

"But some are more equal than others: the reciprocal relevance of community psychology and interdisciplinary research on health and income inequalities"

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This symposium is entitled 'Community psychology approaches to reducing health inequalities'. We have just heard Professor Bracke talking, in some detail, about 'inequality and health'. In this paper I will argue that the implications of this research for community psychology are profound but also that community psychology can contribute greatly to understanding and preventing distress and ill health originating in inequality.

I will first give a brief overview of the key features of the values and assumptions of community psychology. I will then return to the inequality and health literature and summarise what I regard as the key issues. I will then unpack some of the challenges and opportunities for research, action and praxis. Firstly then . . .

What are community psychology approaches?

In most countries, few members of the public, policy makers or even social scientists, have heard of 'community psychology'. However, community psychology is actually widely dispersed not only throughout Europe but globally - with community psychology teaching, practice and research found in Australia, New Zealand, South Africa and in Central, North and South America. Moreover, community psychological practice outside Universities is arguably even more widespread. Community psychology does take culturally specific forms in different places at different times but, underlying superficial diversity in community psychological approaches around the world, there are some important deeper commonalities.

Wherever one finds them, community psychologists are concerned with the consequences for social and psychological well-being of our societal arrangements. I am using 'societal' here as shorthand for social, organizational, cultural, socio-structural and politico-discursive arrangements.

Whilst most psychologists faced with a psychological problem, look first, hardest and longest for its psychological origin, most *community* psychologists look first, hardest and longest for the *societal* origin of which it is the consequence.

Similarly, whilst most psychologists assume that most psychological problems require psychological solutions, most *community* psychologists assume that most psychological problems require societal solutions. Indeed, community psychologists believe that looking for psychological causes of what are actually the consequence of societal arrangements is not only scientifically but also ideologically problematic – re-positioning the consequences of societal arrangements as the consequences of personal failings and compounding distress by blaming victims of oppression for being the cause of their own distress.

Moreover, most community psychologists believe that the scale of distress and ill health consequent upon our societal arrangements, is so great that it would be impossible to train and resource enough clinicians to treat people one at a time, even if such individual treatment were widely effective (which is in doubt) or morally acceptable

(which is questionable). Rather, community psychologists argue that to make an appreciable difference to the scale of individual and collective suffering consequential upon our societal arrangements, we must engage in prevention, intervention and policy change at the collective level - rather than in treatment at the individual level.

Whilst most psychology is based on a positivist philosophy of science which privileges the search for one to one cause–effect relationships, most community psychologists assume that most health problems are the consequence of the interaction over time of many factors on a variety of levels: from international structural factors via national, neighbourhood, organizational, family and personal factors.

Let us dwell for a moment on the personal. Most community psychologists find the term ‘social causation’ both useful and problematic. This is because the notion of ‘cause’ fits well with that of ‘consequence’ but uneasily with libertarian community psychological values and assumptions. To expand, most community psychologists assume that the subject matter of psychology – what psychology is ultimately ‘about’ - is quite different from that which non-social sciences are ‘about’, in that our subject matter is composed of socially and subjectively constituted moral agents, whilst the notion of ‘cause’ seems to imply a deterministic (and, in psychology, reductionist) world view in which people come to be seen as the passive sites where cause-effect relationships are played out and where persons as self-determining moral agents become somehow rendered invisible.

Most community psychologists assume that their subject matter is characterised by consciousness and work on the assumption that it is not just an illusion that human beings characteristically make real, if constrained, choices, bear responsibilities, make sense of what is going on, formulate and carry out plans in line with past memories, future expectations and transcendent values.

Most community psychologists, therefore, insist that free will, albeit severely constrained free will, is a ‘given’ to be explained – rather than an illusion to be explained away. Crucially, most community psychologists believe that the social world impacts on persons largely through their understanding of it, that subjectivity is a defining feature of what it is to be a person and that, reflexively, this is as true for community psychologists as it is for the people with whom they work. Most community psychologists, therefore, try to develop and use research methods which can engage with others’ subjective experience and which allow them to use their own subjectivity as a resource, rather than to exclude it as a liability.

