International Journal of Physiology, Nutrition and Physical Education 2018; 3(1): 824-828

ISSN: 2456-0057
IJPNPE 2018; 3(1): 824-828
© 2018 IJPNPE
www.journalofsports.com
Received: 18-11-2017
Accepted: 22-12-2017

Dr. Dileepkumar S Navale
Dept. of Psychology, Gulbarga University, Kalaburagi, Karnatak, India

Correspondence
Dr. Dileepkumar S Navale
Dept. of Psychology, Gulbarga University, Kalaburagi, Karnatak, India

Poverty and mental health

Dr. Dileepkumar S Navale

Abstract
While there is increasing evidence of an association between poor mental health and the experience of poverty and deprivation, the relationship is complex. We discuss the psychological data on mental health among the different socio-economic groups, look at the cause-effect debate on poverty and mental health and the nature of mental distress and disorders related to poverty. Issues related to individual versus area-based poverty, relative poverty and the impact of poverty on woman's and child mental health are presented. This review also addresses factors associated with poverty and the difficulties in the measurement of mental health and illness and levels/impact of poverty.

Keywords: Mental health-poverty-socio-economic status

Introduction
The relationship between poor mental health and the experience of poverty and deprivation has been well studied and an association between the two factors has been established. The World Health Organization report [1] on mental health states 'Mental disorders occur in persons of all genders, ages, and backgrounds. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education. The link is however, complex and is influenced by numerous factors.

Prevalence of mental illness and socio-economic status
Psychiatric epidemiological surveys since the late 1930s have reported higher rates of mental illness in low-income communities [2]. Early studies showed this in major mental illnesses like schizophrenia. Recent evidence suggests this is the case with other groups of psychiatric disorders as well [3].

Common mental Disorders: Minor or no psychotic psychiatric morbidity that is largely constituted by symptoms of anxiety and depression are frequently encountered in the general population. These are among the most important causes of morbidity in primary care settings and produce considerable disability [9, 10]. While earlier studies looking at socio-economic issues focused on schizophrenia, recent literature has concentrated on the association with this group of disorders. These, termed "common mental disorders" (CMDs), are reported to be most prevalent among those with the lowest material standard of living, especially among those with a long-term experience of poverty [3, 4].

Schizophrenia: Early work of Faris and Dunham in 1939 [2] showed first admissions for schizophrenia to concentrate in the inner city, lower socio-economic areas of Chicago. This was supported by other studies that followed [4]. Some later studies however reported that the actual incidence of schizophrenia does not vary with social class, but rather that the lower socio-economic status was secondary to the psychotic illness [5].

Mood disorders: Analyses of the data from the Epidemiological Catchment Area study, a large community survey in the United States [6], indicated that the lowest socio-economic group manifested twice the risk of major depressive disorder (MDD) than the highest income group.

The National Comorbidity Survey (NCS) concluded that individuals with low socio-economic status demonstrate higher risk for MDD than individuals who are economically well-off [7]. Bipolar affective disorder on the other hand is reported to occur more in the upper socio-economic strata [8].

Common Mental Disorders: Minor or non psychotic psychiatric morbidity that is largely constituted by symptoms of anxiety and depression are frequently encountered in the general population. These are among the most important causes of morbidity in primary care settings and produce considerable disability [9, 10]. While earlier studies looking at socio-economic issues focused on schizophrenia, recent literature has concentrated on the association with this group of disorders. These, termed "common mental disorders" (CMDs), are reported to be most prevalent among those with the lowest material standard of living, especially among those with a long-term experience of poverty [3, 4].The explanatory models of persons suffering from common mental disorders have been described in a number of studies, in all of which poverty and socio-economic problems have been cited as one of the most important factors causing emotional distress [11, 12]. Though individual perceptions of illness are not evidence of a causal association, these substantiate the epidemiological findings.

Poverty and Suicide: Suicide is a multifactorial event. While mental illness is a significant risk factor, researchers in developing countries including India, note that often it is the individual's psychosocial context and stress which are the most common correlates of suicide. Among the commonly reported stressors are financial hardship, lower education and unfulfilled expectations at work [13, 14]. The high rates of suicide in the unemployed, marginalized and those subject to rapid and significant social change [15], is explained by the fact that suicide has been interpreted not only as a gesture of despair but also a means by which to express a deeply felt sense of having been wronged. Thus it may be seen an option to those who perceive themselves as wielding little power to make a change [16]. While poverty is easily understood as an individual -level risk factor, an ecological perspective on suicide that analyses the problem at a community level also suggests that areas of poverty, deprivation, unemployment and poor education are associated with higher suicide rates [17].

