

10 Social Inequalities and Mental Health: An integrative approach¹

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Introduction

This chapter draws together work exploring the significance of social inequalities for mental health and mental health services, work which has gained impetus and status over the last 20 years. At the beginning of the new millennium the importance of inequality is finally being acknowledged in the public agenda of mental health services (see, for example Acheson, 1998; DH, 2002, 2003, 2005), though these policy directives and initiatives are only just beginning to make their mark on service provision. While increasing numbers of people within mental health services recognise the importance of social inequalities most are very uncertain about what this means for their practice. Against this background, our intention is to make the developments in this disparate field as meaningful and as accessible as possible to practitioners

Defining Social Inequality

So what is social inequality? It exists when attributes such as gender, 'race' and class affect our access to socially valued resources including money, status and power - our chances of having lives of comparative privilege or disadvantage. These arrangements are unfair because they serve some groups at the expense of others: there are fundamental conflicts of interest at their core. However, inequalities are often difficult to detect and challenge because they are hidden by ideologies that name the processes associated with their perpetuation as 'normal' and 'just', and their damaging consequences the fault of the disadvantaged. In short, we are discouraged and deflected from thinking about inequality, and even when we make an effort it is generally much easier to have conversations about diversity, multiculturalism, social exclusion and difference.

Reflecting on social inequality is also personally challenging, because it is an invitation to review our own lives i.e. our own experiences of advantage, disadvantage, power and powerlessness. Not only does the current arrangement accord privileges and disadvantages to each of us, but it also provides the basis for our many identities. When we ask "Who am I?" and "Who are you?", it is gender, 'race' and ethnicity, class, age, sexuality and so on, that come to the fore, accompanied by a sense of how these characteristics are valued or devalued and their capacity to shape access to good things in life. It is common, therefore, to encounter both social and personal resistance to the process of thinking and talking about social inequalities. Not only is there resistance, but the structures in which mental health professionals work do not provide 'safe spaces' to talk about these issues (SCMH, 2002). The question therefore remains: how can we progress the discourse on inequalities and mental health if we are not able to talk about it openly?

Mental health providers need to be alert to the major determinants of inequality in this society, which include, gender, 'race', class, age, and sexuality. They also need to be especially mindful of the power relationship between those who provide and those who use mental health services and the disempowering consequences of being labelled a

¹ In Bell, A., Ed. (2005). Beyond the Water Towers: The unfinished revolution in mental health services 1985-2005. London, Sainsbury Centre for Mental Health.

user of psychiatric services. Inequality becomes additionally significant for the majority of people who use mental health services because it is both a cause and a consequence of their distress. The recent report by the Social Exclusion Unit (2004) found that people with mental health problems are amongst one of the most disadvantaged and socially excluded groups in society; this is cogently illustrated by Trivedi (2002) in her account of the 'spiral of oppression'.

Arguably, some dimensions are likely to have greater psychological significance than others. Gender inequality has particular significance for mental health because families are the place in which females and males whose structural relationship is one of inequality live together, and where we construct our gender identities as children and adults. That said, in practice we caution against leaping to conclusions about the significance of any particular parameter of a person's life: there are no short cuts to hearing from them about their lives (Kalikhat, 2004). It is also important to remember that while some dimensions of social inequality such as marital status are not major determinants of social structure they may nonetheless be of great psychological significance for particular individuals, and mental health workers need to remain open to this possibility. The individual's own narrative and lived experience should be at the core of any attempt to understand and respond to the impact of social inequality on their physical and emotional well-being.

Status of the approach

People engaged in struggles for equality and civil rights have largely been responsible for bringing the psychological consequences of inequality to the attention of the field of mental health. Theory and practice have emerged in the context of social movements representing the interests of women, people from Black and ethnic minority groups, gays and lesbians, and mental health service users. This has two important implications.