Crucial though the consciousness and subjectivity of persons are, most community psychologists assume that there is a context within which that subjectivity is embedded and which is in constant reciprocal interaction with it. However, the community psychological notion of ‘context’ is a little different from the taken-for-granted, everyday, notion of context and therefore needs to be unpacked.

‘Context’ is understood by most community psychologists as a multi-level phenomenon which embraces, but goes far beyond, the immediate environment to include material, environmental, family, organisational, neighbourhood, policy, cultural, societal, multinational and discursive levels in continuous reciprocal interaction over time.

Although for expository purposes, consciousness and context have here been introduced separately, ‘contextualised-consciousness’ is, for most community

psychologists, actually an irreducible unit with emergent properties, that is, properties of the combination of context and consciousness which each does not have separately. 'Contextualised-consciousness', community psychologists claim, cannot be broken down into component parts without losing its defining emergent characteristics. To focus in a reductionist way on consciousness alone is to err into naïve 'psychologism'. To focus in a reductionist way on context alone is to err into naïve 'sociologism', reducing persons to mere ciphers of socio-structural forces.

The point being made here is not the important but limited one that research on the person in the context of the community allows more ecologically valid generalisations than research on the person in the context of the laboratory but the point that that personhood is an emergent property of socially 'contextualised-consciousness'.

To move on, wherever one finds them, community psychologists regard control as central. Research has repeatedly found that people with emotional and psychological problems usually have little control over key factors affecting them: some talk of this as low 'discretion latitude' and others as 'disempowerment'. Whatever one calls it, decreasing control has been found to affect the mental health of individuals negatively and increasing control has been found to affect the mental health of individuals positively.

Note that the amount of control one has is powerfully structured by our societal arrangements: and that relative wealth, socio-occupational stratification, gender and dominant (especially ethnic) group membership are regarded as key. Effective community psychology interventions therefore involve redistributing control in the direction of the relatively powerless to increase their control over factors affecting their lives. Not surprisingly, the status quo - which does not like giving up its capacity to control - usually resists this redistribution of power.

Community psychologists believe that the status quo does not only exert control reactively when challenged but exerts control proactively as an everyday function of its existence. Much of this control is built into our multi-level social context, particularly into dominant narratives and discourses. Narratives about what is responsible for ill health and distress and which favour the interests of the status quo are often internalized, become taken for granted and are not easily challenged. The importance of 'surfacing' and contesting these oppressive internalized narratives and discourses through processes of 'conscientization' and other means has been emphasized by Latin American community psychologists as being a central task of community psychology. Psychologies that do this, rather than collude with the status quo, are '*critical* psychologies'. A community psychology approach, which aims for deconstruction of oppressive individualistic accounts and transformation of societal causes of distress rather than amelioration of psychological reactions to stressors, is thus a *critical* community psychology approach.

The community psychologist's concern with control extends to the very processes of research and action. In carrying out their work, community psychologists strive to maximise community participants' control over key dimensions of the process and to minimise their own 'power over' participants. In research terms this means they are likely to prefer research methods such as depth interviewing which allow participants to actively determine what is talked about and how it is articulated rather than methods like

surveys where participants are passively processed through issues and questions pre-structured by the researcher.

As for interventions, community psychologists favour collaborative multilateral co-research and co-action 'with' participants over unilateral work 'for' them. Indeed, the promotion of co-operative, heterarchical, relationships rather than competitive hierarchical ones, both as process and outcome, is a key aim of community psychology.

Just as disempowerment has been found to be intimately bound up with poor mental and physical health, so social support, whether one to one, many to one or many to many, has been repeatedly demonstrated to be intimately involved in the enhancement of mental health.

