drop by half (Wilkinson and Pickett, 2009, 67).

To understand how increased income equality brings about healthier societies, imagine a very unequal society. Then imagine what happens when inequality is reduced. Adapting an idea of Donnella Meadows (1990), imagine living

in a village of one hundred people. Each night, all the villagers eat dinner at one long table. Servers distribute food in the way that income is distributed in the world. One person receives 56 dinners; he eats one and throws the rest away. Nineteen people receive a plate and side dish. Eighty people an average receive a soup spoon of rice. (Ortiz and Cummins, 2011). Since you are among the eighty, you feel an injustice has been done to you. "Inuria", the Latin word for injustice, means both injury and insult; you experience both (Gilligan, 2001, 2011). First, you may be injured- malnourished and physically ill. Second, you may be insulted; it is apparent that you do not exist in the eyes of the man who is throwing away food at the other end of the table. Moreover, those in the middle, with more than enough to eat, glance at you with pity or contempt. You may then feel powerless, ashamed and humiliated. You may enter a spiral of increasing amounts of shame and rage, or shame and depression (Scheff, 2013). This leads to chronic physiological arousal, increased illness and a shorter life (De Maio, 2010,70). The unjust dinner party is a microcosm of the daily experience of millions, with accordingly high rates of many health and social problems (Wilkinson and Pickett, 2009).

When citizens act to reduce income inequality, these injuries and insults diminish. Along with a broader distribution of power, there is greater social cohesion, trust and social mobility. The health and well being of the society improves. Greater equality of income allows liberty and solidarity to flourish.

Many people agree that increasing income equality should be a central social goal. For example, 92% of the residents of the United States would prefer to live in a much more equal country, such as Sweden (Norton and Ariely, 2011). Yet millions in many countries vote for governments that oppose the increase in income equality that would benefit them. It is necessary to understand why this occurs and to learn if therapists play a role.

II An obstacle to achieving greater income equality: the ideology of the corporate class

One percent of the world's population takes 56% of the world's income (Ortiz and Cummins, 2011). William Robinson argues that this one percent is best understood as a global corporate class (2004). Beneath it is 19% of the world's population, a credentialed class of managers and professionals with 27% of the world's income. The remaining 80%, with 17% of the world's income, make up a "new working class" (Perucci in U'Ren, 2011). Many in the working class are active in movements to decrease income inequality.

To oppose these egalitarian movements, the corporate class employs two types of power. Following Machiavelli, Antonio Gramsci argues that one should think of power as a centaur, half beast half human, a combination of force and consent (Anderson, 1976). To win consent for extreme inequality**,** the corporate class attempts to persuade the majority that such inequality is good or natural. To do this, the corporate class argues for a set of ideas about human nature and society that take

extreme inequality for granted. This set of ideas- an ideology- describes the interests of the dominant class as the interests of all (Jary& Jary, 1991). Put briefly, ideology is knowledge in the service of power.

Members of the corporate class use two methods to convey this ideology (Kerbo, 2012). First, they attempt to persuade the majority to accept extreme inequality on principle. For example, in the United States, members of this class frequently emphasize the equality of opportunity that is inherent in social mobility. (They do so even though social mobility is less prevalent in the United States than in more equal countries such as Denmark.) Thus people with low incomes, believing in equality of opportunity, may blame themselves when they remain poor. Thus the oft- stated belief in equality of opportunity serves to justify extreme income inequality**.**

Second, the corporate class employs professionals such as teachers, scientists and doctors. These professionals may unwittingly persuade the majority that extreme inequality is the norm. Professionals do this indirectly, by veiling practical problems due to injustice as technical problems requiring experts to solve. (Habermas, 1989, 257). By doing so, they weaken the attempts to solve them through democratic politics. As professionals, therapists often play this role.

III How Therapists Sometimes Convey the Ideology of the Corporate Class

To understand how therapists inadvertently play this role, imagine the story of Maria. Maria had been injured in a factory. While she was getting medical care, she asked for psychological help. She went to a mental health clinic and took her seat in the waiting room. Maria, a recent immigrant, had never been in a mental health clinic. She was astonished. People in the waiting room, who were likely to have troubles in common, who might have shared valuable knowledge, did not even look at one another. They would all go into individual rooms to talk with experts. These institutional arrangements discouraged members of the working class from becoming acquainted and organizing around common goals.

A psychiatrist, a courtly man in his fifties, ushered Maria into an office and asked her why she had come. She said she was sad. Instead of considering her sadness as a response to events in her life, the psychiatrist diagnosed a mild depression. He used the criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). In using the Manual's decontextualized criteria for depression, the psychiatrist ignored a 2,500 year-old tradition of thought about sadness. In that tradition, "clinicians explained the context and meaning of symptoms in deciding whether someone is suffering from intense normal sadness or a depressive disorder" (Horwitz and Wakefield, 2007). The context of the symptoms often includes an experience of extreme income inequality. Thus by largely ignoring the context of Maria's sadness, the psychiatrist diverted attention from the extreme inequality that lay at the root of it.