Firstly, literatures have typically developed along one dimension of inequality with the implications for the disadvantaged group as the focus. As Beckett and Macey (2001) observe, "academics, policy makers and activists in Britain have a long tradition of ignoring the intersections and interactions between these social divisions", though there are some scholars who are an exception to this (Beckett & Macey, 2001; Weber, 1998; Williams, 2005). To illustrate, the recent policy aimed at improving service provision to people from Black and ethnic minority communities (NIMHE, 2003) contains no mention of gender. Keating *et al.* (2003), in a review of mental health services on issues of ethnic diversity, found that a potent mix of gender blindness and negative views of minority cultures contributes to Black and minority ethnic women's mental health needs being severely neglected across the spectrum of research, policy development, service provision and practice. Such unitary definitions of oppression have limited value within mental health services; they limit our perception of the complexity of human existence and also create situations that force groups to compete for resources.

Secondly, achievements in the development of knowledge and service provision that give centrality to inequality lie mainly at the margins: this is nicely illustrated by the title of the women's mental health strategy *Into the Mainstream* (DH, 2002). The limited impact is also evident in mainstream policy makers' and service providers' attempts to address inequality. These are typically located in the context of discussions about service access or inequalities in health outcomes – limited debates that are premised on the uncritical acceptance of the status quo within mental health services: particularly the traditional processes used to categorise, name, and treat emotional distress. The thinly scattered service developments that do take social inequalities seriously are

typically characterised by their struggles for survival, recognition and acceptance. By definition these small scale specialist services to groups such as women and Black and ethnic minorities offer a perspective that involves an understanding of the reality of people's experiences in the context of social inequalities (Keating, 2002). However, the knowledge and competencies accrued within these services are seldom integrated into mainstream practices, nor do they inform the training of mental health professionals (Scott & Williams, 2004).

In summary, the body of knowledge about the implications of social inequalities for the field of mental health which has accrued during the lifetime of the Sainsbury Centre for Mental Health lacks both integration and value. Given this we suggest that important next steps are to develop an integrative framework that will enable mental health practitioners to respond sensitively and constructively to the complex effects of social inequalities.

Inequalities and mental health

A common approach in this field is to trawl the research literature and statistical data to look for difference in mental health outcomes for people from different social groups defined by gender, race, and so on. However, interpreting this kind of data is notoriously tricky as evidenced by the long and troubled debate about 'race', culture and schizophrenia (Fernando, 2003). Instead, we suggest it is more constructive to take the existence of social inequalities as a factual starting point and from this explore the implications for mental health and mental health services. Once this decision has been taken it is not difficult to find out about the mental health implications of social inequalities.

These are some of the ways of building the knowledge, wisdom and skills to work from an inequalities perspective:

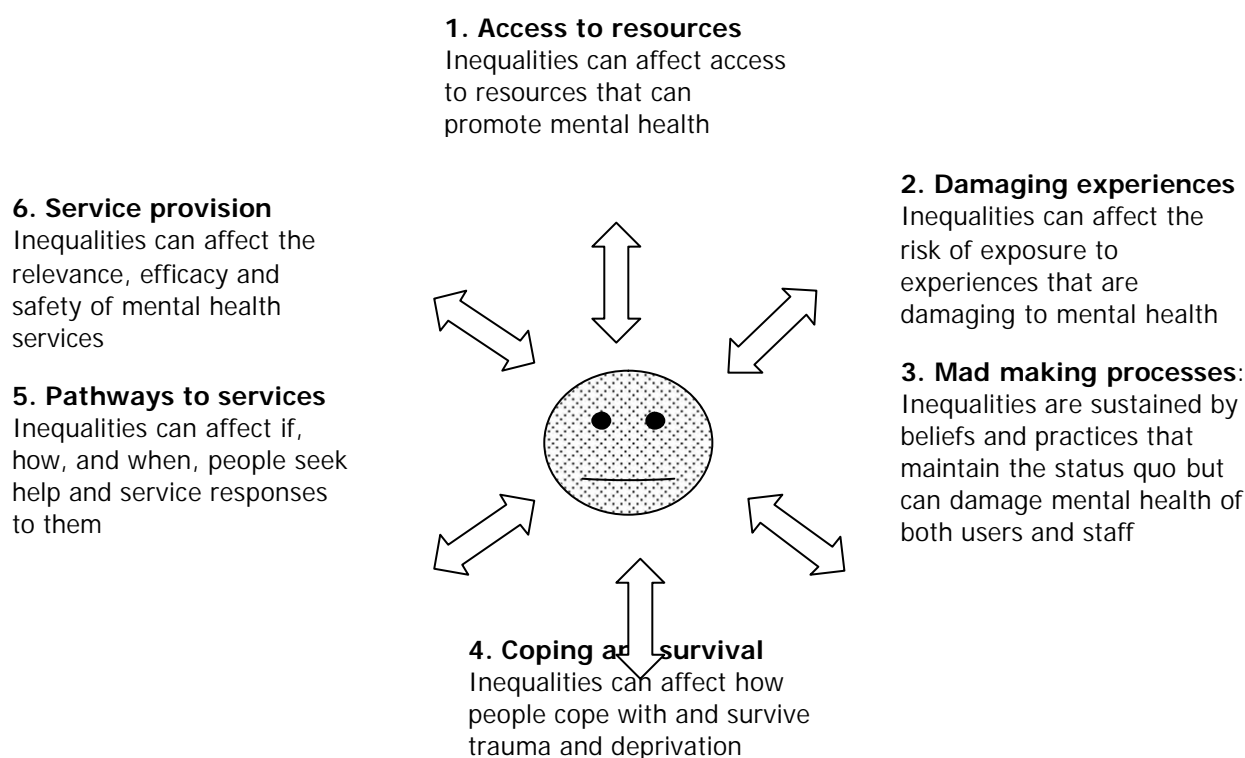
1. Listening to, and continuous learning from, those who know most about the challenges of psychological survival in an unequal and unjust society, as well as the risks of revictimisation within mental health services.
2. Familiarity with the facts and figures outlining the parameters of people's lives in this inequitable society; these are readily available on government websites as well as those posted by campaigning and advocacy groups (see References).
3. Becoming knowledgeable about the extensive body of work exploring the mental health impacts of inequalities (Ballou & Brown, 2002; Belle & Doucet, 2003; Bhui, 2002; Fernando, 2003; Rogers & Pilgrim, 2003; Tew, 2005; Williams, 2005).
4. Becoming knowledgeable about theory and research that sensitises us to the ways that the power of psychiatry can support the interests of privilege to the detriment of the individuals it seeks to help (Burstow, 1992; Fernando, 2003; Penfold & Walker, 1984; Rogers & Pilgrim, 2003; Williams, 1999).
5. Selective use of 'grey' literature and the media (e.g. *Asylum* magazine; *What Women Want*, Mental Health Media, 2002).
6. Reflection on our own experience of power and powerlessness.
7. Seeking information about innovative services (Mental Health Media, 2002; Rivera, 2002).
8. Getting involved in relevant social action (Cogan, 1996).

Developing understanding

We now map out the crucial areas of concern for mental health practitioners and policy makers, along with brief commentary. Our intention is to inform the development and provision of training, and to support self-directed learning in the absence of institutional support. It is important to state at the outset that Figure 1 draws attention to the damaging *potential* of social inequalities and invites us to think respectfully about the dynamic ways in which people resist, struggle and cope: it is not a description of inevitable consequences for individuals or indeed for mental health services.

[Insert Figure 1]

Figure 1: Inequalities and the risks for mental health and mental health services



1. Access to resources

Social inequalities create conditions under which some groups of people are treated less favourably than others in society, including having less access to resources known to support and promote psychological well-being. These resources include satisfying work, money, education, leisure, housing, status and value. For example, the latest census (White, 2002) found that people from minority ethnic groups had far higher rates of unemployment than their white counterparts. In addition to the wealth of statistics and research findings that can be used to broaden our understanding of these parameters of people's lives, we need to listen carefully to lived experience. To illustrate, this is Alison, 31, who earns the national minimum wage of £4.50 an hour.