Community psychologists tend to be sceptical of the competence of professional 'experts', and especially of '*psychological* experts', mindful that such expertise is often wielded to control and that many disadvantaged community members only come across psychological experts as bearers of bad news and/or oppressive power: when their children are labelled as problematic at school by educational psychologists, when work is intensified in their jobs by occupational psychologists, when they hear from clinical psychologists that they have not only lost their job but that they are also 'losing their mind'. The effectiveness of such experts in dealing with the problems brought to them by community members is often, according to community members themselves, very limited and very problematic. Indeed some expert 'solutions' are more problematic than the original problem. Presenting to a psychological expert with depression which has its origin in structural inequality only to be offered cognitive behaviour therapy or anti-depressant medication can be an alienating experience and indeed, given the victim-blaming implications of the former and the side effects of the latter, could compound rather than reduce difficulties.

On the other hand, most community psychologists tend to appreciate the competence possessed and exercised by 'ordinary' community members in relation to the issues of concern. They often have insightful understanding of key phenomena and clear views about what is needed, though inadequate resources to intervene. It is, for most community psychologists, more important to look for, celebrate and facilitate competence, resources and strengths than to look for, lament and supplement deficits, needs and weaknesses.

Finally, community psychologists regard social change as the key issue. The ultimate aim of most community psychologists is not only, or even mostly, to research, understand and document distress but to prevent, reduce or eliminate it by changing the societal arrangements upon which it is consequent.

What then, in summary, is community psychology? Community psychology is a critical psychology which seeks to prevent or reduce the negative mental health consequences of our societal arrangements by working collaboratively at both objective and subjective levels with persons, in their everyday community contexts, to increase their control over their lives through facilitating their competence to bring about social change.

With this clarification of what a 'community psychological approach' is, let us turn back to the key features of the inequality and health literature.

I want to bring out two key issues about inequality and well-being. In this I have been heavily influenced in my understanding by the work of Richard Wilkinson, on whose work (see below) I have drawn heavily in preparing the following section.

The unequal distribution of health *within* developed societies

The first issue I want to emphasise is the shocking, but by now almost taken for granted, inequality in distribution of health *within* our developed societies. For all of us, the higher we are located in the social hierarchy of our society, the longer our life expectancy. We, and those in our social circles, are likely to live between five and ten years longer (15 years in some case) than the poorest people, and those in their social circles, in the societies in which we live. Although, there is some variation from society to society, in the developed world, people at the bottom of the social hierarchy have death rates between two, three and sometimes even four times higher than those at the top.

This not just the result of comparing the life expectancy of the very poor with that of the very rich - even those who are quite affluent have poorer life expectancy than those who are very affluent. In society after society a continuous gradient has been found from those lowest in the hierarchy with the worst death rates via those in the middle of the hierarchy with intermediate death rates to those highest in the hierarchy with the best death rates.

The relationship between position in the hierarchy and health is found however people's place in the hierarchy is operationalised: in terms of how much income they have, in terms of what their occupation is (or isn't), in terms of when their formal education ceased or in terms of where and how they live.

Low hierarchical position is not only associated with one or two main causes of death: nearly all of the main causes of death follow the same pattern.

Sceptics may wonder if the association between poor health and low position in the social hierarchy can be explained by people whose health deteriorates finding themselves 'drifting down' the social hierarchy. However, research following people over their life span suggests this makes very little difference to the distribution of health at the population level.

Similarly, sceptics may wonder if the relationship between hierarchical position and health simply represents an accumulation of individual risk factors: that people lower down the social hierarchy engage in less healthy behaviour than those higher up and have access to worse medical care when ill. In fact research suggests that health related behaviour and medical care account for little of the difference in health between those at the top and bottom of the hierarchy.

A study, which is often cited as an exemplar in connection with these issues, is Marmot's 'Whitehall study'. This was a study of 17,000 middle class civil servants working in UK Government offices in Whitehall, London. Each employee was categorised in terms of the hierarchy of employment grades in the civil service with the assistance of the employer. Even after controlling for smoking, cholesterol, glucose tolerance, blood pressure and height, the death rate from heart disease was four times greater for junior as opposed to senior office staff. The second issue I want to emphasise here is

The unequal distribution of health *between* developed societies.