Mental health issues associated with poverty

The association between poverty and mental health can be explored under various headings.

Distress as a result of poverty: Poverty brings along with it a lack of opportunity, reduced availability and accessibility to resources and a greater likelihood of experiencing difficult events. The resultant distress may manifest in a variety of presentations including emotional states such as low mood and sadness, frustration or discontent; in the Indian setting many individuals may also present with physical symptoms for which there is no identifiable organic cause. On enquiry the individual often attributes his problems to the state of poverty and its attendant hardships. A British survey which asked respondents what they had experienced as a result of being poor recorded difficulties in relationships with friends and family, being bored, feeling a failure or looked down upon, in addition to feeling depresse [18].

Poverty as a risk factor for mental illness: Poverty, acting through economic stressors such as unemployment and lack of affordable housing, is more likely to precede mental illnesses such as depression and anxiety, thus making it an important risk factor for mental illness [19].

Psychological diagnosis leading to poverty: One of the difficulties in research on the relationship between poverty and mental health is the issue of 'drift'. Since the 1930s several studies have reported that the greater prevalence of schizophrenia in people of lower socio-economic status is a result of the psychiatric disorder and not due to poverty. Researchers proposed the 'Drift hypothesis' that stated that the disorder results in deterioration in functioning to such an extent that the individual drifts down to a lower socio-economic state. This theory suggests that the greater proportion of observed psychiatric symptoms and admissions from poorer areas is the result of inward migration of people with mental health problems who are attracted to such areas either due to decreasing income or due to 'disintegration'. This hypothesis is most commonly described for patients with schizophrenia; there is little evidence of this downward drift in people with other psychiatric disorders. Currently, research has focused on multi-factorial explanations which accept the possibility of some drift, whilst also acknowledging that, particularly at the lower levels of symptomology, drift is less likely to occur [18].

The economic burden of mental disorders

The presence of mental health problems results in an enormous financial burden on individuals, their families and society as a whole, in addition to the emotional toll they carry. The mental illness affects the ability of the ill person to secure employment. In the United Kingdom, a 1995 survey revealed that over half of the people with psychosis were classed as permanently unable to work, about a fifth were in employment and one eighth unemployed [1]. In those previously functional and employed, following the onset of the illness, there is a loss of productivity as a result of absenteeism or poor quality of work.

The treatment of mental illness involves significant expenditure secondary to the utilization of health resources. Many mental disorders are chronic and require long-term medication. In countries such as India where most people do not have health insurance and have to pay for treatment, this places a huge burden on the family. Side-effects associated with the medication result in additional costs, for example, elevated blood sugars and lipids secondary to the use of the atypical antipsychotics agents are associated with extra costs related to the monitoring for these metabolic side-effects, as well as their treatment.

Psychological conditions such as mood disorders and schizophrenia also carry an independent risk of physical morbidity secondary to lifestyle and neglect. The treatment of these disorders therefore adds to the burden. In a study involving patients with co-morbid schizophrenia/schizoaffective disorder and diabetes mellitus, limited financial resources and material deprivation interfered with access to the resources necessary for adequate diabetic self-care [20]. Economic hardship also affects the ability of individuals with mental illness to re-integrate into society. The impact of poverty on daily living was assessed for residents of a mental health care facility. Individuals reported difficulty meeting basic needs, such as clothing, shoes and personal care items. The poverty interfered with their ability

to participate in productive activity, contributed to significant stigma and hampered their ability to build and sustain social relationships [21].

The relationship between impoverishment and mental illness is, at the least, bi-directional, as poverty is a risk factor for certain mental illnesses which can in turn worsen the economic circumstances of the person and their families.

The correlates of poverty that influence mental health

Physical correlates of poverty: The state of poverty is associated with a variety of issues, causative as well as consequential-deprivation, a lack of opportunity, reduced access to and availability of resources and poor economic conditions. Factors such as education and employment have a two-way relationship with poverty. The lack of employment results in financial difficulties and poverty results in reduced opportunity to be gainfully employed. Unemployed persons and those who fail to gain employment have more depressive symptoms than individuals who find a job [22]. Further, employed persons who have lost their jobs are twice as likely to be depressed as persons who retain their jobs [23].