"Equality doesn't exist in my world. I'm working in a 21st-century sweatshop for the minimum wage with hundreds of other women. All our managers and supervisors are men, who show us no respect or consideration. Is this what equality was supposed to be about? All the crappy jobs in this country are done by women like me, who also do most of the child-caring. Having it all's a joke - we have the worst of all worlds." (quoted in *The Independent*, 2004)

The effects of social inequalities on access to material, social and psychological resources is typically detrimental to people from disadvantaged social groups. However, it is important for mental health workers to be aware that these conditions have the potential to strengthen relationships within groups which enable people to seek support and validation from each other. The power of these processes in achieving social and personal change are well documented (DeChant, 1996).

2. Exposure to damaging experiences

Social inequalities create conditions which increase the likelihood that some groups of people will be exposed to experiences that are detrimental to their mental health. These experiences include working in de-valued, dangerous and unpaid jobs, and being exposed to bullying, harassment, abuse and violence. For example, we know that offences are committed against people simply on the basis of their membership of a minority group:

"To be attacked, beaten up or otherwise abused, and to find the police response one of indifference, is the not infrequent experience of homosexuals, and blacks too ..." (Pyke, 2004)

The 2000 British Crime Survey (Clancy *et al.*, 2001) estimated the number of racially motivated offences against minority ethnic groups at 280,000. Furthermore there is evidence that crimes motivated by hatred are particularly damaging to psychological well being (White, 2002). There is also an extensive literature on the challenges to psychological well being from domestic violence and sexual abuse (Williams, 2005) and racial oppression (Fernando, 2003; Trivedi, 2002). It is crucial for the quality of mental health services that staff have the competencies to help people come to terms with such experiences in ways that enable them to claim a better future.

3. Mad-making processes

Systems of inequality are given stability by a range of social psychological processes, some of which have particular significance for mental health.

Identity

A significant part of our identity is derived from our membership of social groups, and we receive greatest encouragement to adopt identities that are compatible with the requirements of the social status quo. Hence, people from disadvantaged groups are expected to possess or acquire qualities that are useful to those who are more powerful; and to be grateful, and compliant despite their oppression. To illustrate, 'good women' are not expected to get angry, and disabled people are expected to be co-operative and grateful. The psychological significance of such requirements and injunctions are of central significance for mental health (Burstow, 1992; Williams, 2005).

The mental health costs of inequalities are not only borne by the disadvantaged but also by those who are privileged by the status quo: there are mental health risks when identities are derived from unequal relationships. To illustrate, masculinity underpins

the social dominance of men; being manly is equated with power – over women or other men – but this is at the cost of emotional entitlement. Successful male socialisation requires men to be silent and strong, leaving individuals little scope to acknowledge and deal constructively with feelings of vulnerability or powerlessness.

"As a boy I was not allowed to feel scared...if I cried or broke down I was a sissy not a man. My father was lost at sea when I was nine years' old. I was informed...that I was now the man of the house, had to be strong, keep my chin up and look after the women...the forced denial of the experience of grief was impossible for me to cope with" (quoted in Bertram, 2003).

Furthermore it is white, middle-class heterosexual men, who are most likely to accrue the rewards of fulfilling this script. This is unlikely to be the case for men who are poor, unemployed, from Black and minority ethnic groups, for whom the gap between the expectation of dominance and their experience of powerlessness may be extremely distressing.

Significant Dynamics

It is crucial for mental health service providers and policy makers to be sensitive and responsive to the ideologies, processes and practices that maintain and challenge inequalities. These dynamics are detectable in our own lives, in the lives of people using mental health services, and in the interactions that take place throughout mental health services. The evidence base for their existence and effects is scattered throughout the various inequality literatures. While most of this literature is concerned with risks to the mental health of the disadvantaged, there is also growing evidence about the risks to the mental health of people from privileged social groups. Though this latter development does not have much appeal to the activists who have developed this field, it is important to remember that those people who use mental health services are most likely to be the casualties of systems of inequality rather than those who have reaped their material and psychological benefits. Table 1 shows some of the dynamics that can help develop a systemic understanding of the personal damage and distress created by inequalities.

