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Mutual Influences of Poverty and Mental Health Disorders and the Key Role of Psychological Interventions to Resolve the Problem

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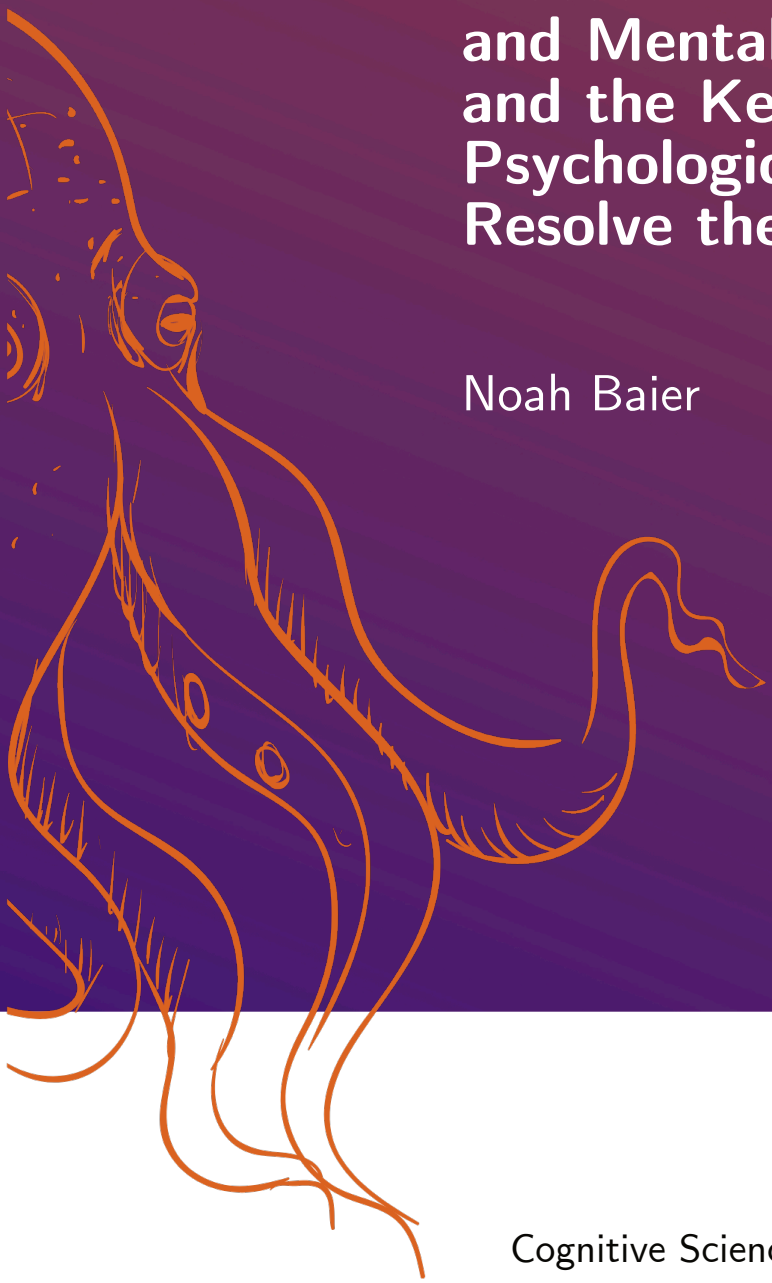

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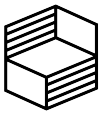

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1 Introduction

The world nowadays is facing many challenges on a global level. Recent events relating to the coronavirus pandemic certainly have not made things easier. Effects of the isolation forced upon people haves once again underlined the importance of mental health care, and the inevitable consequences of lack thereof. In South Africa, almost a third of the population has experienced a mental health disorder in their lifetime (Stein et al., 2008). Similarly, almost half of the population falls under the poverty line (Fransman & Yu, 2018). These findings appear in other countries as well, such as Indonesia and Chile (Araja, 2003; Tampubolon & Hanandita, 2014). Consequently, the question arises whether there could be a link between poverty and mental illness. As I will discuss in the following pages, there is clear evidence for a correlation between these two factors. I will explore the concepts of social causation and social drift, which give deeper insight into the mutual influence of these two factors. Further, we will see that psychological interventions play a key role in reducing mental health disorders in the face of poverty.