Limited resources result in reduced opportunity for education which in turn prevents access to most professional jobs, increases vulnerability and insecurity and contributes to a persistently low social capital. The prevalence of common mental disorders is known to be higher among individuals with low educational levels [19]. The National Co-morbidity Survey identified lower level of education and a lower income as risk factors associated with having MDD co-morbid with another mental disorder as opposed to MDD alone [7].

Poverty also results in reduced opportunity for reasonable housing and accommodation that influence emotional wellbeing. Chronic poverty often is associated with lower levels of family and community support, alcoholism, having greater experiences as well as fear of crime and violence, abuse and high rates of family desertion especially for men.

Psychological correlates of poverty: The psychological impact of living in poverty is mediated by stigma, social isolation, exclusion and the shame and humiliation of poverty [19]. People experiencing poverty report higher levels of hopelessness, fatalism, a lack of control over their circumstances, an orientation towards the present rather than the future, and lower levels of satisfaction with life than the better off. These characteristics are not only prevalent, but these also perpetuate themselves and the poverty that induces them. This makes it difficult for those in poverty to effectively change their socio-economic status.

Absolute or relative poverty

Relative poverty: Absolute poverty is not the only contributor to mental ill health. Relative poverty - dissatisfaction with one's lot in life compared to that of others – is seen in every society and seems to correlate with emotional distress. In developing countries like India with the rapid social and economic changes that are occurring, there is rising inequality which results in a growing incidence of anxiety and clinical depression. In India, being in debt is a particular source of stress and worry.

The Working Poor: While unemployment is a definite stressor, being in paid work is not a solution if the individual remains poor. Working poverty, represented by financial deficiency and restricted standards of living, was significantly negatively correlated with psychological well-being; it was also associated with increased risk of unmet mental health need [24]. There is evidence of the association between insecurity of income flow and common mental disorders. A study in Chile reported a strong relationship between acute income drop in the previous six months and the risk of mental disorders [25]. The spate of suicides of farmers in India is attributed to the impact of financial insecurity resulting from an inability of the small-scale farmer to cope with the economic challenges of a rapid globalization [26].

Mental health status and individual or area-based deprivation

Much of the research on the association between mental health and socio-economic status has been at area level rather than at the level of the individual. Studies have shown higher rates of psychiatric admissions for psychotic as well as non-psychotic conditions and suicidal behaviour in geographical areas with higher levels of deprivation and unemployment rates [27-29]. They have also reported highly significant correlations between psychiatric symptoms in individuals and more deprived locations [30]. This cumulation of mental disorders in deprived urban areas has been explained by the lower socio-economic status of the residents at the level of the individual rather than the cumulation of problems in deprived areas [4]. Studies at the level of the individual have shown that people living in economic hardship, especially on a long-term basis, were much more likely to be suffering from clinical depression than those not.

Duration of poverty and mental health

A sudden change in an individual's socio-economic status may result in acute and extreme distress and even suicidal ideation and attempts. However, research also argues that experiencing sudden economic loss can lead to a restructuring of financial resources and relationships in some individuals[31]. More chronic deprivation is more often associated with a sense of learned helplessness and hopelessness and has been most consistently linked to poor socio-emotional well-being. Studies that have reported on the relationship between the duration and developmental timing of poverty to children's development mention that chronically poor families provided lower quality child rearing environments and children in these families showed lower cognitive performance and more behaviour problems than did other children [32].

Children, poverty and mental health

Research suggests that household income influences child mental health. Children from low-income families appear to have higher levels of depression and anti-social behaviour - such as bullying, being cruel, breaking things, cheating or telling lies-than children from more advantaged households. Children in chronically poor families show lower cognitive performance. A change in household income also influences the child's mental health. Drops in income increase depression and anti-social behaviour, while a move out of poverty and an improvement in household income results in improved child mental health [33].

Adolescents who experience poverty are more likely to engage in drug and alcohol use at earlier ages, initiate sexual activity earlier, have increased mental health problems, and lower levels of academic achievement. The changes in the family due to economic strain are linked to externalized behaviors (marked by defiance, impulsivity, hyperactivity, aggression and anti-social features) in boys and internalized behaviors (evidenced by withdrawal, dysphoria and anxiety)

in girls[34]. It is evident that the child who experiences poverty may also experience other life adversities [35]. Poverty results in a less favourable family environment and poor quality parenting. It diminishes the ability of parents to provide supportive, consistent behaviour and may render parents more vulnerable to debilitating effects of life events. Parental mental health and behaviour in turn influences well-being of the child. The risk factors that additively influence a child's psychological adjustment include parents' employment and educational status, family size, maternal mental health, parental divorce, unsafe living environment, and parenting behaviours [32, 34].