[insert Table 1 here]

4. Coping and survival

We can draw on many resources in our struggles to survive and cope with the damaging effects of inequality including religion, spirituality, attachment to communities, social networks and political action (Faulkner & Layzell, 2000). However, our access to the internal and external resources that help us survive the losses and challenges of life is also affected by social inequalities (Waldrop & Resick, 2004; Walters & Charles, 1997). The internal factors include self-esteem and identity derived from, for example, our gender, 'race', and class; the external factors include social support, money, education, time and community involvement. Hence the survival strategies of people whose lives are shaped by multiple oppressions - which may include reliance on self-medication with alcohol or drugs, eating distress, and self harm - need to be understood in the context of severely limited options, and a likely background of repeated failure to change their lives and feelings. Most mental health workers have not been trained to appreciate this, and in the absence of these understandings the strategies used by individuals to survive intolerable feelings often evoke alarm and punishment and keep the focus on problems, rather than understanding and respect and an acknowledgement of the individual's own coping strategies and resilience (Williams *et al.*, 2004).

5. Pathways to services

Research confirms that gender, 'race', class and sexuality are significant determinants of an individual's pathway to, exclusion from and avoidance of services. A social inequalities perspective is crucial for making sense of these patterns and for taking steps to address problems of equal access. It provides an important reminder that attempts to address inequality in access should not be narrowly associated with an increase in services. As Rogers and Pilgrim (2003) note it is crucially important to take heed of the social control functions of mental health services. A stark illustration of this is the over-representation of African-Caribbean patients in the most controlling sectors of mental health services (Fernando, 2003; SCMh, 2002). Their entry into care is characterised by hospital admissions under a section of the Mental Health Act, over-involvement of the police, the forcible administration of medication and contentious staff-user interactions (Goater *et al.*, 1999; Thornicroft *et al.*, 1999). Within these communities there is understandable reluctance to engage with mental health services which are associated with being detained in hospital in confined and restrictive environments, and the risk of death (SCMH, 2002). On the basis of this evidence it is clear that the priority should be to challenge inequalities within mental health services, whilst promoting the development of services that are responsive to the mental health implications of sexism, racism and other inequalities.

6. Service provision

Dominant models of distress which emphasise diagnosis, individual pathology and medicalised responses to distress, serve the status quo by detracting attention from social inequalities. In these ways, the connections between a person's behaviour, distress and lived experience are severed, and without these understandings behaviour is easily understood as meaningless, out of control and dangerous. Treatments and interventions continue to be based on narrow clinical definitions which result in a medical response with a reliance on prescribing medication, even though many mental health practitioners are now well aware of the psychological damage caused by the abuse and misuse of power, injustice and maltreatment (Rogers & Pilgrim 2003; Williams & Scott, 2002). It is simply that in the absence of relevant training staff are at a loss about how to respond.

Mental health services replicate the discrimination experienced in wider society, which includes an over reliance on the more controlling and restricting aspects of treatment. Here, a service user talks about her experience of seeking help from mental health services as a Black person:

“...coming to mental health services was like the last straw...you come to services disempowered already, they strip you of your dignity...you become the dregs of society”. (quoted in SCMh, 2002)

Gender and other social inequalities also have discernible effects on understandings and definitions of mental health. To illustrate, even though femininity is demonstrably linked to clear mental health risks, studies find that women who have internalised these characteristics are generally considered to be normal and mentally healthy. Furthermore, as we have noted elsewhere (Williams & Keating, 2000) when training desensitises mental health workers to the powerful effects of inequality on mental health, they are unlikely to be aware of the potential damage inherent in inequalities within services. This is evidenced by the tolerance shown towards abuse and violence within mental health services. It also includes the failure to understand the power relations associated with the huge inequality that exists between providers and users of

services. The effects of this are extensively reported by service users (e.g. ReSisters, 2002) who complain of being endlessly judged and found wanting; of being blamed for not changing and for being difficult, angry, and fearful; and who describe being devalued and treated disrespectfully and having their needs, reputations, histories and futures defined by others.

“Nobody treats you like a human being, you are treated like another commodity...and yet you will have to go through dissecting a lot of your personal issues and it goes nowhere...why is it that professionals treat us like second class citizens, especially within mental health ...why is it that you can never erase a label? Why does it stick for life?” (quoted in SCM, 2002)

People known to use mental health services are likely to be further burdened from being categorised in such ways (Rogers & Pilgrim, 2003). For example, a brief spell in hospital can seriously affect an individual's access to their children, social networks, employment, and stable accommodation.