Maria also said she hoped for a different future with adequate pay and safe working conditions for herself and others. However, the psychiatrist did not respond. Instead, the psychiatrist thought most about things that he could see or measure. In doing so he used a positivist theory of knowledge, "the belief that the only valid knowledge is that obtained by the empirical method: the verification of hypotheses by recourse to data accessible to our five senses" (McWhinney, 1997,71). The liberation psychologist Ignacio Martin-Baro says, "The most serious problem of positivism is rooted precisely in its essence; that is, its blindness towards the negative. Recognizing nothing beyond the given, it necessarily ignores everything prohibited by the existing reality; that is, everything that does not exist, but would under other conditions be historically possible (1994, 21). Thus the psychiatrist subtly disqualified Maria's hopes for a future society of greater equality.

At the end of the interview, the psychiatrist left the room to refer her to a therapist. With much of her social history ignored, and her hopes for a different future discounted, Maria found herself alone in a medicalized present; she hoped the therapist would be sympathetic.

In summary, Maria's psychiatrist, like many doctors, diminished two challenges to the corporate class, working class solidarity and the claim to have legitimate objections to the an unjust economic order (Navarro, 1986). Fortunately therapists in democratic traditions instead have worked collectively and changed their own practices to foster a more equal society. We can learn from them.

IV Reforming Mental Health Care Systems and Changing Practices To Foster Greater Equality of Income

Reform through collective action logically begins with participatory action research, led by service users and professionals, in a particular time and place (Montero, 2009, 76). All that I can do here is note some ideas that may be helpful in that effort. To that end I have drawn on liberation psychology (Montero, 2009), critical psychiatry (Thomas & Bracken, 2004) and Italian democratic psychiatry (Basaglia, 1987). The work of social theorists such as Jürgen Habermas (1989) and that of sociologists has also been invaluable.

In considering collective action, a memorable simple conception of a mental health care system may be useful, though not true. Adapting an idea of the medical sociologist Robert Castel, imagine a mental health care system as a pentagon (1988). The five points represent essential parts: theory, united groups of practitioners, laws, institutional structure and practice. (A mnemonic is "TULIP".) Imagine lines connecting each point of the pentagon. Castel argues that these lines, the relationships between the parts of the system- are what need changing. For example, a law, passed, should be enforced and lead to changes in practice. A theory, revised, should change practice. (In order to focus on describing a mental

health care system that fosters greater income equality, I will not discuss groups outside the system attempting to change each part. Later, in devising a strategy of change, these groups, such as the drug industry, would need to be discussed.)

With the simplified image of the pentagon in mind, I will note the five parts of the system and give examples of change in each one. Examples are mostly drawn from the Italian democratic psychiatry movement.

1) Theory

One task of a theory is to describe the types of knowledge that are valued. For example, starting in the 1960's, Italian democratic psychiatrists argued for increasing the types of knowledge used to understand distress. One of their leaders, Franco Basaglia, began as a neuropsychiatrist. He saw the value in medicine of positivism, of a doctor taking on the role of an objective observer of diseases and patients. He saw this as necessary but not sufficient. He became interested in hermeneutic knowledge. To gain this type of knowledge the doctor and patient reach a shared understanding of a dilemma through a conversation. As the word conversation implies, both the therapist and patient are converted, changed; they do not remain what they were. (Gadamer, 1975, 341). Thinking in this way "precluded objectifying, that is enclosing individuals within any system of fixed psychological categories" (Basaglia, 1987,7). However, he later realized that even this type of knowledge was not sufficient to understand the experience of living under industrial capitalism. This included the experience of psychiatric care.

Franco Basaglia and others turned to the work of Antonio Gramsci, and began a social analysis of the role of asylums and psychiatry. Franca Ongaro Basaglia, a psychiatrist and member of the Venetian Senate, writes, "The problem of psychiatric illness and its institutions developed in our society primarily under industrial capitalism as a question of public order. It came into being as a *socio-political problem,* namely the defense of the healthy and working community from elements that would not conform to its modes of behavior and rules of efficiency" (1992). When poor, unemployed people became disruptive, psychiatrists sometimes exaggerated their risk, committing them to asylums. Asylums were "repositories of poverty expressed as madness" and psychiatrists "functionaries of consent" (Basaglia, 1987).

2) United Groups of Practitioners

Italian psychiatrists argued that a new organized group of field workers was needed to help patients solve the social problems they faced. The field workers would need to know a great deal about housing, education and employment. But highly trained experts were not needed for this task. A more recent example of a new organized group is that of peer specialists, people who have gotten care in the system and now provide it to others.

3) Laws

In Italy in the 1950's, a psychiatrist could know the intimate details of patients' lives and also commit them to hospitals. This diminished the patient's sense of self. Responding to this, psychiatrists worked to pass a law preventing psychiatrists from committing their own patients. Two other psychiatrists and the mayor of the town then made this decision. This example shows how a change in a theory about the self led to changes in laws and then in practice.

4) Institutions

We would first ask where, in society, one should work to create democratic organizations of mental health care. In the 1970's, Italian psychiatrists worked closely with existing institutions such as labor unions to do just that. Today, given the increased hostility of the corporate class, the sociologist Erik Olin Wright argues that creating cooperatives, outside existing organizations, is more promising (2010).