Women, poverty and mental health

Being female is reported to be a risk factor for common mental disorders. Studies from India have shown that poverty and deprivation are independently associated with the risk for common mental disorder in women and add to the sources of stress associated with womanhood [36]. Among women in poverty, there is support for a significant association between economic hardship and reports of psychological distress due to such issues as being the sole childrearing adult in a household, multiple roles, unequal power relations with men and a sense of powerlessness [37]. Interviews with relatives of young women in rural China who had committed suicide and the survivors of suicide attempts revealed that hopelessness was a core experience, associated with poverty, limited educational and work prospects and the migration of husbands to urban areas for employment; these were in addition to other issues such as stigma for failing to produce a son, spouse and family abuse and forced marriages [19].

Depression during pregnancy is a common problem and is associated with indicators of socio-economic deprivation as well as other problems such as violence and loss of an intimate relationship [38]. Within a household, studies reported that some members of the household go without certain goods and services in order to increase the amount available for others; parents most commonly go without on behalf of children and women are most likely to go without than men [18].

The Complexity of Measurements

Measurement of mental health and illness: The relationship between poverty and mental health is complicated by the difficulties in the measurement of mental health and illness. The clinician's impression may be different from the individual's perspective. A clinical approach may medicalize an individual's distress, accord it a diagnostic label and prescribe medication; alternatively the distress may be considered a normal consequence or reaction and therefore ignored. Other problems include possible bias in psychiatric models of mental health such as making more frequent diagnoses of disorders such as schizophrenia in certain ethnic or marginalized groups.

Some studies have avoided the clinicians' definitions of mental health by using the respondent's own perceptions of their mental health and the impact of poverty. Self-perceived mental ill- health is a good reflection of how people view their mental health and the way this is affected by living circumstances and the experience of exclusion. The negative aspect of the self-assessment question is that the stigma associated with mental ill- health may result in an under-reporting of mental illness. Such self-assessments would require additional objective measurements using standardised clinical interview schedules to strengthen the analysis as well as enable comparisons with other studies and groups [18].

Indicators of Poverty: Poverty is a term open to a number of different definitions. Studies on poverty and mental health have utilized a variety of indicators of poverty. These include low income, lack of material possessions, lack of employment, and housing difficulties. Several studies showed a statistically significant relationship between prevalence and indicators of poverty, the most consistent relationship being with low educational levels [19].

Conclusion

Several studies on schizophrenia have shown better recovery in developing countries including India [39], where there is widespread deprivation. World-wide, not all those below the poverty line are depressed or suffer from other mental disorders. Many cope well despite adversity and difficult economic circumstances. This resilience is often attributed to family and social support networks as well as individual personality traits. The challenge is to identify these protective qualities and utilize them to help and prevent mental health problems.

It is evident that poverty and mental ill health are linked together in a complex manner. Insecurity, low educational levels, inadequate housing and malnutrition, which are the correlates of poverty, are recognized as contributing to common mental disorders. Mental disorders envisage costs in terms of long-term treatment and lost productivity. The two are thus linked and affect several dimensions of individual and social development. While adequate and appropriate investment in mental health care services and research is a necessity, efforts to alleviate poverty are an essential component of emotional health. Health policy-makers and planners must recognise the needs of the vulnerable and focus on the psychological as well as social aspects of health in order to be truly effective.

References

1. World Health Organization. Investing in mental health.2003.http://www.who.int/mental_health/media/investing_mnh.pdf.
2. Faris REL, Dunham WW. Mental disorders in urban areas. Chicago: University of Chicago Press, 1939.
3. Weich S, Lewis G. Poverty, unemployment, and common mental disorders: population based cohort study. BMJ. 1998; 317:115-9.
4. Reijneveld SA, Schene AH. Higher prevalence of mental disorders in socioeconomically deprived urban areas in the Netherlands: community or personal disadvantage? J Epidemiol Community Health. 1998; 52:2-7.
5. Goldberg TE, Morrison SL. Schizophrenia and social class. Br J Psychiatry. 1963; 109:785-802.
6. Regire DA, Farmer ME, Rae DS, Myers JK, Kramer M, Robins LN, *et al*. One-month prevalence of mental disorders in the United States and sociodemographic characteristics: the Epidemiologic Catchment Area study. Acta Psychiatr Scand. 1993; 88:35-47.
7. Blazer DG, Kessler KC, McGonagle KA, Swartz MS. The prevalence and distribution of major depression in a national community sample: the National Comorbidity Survey. Am J Psychiatry. 1994; 151:979-86.
8. Lenzi A, Lazzerini F, Marazziti D, Raffaelli S, Rossi G, Cassano GB. Social class and mood disorders, clinical features. Soc Psychiatry Psychiatr Epidemiol. 1993; 28:56-9.
9. Ormel J, VonKorff M, Ustun TB, Pini S, Korten A, Oldehinkel T. Common mental disorders and disability