Conclusions

The mental health workforce needs a thorough-going understanding of the implications of social inequalities. For this to be achieved there needs to be a much greater willingness to give inequality priority on the mental health agenda, and for it to be a central theme in the training of all mental health staff. When this happens staff are empowered (Scott & Williams, 2003), so it is encouraging, therefore, that “Challenging Inequality” has been identified as one of the *Ten Essential Shared Capabilities* (DH, 2004) that all staff are expected to have. It seems that the NHS modernisation and equalities agendas, however imperfectly realised, are providing some opportunities for change.

One of the important ways in which mental health services can respond at this point is by a clear commitment to the principles and values that underpin drives toward equality. It is also absolutely crucial that social inequalities are identified as having central significance for mental health and service provision. Inequalities, and their impact on the language, organisation and practices of mental health services, should not go unchallenged. This means incorporating an integrated understanding of different oppression systems into our thinking, and developing a shared approach to exploring the implications for our work in services. It also means avoiding simple allocation of blame and responsibility, and the application of neat divides between victims/perpetrators and user/providers of mental health services. There is now a powerful case for a radical change and we can no longer plead ignorance as an excuse.

Acknowledgements

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Practices & Processes	Function	Risks for the mental health of the disadvantaged	Risks for the mental health of the advantaged
<p>Attribution of inferiority and superiority</p> <p><i>"I was classed as no good 'cause I was a single parent."</i> (quoted in ReSisters, 2002)</p> <p>Blaming, derogating, ridiculing</p> <p><i>"But that's what these men do... they make you feel so small that you agree that ever thing is your fault."</i> (quoted in Humphrey & Thiara, 2003)</p> <p><i>"I was told that I encouraged the other patients."</i> (quoted in Baker, 2000)</p>	<p>Supports the status quo in inequitable relationships</p> <p>Supports inequality by identifying a person or group as the problem not inequality</p>	<p>Damage to sense of self; limits control over one's body and labour, and access to resources</p> <p>Damage to identity and self-esteem; self doubt; feelings of embarrassment, guilt, sadness and depression; and of being harmed not helped by mental health services</p>	<p>Anxiety, anger and frustration at not actually feeling powerful and invulnerable; risks to self and others of attempting to take more power and control; contact with criminal justice system</p> <p>Erodes the hope and creativity of mental health staff and increases their risk of burnout</p>
<p>Denial and indifference</p> <p><i>"Doctors don't want to know about past domestic violence, just up the valium and I was walking around like a zombie."</i> (quoted in Barron, 2004)</p> <p><i>"No action was taken and I was told 'as I am good looking' I should expect it to happen."</i> (quoted in Baker, 2000)</p>	<p>Supports inequalities by denying, minimising and trivialising their consequences</p>	<p>Isolation, vulnerability, increased risk of further abuse; and of being harmed not helped by mental health services</p>	<p>Alienation and dehumanisation of mental health staff</p>
<p>Deference</p> <p><i>"You know so much more than I do; so tell me, what should I do?"</i> (quoted in Burstow, 1992)</p>	<p>Supports inequalities by giving power and authority to others</p>	<p>Internalisation of feelings of inferiority; loss of power and control and associated risk that this will be abused; acceptance of psychiatric authority</p>	<p>Overburdened with feelings of responsibility for others; limited feedback from others can impede personal development</p>
<p>Discrimination</p> <p><i>"I went to see a psychiatric nurse who was assessing me. She was completely homophobic . . . she was so rude to me and so horrible to me . . . and I was very, very vulnerable and I thought I just can't face it."</i> (quoted in King & McKeown, 2003)</p> <p><i>"Coming to this country (from Jamaica) ...working and working to bring up your family and every day being treated like that, people looking down at you."</i> (quoted in ReSisters, 2002)</p>	<p>Maintains and accentuates existing inequalities, may be unconscious or conscious</p>	<p>Blocks opportunities; limits access to valued resources; increases exposure to conditions that are damaging</p> <p>Denigrating views may be internalised with implications for self validation and social support</p> <p>Fear of seeking help from services</p>	<p>Can erode self-respect and personal integrity</p>