2 Poverty and Mental Health

In order to understand the relationship between poverty and mental health we must first address an apparent issue at hand. Poverty is a vague term and is relative depending on the cultural context. This makes it difficult to accurately analyze a causal relationship. Conventionally, poverty is defined as people living with less than 2$ per day (Toye & Infanti, 2004). However, this does not consider international differences in what a dollar can buy in a given country. While it is better to measure poverty relatively (by the society's average income), this still does not take other social limitations of income into account (Lund, 2012). These limitations might comprise economic opportunities given to privileged societies only, or location and transportation issues of societies in poverty. Despite the ambiguity of poverty, psychological literature has repeatedly shown that there seems to be a positive correlation between poverty and mental health disorders throughout the world (Lund, 2012). For instance, in the UK, researchers found that people with mental health disorders have a greater risk of drifting into financial problems. On the other hand, people with financial problems were similarly more likely to develop a mental health disorder (Jenkins et al., 2008). Therefore, humans affected by poverty seem to be at a much higher risk of developing detrimental mental health disorders, and similarly, mental health often leads people to economic disadvantages and finally poverty (Lund, 2012).

No matter the economical or social status, mental health disorders are an omnipresent challenge in any society. The findings of Lund (2012) and Wahlbeck et al. (2017) indicate that there is a causal relationship between economically disadvantaged societies and their levels of mental health problems. While research is still sparse on this topic, we can nonetheless theorize about a possible link (Lund, 2012). The reasons for this link are quite intuitive. The factors associated with poverty such as food insecurity, unemployment, violence, lacking medical care, the risk of being homeless, and many more can have a profound impact on an individual's well-being. The distress caused results in an increased risk of developing mental health issues and ultimately disorders. For instance, a study conducted by Fernald and Gunnar (2009) showed that cortisol levels in children were greatly reduced when their families received cash transfers to alleviate some of the issues of poverty. Scientific research on this topic agrees that the compounding of social, economic, and physical environments has a large influence on the mental well-being of people (Wahlbeck et al., 2017). This relationship is often referred to as social causation (Lund, 2012).

The other linkage observed in many studies is referred to as social drift (Lund, 2012). According to this theory, people who are affected by mental health problems tend to drift into an economic

disadvantage. This happens as they are disabled by their mental disorder to perform certain tasks, and tend to have high expenses for mental health care. Some research has pointed out that schizophrenia and neurological disorders such as epilepsy are mainly involved in the social drift hypothesis as they typically hinder patients from performing activities required at their job. The social causation hypothesis might also apply to common mental health disorders such as anxiety and depression (Sareceno et al., 2005). Nonetheless, this seems to be a complex relationship, and the causal pathways might move in both directions for each of the disorders (Lund, 2012).

While the studies consulted provide evidence to tie economical standing to mental health, other studies show different results. A paper that focused on feelings of happiness in Bangladesh found that despite the economical challenges the country faces, people report high levels of happiness (Camfield et al., 2007). The reason for this difference, however, could be that Camfield et al. (2007) focused on the importance of close relationships among people in Bangladesh. They concluded that relationships are a central anchor of people's well-being, and are potentially prioritized more in Bangladesh than in high-income countries. Their findings thus do not contradict the main points by Lund (2012) and Wahlbeck et al. (2017). It is important to note that we are interested in the effects of disadvantages caused by low financial income on mental health and not any other independent factors, such as interpersonal relationships.

3 In contexts of high levels of poverty, can psychological interventions play any role in reducing mental disorders?

So what is it that can help people break this vicious cycle? The social drift hypothesis can be addressed by scrutinizing mental health in societies affected by poverty. Unfortunately, especially for low- and middle-income countries (LAMICs), diminishing attention is given to mental health care (Van't Hof et al., 2011). A majority of the countries that qualify as LAMIC have no mental health care policy to address these issues (Organization, 2005). For the countries that do have a policy, only a negligible amount of the budget is spent on mental health (Organization, 2008).