across cultures. JAMA. 1994; 272:1741-8.
10. World Health Organization. The World Health Report 2001-Mental health: new understanding, new hope. Geneva: World Health Organization, 2001.
11. Patel V, Gwanzura F, Simunyu E, Lloyd K, Mann A. The explanatory models and phenomenology of common mental disorder in Harare, Zimbabwe. Psychol Med. 1995; 25:1191-9.
12. Patel V, Pereira J, Mann, A. Somatic and psychological models of common mental disorders in India. Psychol Med. 1998: 28:135-43.
13. Manoranjitham S, Abraham S, Jacob KS. Towards a national strategy to reduce suicide in India. Natl Med J India. 2005; 18:118-22.
14. Prasad J, Abraham VJ, Minz S, Abraham S, Joseph A, Muliyil JP, *et al*. Rates and factors associated with suicide in Kaniyambadi Block, Tamil Nadu, and south India, 2000-2002. Int J Soc Psychiatry. 2006; 52:65-71.
15. Vijayakumar L, John S, Pirkis J, Whiteford H. Suicide in developing countries (2): risk factors. Crisis. 2005; 26:112-9.
16. Pearson V. Ling's Death: An Ethnography of a Chinese Woman's Suicide. Suicide Life Threat Behav. 2002; 32:347-58.
17. Whitley E, Gunnell D, Dorling D, Smith GD. Ecological study of social fragmentation, poverty, and suicide. BMJ. 1999; 319:1034-7.
18. Payne S. Poverty, social exclusion and mental health: Findings from the 1999 PSE survey. Poverty and Social Exclusion Survey of Britain: Townsend Centre for International Poverty Research. Bristol: University of Bristol, 2000.
19. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ. 2003; 81:609-15.
20. El-Mallakh P. Doing my best: poverty and self-care among individuals with schizophrenia and diabetes mellitus. Arch Psychiatr Nurs, 2007; 21:49-60.
21. Robert DW. Poverty and mental health: A qualitative study of residential care facility tenants. Community Ment Health J. 2003; 39:139-56.
22. Simon GE. Recovery from depression, work productivity, and health care costs among primary care patients. Gen Hosp Psychiatry. 2000; 22:153-62.
23. Dooley D, Catalano R, Wilson G. Depression and unemployment: Panel findings from the epidemiologic catchment area study. Am J Community Psychol. 1994; 22:745-65.
24. Vetter S, Endrass J, Schweizer I, Teng H, Rossler W, Gallo WT. The effects of economic deprivation on psychological well-being among the working population of Switzerland. BMC Public Health. 2006; 6:223.
25. Araya R, Lewis G, Rojas G, Fritsch R. Education and income: which is more important for mental health? J Epidemiol Community Health. 2003; 57:501-5.
26. Sundar M. Suicide in farmers in India. Br J Psychiatry. 1999; 175:585-6.
27. Gunnell D, Peters T, Kammerling M, Brooks J. The relationship between parasuicide, suicide, psychiatric admissions and socioeconomic deprivation. BMJ 1995: 311:226-30.
28. Boardman AP, Hodgson RE, Lewis M, Allen K. Social indicators and the prediction of psychiatric admission in different diagnostic groups. Br J Psychiatry. 1997; 171:457-62.
29. Croudace TJ, Kayne R, Jones PB, Harrison GL. Non-linear relationship between an index of social deprivation, psychiatric admission prevalence and the incidence of psychosis. Psychol Med. 2000; 30:177-85.
30. Harrison J, Barrow S, Creed F. Mental health in the north west region of England: association with deprivation. Soc Psychiatry Psychiatr Epidemiol. 1998; 33:124-8.
31. Elder GH, Caspi A. Economic stress in lives: Developmental perspectives. J Soc Issues. 1988; 44:25-45.
32. National Institute of Child Health and Human Development Early Child Care Research Network. Duration and developmental timing of poverty and children's cognitive and social development from birth through third grade. Child Dev. 2005; 76:795-810.