As we have seen, *within* societies richer people live longer and are healthier. However when one looks at differences *between* so-called ‘developed’ countries, richer countries do *not* have healthier populations than poorer ones. In fact, life expectancy has been shown to be greater in some countries like Greece, Japan, Iceland and Italy which are poorer in terms of GDP than in richer countries like the USA or Germany. Whilst a degree of national wealth is necessary to achieve minimal standards of nutrition, shelter, hygiene etc., once that has been achieved (and all the developed OECD nations have done this), some countries are twice as rich as others (in terms of per capita income) but no healthier.

As Wilkinson (2000:11) puts it: “among the developed countries it is the most egalitarian that have the highest life expectancy, not the richest.” This is not a wild, if radical, claim based on a single study.

Even in 1996 Wilkinson was able to refer to a “growing body of new evidence which shows that life expectancy in different countries is dramatically improved where income differences are smaller and societies are more socially cohesive” (1996: 1) and could refer to confirmatory reports by “at least 8 different research groups using some ten separate sets of data drawn at different dates, from different groups of developed and developing countries on cross sectional and time series bases” (1996:78).

By the time the book was about to go to press and he was writing the Preface, Wilkinson could add that whilst writing the book his thesis had been “amply confirmed . . . by other researchers using independent data” (1996: x) including major studies at Berkeley and Harvard. By 1998, Wilkinson could write that in addition to reports cited in his book: “another seven more have been published or are forthcoming” and by 2000 Wilkinson could write that “there is now a score of reports of this relationship – among developed and less developed countries. . . . In contrast only 2 reports have failed to show this relationship and they were based on the same data set; even here it was only death rates for those over 65 that did not fit the pattern” (2000:11). In preparing this paper I contacted Richard Wilkinson for an update on the position. He told me that research is in press which shows a clear relation between inequality and health across over 500 cities in 5 countries (Wilkinson, 2003: personal communication). Whilst not exception free the evidence is impressive and growing.

It is important to note that the greater the inequality at the societal level the greater the risk of death from most causes, including cardiovascular disease, infection, respiratory disease, cancer, alcohol consumption and accidents.

It is also important to note that the differences between healthy and unhealthy societies are not just accumulations of individual risk factors. Individual health risks (such as smoking) are far outweighed by societal ones (like income inequality).

It is also important to note that healthy egalitarian societies are not healthier just because there are fewer relatively poor people with poor health: in more egalitarian societies people throughout the social hierarchy benefit in terms of health.

It is also important to note that “statistical analysis shows that income inequality affects health independently of expenditure on medical care and of the prevalence of smoking” (Wilkinson: 2000:11).

Finally, for now, much of the work reported above has looked at the relationship between inequality and life expectancy. This is largely because data about death are available and relatively unproblematic regarding social definition. However violent crime

has been shown to be even more strongly related to income inequality than total mortality is and Wilkinson (1996:5) wonders whether the consequences of income inequality for “quality of life are not more important than the effects on the length of life”, referring to the “sources of social stress, poor social networks, low self-esteem, high rates of depression, anxiety, insecurity, the loss of sense of control” which he posits as the consequences of income inequality.

Reconciling the health effects of income differences within and between societies

At first sight there seems to be a contradiction between the health effects of income differences within societies (where the richest tend to be the healthiest) and income differences between societies (where the richest do not tend to be the healthiest). However, the apparent contradiction evaporates if one sees both as expressions of the health consequences of inferior position in the social hierarchy. The health effects of income differences *within* societies show the effects of *position* in the hierarchy relative to other people. The health effects of income differences *between* societies show the effects of *distance between positions* in the hierarchy. In non-egalitarian societies one not only has to cope with one’s relative position in the hierarchy but also with the greater distance between oneself and others above one. Put simply, it is humiliating enough to come last in the race but it is even worse to come last by a mile than to come last in a photo-finish.