<p>Exploitation and abuse</p> <p><i>"The psychiatric problems have stemmed from the way I was treated as a child – physically abused by my mother, sexually abused when I was 10, raped when I was in care at 13, raped by other males in care when I was a bit older."</i> (quoted in ReSisters, 2002)</p>	<p>validates and takes advantage of an inequality - this can also occur in the context of provider/user relationships in mental health services</p>	<p>Damage to sense of self, dissociation; alienation, chronic exhaustion</p>	<p>Alienation from meaningful intimacy</p>
<p>Intimidation and coercion</p>	<p>Use of fear to preserve existing power relations</p>	<p>Erosion of self; feelings of fear and of being trapped and helpless</p>	<p>Alienation from meaningful intimacy</p>
<p>Legitimation and authorisation</p>	<p>Supports inequality on grounds of normality</p>	<p>Having experiences and distress labelled as madness and being treated chemically</p>	
<p>Marginalisation</p> <p><i>"Women's mental health issues appear to have a lower status and services rely heavily on professional having a personal interest."</i> (quoted in Williams <i>et al.</i>, 2001)</p>	<p>Supports inequality by limiting power of disadvantaged groups</p>	<p>Not being heard or taken seriously</p> <p>Efforts to assimilate</p>	
<p>Medicalisation and individuation</p> <p><i>"Our needs are ignored, we are treated as illnesses."</i> (quoted in Williams <i>et al.</i>, 2001)</p> <p>Normalisation</p> <p><i>"Pathologising women who do not follow gender norms in lifestyle/behaviour..."</i> (quoted in Williams <i>et al.</i>, 2001)</p>	<p>Supports inequality by identifying a person or group as the problem not inequality</p> <p>Validates inequality and punishes deviance; normalises abuses of power</p>	<p>Decreases chances of recovery</p> <p>Increases chances of experiencing further oppression and trauma</p> <p>Constrains personal development and expression of anger - limits ways of coping</p>	<p>Burnout amongst staff</p> <p>Constrains personal development and expression of vulnerability - limits ways of coping</p>
<p>Objectification (sexualisation, racialisation etc)</p> <p><i>"When I was in the 4th grade (at the crippled children's school), a man began to trap me in the hall and say sexual things as well as touch me inappropriately."</i> (quoted in Nosek <i>et al.</i>, 2001)</p>	<p>Power advantage embedded in inequalities are used to exploit the least powerful</p>	<p>Poor self image; self-blame; risk of exposure to traumatic experience</p> <p>These experiences can be intensified within psychiatric services (Cohen, 1994; Keating 2002: Williams, 2004)</p>	<p>False sense of entitlement; Alienation from meaningful intimacy</p>
<p>Projection</p> <p><i>"Klein's theories about projection, where an individual projects his/her own intolerable feelings into the other are central to an understanding of the relationship between bully and target."</i> (Martin, 2004)</p>	<p>Power advantage embedded in inequalities used to get rid of unwanted feeling</p>	<p>Justification for male violence</p> <p>Resentful and demoralised staff can displace feeling on to patients</p>	<p>Detrimental to self development and the possibility of genuinely caring about people.</p>
<p>Resistance, challenge and change</p> <p><i>When people are pushed hard and when they're treated in a brutally unjust way, the reaction is sometimes the opposite of what you might expect. Sometimes the worm turns.</i> (Parris, 2004)</p>	<p>People from disadvantaged groups survive by being knowledgeable about the workings of the more powerful – in some conditions this leads to collective action</p>	<p>Can lead to personal empowerment</p>	<p>An opportunity for personal and moral development i.e. to come to terms with the past and to take responsibility for our behaviour</p>

Chapter 10: Social Inequalities and Mental Health

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Commission for Racial Equality [<http://www.cre.gov.uk>]

Women's Aid [<http://www.womensaid.org.uk>]