We would also ask what amount of resources should be used for such a cooperative. If we keep in mind the distribution of income in the world- illustrated by the example of dinner in the village of 100, we would argue for the preferential option for oppressed majorities (Montero, 2009, 57). That would lead us to imagine lower cost institutions, providing affordable care for all. This would lead in turn to practices that emphasize mutual aid and a limited role for professionals.

5) Practice

To describe possible reforms in practice, I'd like to return to the story of Maria. After visiting the medical model mental health clinic, she went to a democratic therapy center. As a first step she was given a list of meetings from which she could choose. She went to an injured worker's program similar to ones run by labor unions in Maine (USA) in the nineteen nineties (Maine Labor Group on Health 2013).

The injured workers' program had three parts, conversation, education and action. First, she and others met with a facilitator to talk about the emotional experience of being injured. Second, she got advice on obtaining medical care and benefits. Third, she was invited to attend a discussion of plans to change laws to improve workplace safety. The program achieved what the psychiatrist at the mental health center worked to oppose, increased organization among the working class, and the legitimation of objections to the existing order.

While this was helpful, a few weeks later Maria felt she needed to see a therapist at the democratic mental health center. Imagine that you were that therapist. In evaluating Maria's dilemma, you would "go fast, then slow". You would promptly assess for emergencies, such as a risk of suicide or violence, or an urgent medical problem that initially appeared to be a psychiatric one, such as delirium.

If urgent problems were not present, you would then "go slow". You would bracket the question of further diagnosis. (Later, you could remove the brackets if you thought additional psychiatric diagnoses were needed) (Basaglia, 1987). Maria and you then are free to reach a shared understanding of the problem. You would then discuss a social analysis of the problem, on the level of the family, community and workplace.

Finally, you would discuss the need for therapists to reflect on their work and its consequences. You might note that therapists often inadvertently act ideologically to help maintain extreme income inequality, by diagnosing reactions to social conditions as mental illness. You would add that sometimes the therapist might be unaware of the extent of distress that a diagnosis itself can add (Scheff, 2010). You would ask Maria to tell you if you drift into one of these hazards, or others.

After the evaluation, you and Maria would have a better sense of what problem was most important. If Maria were in a crisis, you would consider two things, a theory about crises to guide you and the organization of the response. You would most often think of a crisis as a rite of passage, a transition from a way of living that is impossible to one that is possible. You would avoid thinking of personal crises as relapses into illness (White and Epston, 1990). With your help, Maria would make a plan that would allow her to be in large network of relationships and resources. Then you would let the crisis involve. (Dell'Acqua and Mezzina, 1991.

Refutations

Some therapists may respond to my third argument- that therapists often support the ideology of extreme inequality- by saying that their clinical work has nothing to do with that. However, people in other occupations say the same thing. If one were to accept all of their claims, one would have to argue that that millions of people in hundreds of occupations have little do with creating a severely unequal economic order. This cannot be true, even if the power of individuals varies.

Others may concede the possibility of reinforcing a dominant ideology, but say that they do not follow a scripted set of ideas. True enough. However, what Pierre Bourdieu and Jean-Claude Passeron say about education applies to psychiatry: "Its relative autonomy enables it to serve external demands under the guise of independence and neutrality, i.e. to conceal the social functions it performs and so to perform them more effectively" (1990,178).

Conclusion

Using images and stories, I have made four points.
1) Dinner in the village of 100 illustrated the distribution of income in the world and the harm of extreme income inequality. When this inequality is reduced, rates of mental illness and other problems decrease dramatically.
2) One percent of the world's people, with 56% of the world's income, works to maintain this inequality. They use power that can be compared to a centaur, half beast half human, combining force and consent.
3) Therapists often help win consent for extreme inequality by veiling practical problems due to injustice as technical problems for experts to solve. This was illustrated in the story of Maria at a mental health clinic, her history and hopes for a different future discounted, alone in a medicalized present.
4) Therapists in democratic traditions have organized systems and changed their practices to foster greater equality of income. Imagining a mental health care system as a pentagon, with key elements at each point, allows us to consider how to continue the work of democratic therapists before us.

Earlier, I told the story of Dawn M. She met a sheriff. The sheriff, acting on behalf of an affluent landlord, forced her to leave her home. She then felt as if a force from another world had come into her, in effect the force used by the corporate class to maintain extreme income inequality. In the long run, force alone will be ineffective; the majority must be persuaded to consent. Therapists can participate in the steady withdrawal of that consent, and the creation of more just societies.

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Additional Information

Versions of this paper were presented on the following dates:

10/7/11	Conference in Honor of Tomas Agosin, Bronx Psychiatric Center, Bronx, NY
10/12/11	Department of Sociology, Temple University, Philadelphia, PA
10/27/11	Institute on Psychiatric Services, San Francisco, CA
11/16/11	Department of Psychiatry, Temple University School of Medicine, Philadelphia, PA
10/30/12	Annual Meeting, American Public Health Association, San Francisco, CA