Bringing community psychological and health inequality ideas together

To bring community psychological and health inequality ideas together: hierarchical structuring at the societal level has consequences for psychological and physical health and social well-being.

Hierarchical structuring essentially determines the disempowerment of some relative to others. Inequalities in physical and mental health in developed societies are to a large extent the consequences of disempowering hierarchical position and distance.

In this paper and for this symposium I have dwelled on the determination of hierarchical power by income, occupation, education etc. but one could also add that in addition to these class related indicators, community psychologists would also be alert for the role of sexism, racism and other societal factors in structuring the social hierarchy.

Rather than ‘blaming the victims’ who are relatively disempowered by their hierarchical positioning, we should address those with responsibility for socio-economic policies which create and widen hierarchical differences and we should make the case, on health (and health economic) grounds, for redistributive economic policies.

Prevention, intervention and policy change at the socio-economic level, rather than treatment at the individual level, are required. Effective intervention in relation to health inequality will involve transformation of the societal origins of distress and ill health (income inequality) rather than amelioration of psychological reactions to them.

This will involve redistribution of control and status away from some in the favour of those with lowest status and poorest health. The status quo, which devotes inordinate resources to keeping things as they are, may be expected to resist such interventions but the examples of more egalitarian countries with less health inequalities and the personal social and economic benefits all the way up the hierarchy which go along with them may reassure those with vested interests that change need not be

painfully radical to make a meaningful health difference (though some of us may prefer more radical change).

Nevertheless, tackling health inequalities at the socio-economic level alone is not enough – a multi level approach to understanding and intervention is required. Disempowerment through location in an inferior hierarchical position through relative poverty impacts on persons at least in part through their understandings of their situation and any adequate explanation of, and intervention regarding, health inequality must grapple simultaneously with subjectivity and socio-economics. This requires engaging with the person-in-context, where ‘person’ signifies subjectivity, where ‘context’ signifies multi level societal factors in reciprocal interaction over time and where ‘person-in-context’ signifies an irreducible unity with emergent properties.

Put simply, health inequalities do not have primarily psychological nor primarily socio-economic origins or solutions but primarily psycho-social ones. The social world impacts upon us through our understanding of it – though we must never, solipsistically forget that there is a social world out there impacting on us and that changes in that social world are needed to change that impact.

As for intervention, in working to counter the noxious health consequences of inequality, it is essential to address process as well as outcome issues. This will involve looking for and facilitating community participants’ competence, resources and strengths; striving to maximise community participants’ control over key dimensions of the process; and seeking to minimise interveners’ ‘power over’ participants. Collaborative, heterarchical co-research and co-action ‘with’ participants is preferred over unilateral hierarchical work ‘on’ or ‘for’ participants.

An example

As an example – but not an exemplar - I next briefly summarise an action research project in Scotland, in which Rose Fagan and I sought to contribute to understanding the role of psychosocial aspects of income in the experience and mental health of unemployed members of low-income families; to expose and examine the nuts and bolts of the psycho-social processes linking inequality at a societal level to physiological processes at the individual level; to contribute to the development of innovative participatory methodology; to promote the interests of impoverished unemployed people in line with community psychological values; and to systematically generate auditable accounts of the experience of income related factors.

30 families within one deprived community took part with multiple advice and interview sessions being conducted with different family members (Fryer and Fagan, 2003). We framed this within a set of critical assumptions intentionally repositioning research from documenting psychologically distressing aspects of unemployed poverty to intervening to reduce or prevent distress through both the process and outcomes of research.

We built up a rich picture of how each family member conceptualised the major issues facing the family by building the research around the use of a menu-driven interactive computer program, which allows a person, by keying in their personal circumstances, to work out all the state benefits to which s/he is entitled. Welfare Benefit Advice was delivered through the Lisson Grove Welfare Benefits Program loaded onto a portable notebook computer. Around this central core, audio recorded repeated non-

directive depth interviewing, observation and document analysis were carried out. Field notes were made to keep track of emerging insights. Analysis used a refinement of cognitive mapping, in which emerging themes were mapped through spatial grouping in 2D space of conceptual interdependencies.