This shows that there is a serious lack of treatment opportunities in for those facing mental illness and need it the most. Numerous research studies have been carried out to address the deficiency and test the impact of therapy through psychological intervention. The scientific work of Van't Hof et al. (2011) analyzed a database of studies to identify the effectiveness of psychological interventions in LAMICs. The studies they examined focused on different mental disorders such as major depressive disorder, anxiety disorder, and social anxiety disorders. In most cases, the technique used to treat the mental disorder was cognitive behavioural therapy (CBT). The extensive literature review of Van't Hof et al. (2011) revealed that psychological interventions have a remarkable capacity to relieve mental health disorders, even in LAMICs where mental health care is frequently neglected. Among the various approaches tested, CBT demonstrated the most favorable outcomes. The results were not influenced by the wealth of the country in which it was implemented (Van't Hof et al., 2011, p. 105)

The findings of Lund (2012) support the conclusions of Van't Hof et al. (2011). A systematic literature review by Lund (2012) indicated that psychological interventions have a strong capacity to disrupt the interplay between mental illness and poverty. Not only are these methods successful in improving the mental health of subjects in LAMICs, but also show the potential to improve economic development (Lund, 2012). This conclusion highlights the substantial evidence for the successful implementation of psychological interventions in communities struggling with poverty and its impacts on mental health.

4 Challenges of implementing psychological interventions in LAMICs

Certain challenges might occur when implementing psychological interventions in LAMICs. Many of these countries are densely populated, whilst only offering a few qualified professionals to address mental health care (De Sousaa et al., 2020). In India, there is currently only one psychiatrist for every 125.000 people (Sharma, 2018). There is a large unmet demand for psychological interventions in LAMICs (Patel, 2007). The shortage is difficult to resolve as training for a psychotherapist typically takes up to a decade. Moreover, a significant problem in LAMICs, such as India, is the existing stigma surrounding mental illness, which often leads to discrimination and exacerbates the difficulties faced by individuals affected (Semrau et al., 2015). To shorten the gap in demand and supply, it is important to utilize existing medical and social workers and educate them about essential psychological interventions (de Sousa et al., 2020).

A common belief is that mental health care is an expenditure that low- and middle-income countries cannot afford to make. Research conducted by (Abas et al., 2016), however, provides counterevidence for this belief. They conducted a long-term study in Zimbabwe to analyze the effectiveness and ease of implementation of mental disorder therapy in existing medical care structures. This means that no new staff was needed to provide mental health care, but rather, existing lay health workers were instructed and performed PST (psychology skills training) and positive activity scheduling with patients. The results of their extensive study showed that even in a low-income society such as the city Harare in Zimbabwe, psychological interventions could be implemented in an already existing infrastructure. Interventions were positively received by patients and healthcare workers and could be sustained for a low cost over time (Abas et al., 2016). Similarly, Lund (2012) argued that the cost of mental health care is much lower than the cost of potential consequences that come from neglecting treatment, such as lacking productivity and unemployment. This indicates that despite the belief that LAMICs cannot afford mental health care, it is feasible to implement and sustain it through existing medical care structures, leading to better mental well-being of citizens.

Psychological interventions developed in high-income countries seem to be effective in LAMICs as well, as shown by Patel et al. (2007). Depression could be successfully treated with cognitive behavioral therapy and low-cost antidepressants. Schizophrenia could be effectively addressed by using low-cost first-generation medication combined with psychological treatment such as community-based models of care (Patel et al., 2007).

While these psychological interventions alone seem promising to help the problem of poverty and mental illness, certain social aspects of poverty could be addressed in parallel to achieve higher effectiveness. Wahlbeck et al. (2017) showed that interventions outside the health sector can be applied to mitigate the effects of poverty on mental health. Such interventions may be parenting support programs, job search groups for the unemployed, or housing and urban policies to introduce people to recreational areas to improve mental health (Wahlbeck et al., 2017).

5 Conclusion

In conclusion, there is a clear connection between mental illness and poverty. The social causation and social drift hypotheses explain the reasons behind this relationship, forming a vicious cycle that affects millions globally. Despite the scarcity and stigma of mental health care in LAMICs, various studies have shown that psychological interventions can be successful in offering a solution to the predicament. While there are some challenges that arise when implementing traditional psychological interventions in these societies, we can see that it is possible and effective to treat patients utilizing existing medical structures. Hence, more attention should be given to mental health care in societies affected by poverty. As research for mental health care in LAMICs is still sparse, future investigations

should focus not only on financial aspects but also other social disadvantages associated with poverty such as environmental factors, unemployment, lack of educational and professional opportunities, and how these factors contribute to poor mental health in those affected.

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