During the research some families, with whom we worked, heard of and claimed entitlements to which they did not previously know they were entitled. Other families did not learn of new entitlements but reported that they were relieved to come to understand why they were (and were not) entitled to certain benefits. Some family members used the research intervention to calculate the implications of potential courses of action. Some participants worked out in advance the financial costs and benefits of taking low-paid employment.

Much discussion took place about: the difficulty of fulfilling not only functional and essential consumption needs but also, crucially, symbolic consumption needs which fuelled social exclusion; the psychological functionality of so-called 'irrational' spending and consumption patterns; perceived entitlements and disentanglements; income-source related stigma; negative experiences of State agencies and claiming; expenditure planning and prioritisation of different family members' needs; the domestic division of financial coping behaviour; the use of reciprocal support; coping strategies the pro-social and mental health promoting nature of participation in informal (black) economic activity.

However here I want just to focus briefly on the reported experience of State benefit money (Job Seekers' Allowance) and money earned through 'working on the side' in the black economy.

The receipt of State benefit money was described as redolent with indecency, humiliation, stigma and depression. The passivity and lack of any reciprocity, of an exchange relationship with unemployment benefit was especially thoroughly explicated.

By contrast, money earned from work on the side was experienced quite differently: there was a reciprocal relationship between the hard work done, the payment received and the entitlement to spend it as one pleased. Black economic earnings, unlike dole money, were felt legitimately to be one's own. Moreover receipt of money in exchange for hard physical graft reinforced sense of masculinity for males. Work on the side financial benefits were often earmarked for particular expensive but necessary items. There was explicit disclosure about the pride obtained through doing good jobs inexpensively with self-taught skills. There was talk of being locally respected for the quality of (black) work. There was evidence of the acquisition of sophisticated understanding of the local (black) labour market. Black economic activity was described in terms of what amounted to self-employment market testing: testing out supply and demand for different skills in differing areas, lowering prices and improving services to drive competitors out of business etc.

It is clear that many of the benefits of 'black' money compared with benefit money was that it had quite different significance for respect in one's local community, effectively locating one differently, more respectfully, in the social hierarchy.

In conclusion

There are important lessons in the intersection of community psychology and health approaches. The impact of socio-structural factors on individual health is central –

those health education personnel who exhort those with poorer health to change their diet, take exercise, reduce smoking etc., whilst well intentioned, are missing the point.

Those who engage in one to one therapeutic interventions with victims of inequality may also be well intentioned and may comfort some individuals but they will make no difference to public health. Better to mend the bridge than resuscitate those who have fallen into the river.

Those who work with victims of health inequalities can ask those victims about what is responsible for their distress as much as they like - but structured inequality at the societal level is simply not directly accessible to conscious awareness, especially when people have internalised individualistic victim blaming narratives (for example that the poor health of the poor is their own fault).

Nevertheless, relative inequality at the societal level does not impact directly i.e. materially, on the person. We know that it is not a purely material phenomenon because materially more deprived people (in per capita poorer societies) living in less *relative* poverty (i.e. in more egalitarian societies) are healthier than less deprived people (in per capita richer societies) living in greater relative deprivation (i.e. in less egalitarian societies). The impact of hierarchical inequality is psycho-social: simultaneously subjective and socio-structural.

It seems to me that a, perhaps the, key task is to come to understand the psycho-social processes through which inequality at the societal level impacts on the individual's psycho-physiology to result in bodily processes which result in unhappiness, illness and ultimately risk of premature death whilst resisting pressure to intervene at the psychological level and working with others to bring about socio-economic change to reduce societal inequality to 'delay' the social hierarchy and reduce distance between positions remaining in it.

Some further reading:

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