

The effects of the economic crisis on mental health

The character Gordon Gecko in the film “Wall Street” lived by the mantra “Greed is Good.” The events that unfolded toward the end of 2008 exposed in dramatic fashion the downside to greed and led to the worst global economic crisis since the Great Depression of the 1930s. Economic contagion in the US spread rapidly as many countries experienced failures in key businesses, declines in consumer wealth and increased financial debts. While the economic and political implications have been studied in detail, the impact on health – especially that of mental health – has received much less attention. This essay aims to achieve a critical analysis of causality (or lack thereof) between an economic crisis and mental health, using a combination of statistical review, psychological theories and common logic. This will hopefully impact on our understanding of the causes of mental health problems in times of economic insecurity and assist in developing strategies to ameliorate them.

Before initiating the discussion, it is worth clarifying some key concepts in this paper. While an economic downturn is quantifiable, it is clearly not an easy task with mental health. This is attributable to the variable interpretation of psychological processes across cultures and languages, and also because to a large extent mental health is value-laden. For the purposes of this essay I propose a view of five principal components of mental health which have been accepted by many Western philosophers and summarised by Professor Peter Warr from the University of Sheffield¹. These five interacting components of mental health are **affective-well being, competence, autonomy, aspiration and integrated functioning**.

Of the five components, affective well-being is most subjective, usually self-evaluated on a scale of ‘feeling good’ to ‘feeling bad’. This encompasses the basis of understanding of illness in the average patient. The next three components relate to a person’s behaviour in relation to his/her environment, and in contrast to affective well-being, has an objective side to it. Competence refers to a person’s ability to cope with environmental pressures. Autonomy is the ability of the individual to make decisions and act independent of external influences and also the degree of success of the individual’s interaction with other people. The balance between independence and interdependence is the basis behind a person’s autonomy. Finally, aspiration pertains to the degree to which a person achieves realistic goals and makes efforts to attain them. Integrated functioning is qualitatively different from all the other four components, and is difficult to define. It is more concerned with structural issues than are the previous components, but interpretations and perspectives vary widely and will be analysed when we arrive to them.

Having established this, we can now proceed to the crux of this essay; i.e. an analysis of causation. The economic downturn is likely to exert its impact through a series of interlinked factors, but studies unanimously agree that job-related problems, particularly unemployment, are the key determinant risk factors for mental-health related difficulties.

I shall briefly review the cross-sectional and longitudinal studies relating to unemployment. It follows that unemployment is a major concern in times of an economic crisis. Prospective studies unsurprisingly show that unemployment has a causal influence on depression². Common sense dictates that depression will reduce chance of re-employment and reintegration into an already strained economy and eventually the chronically unemployed suffer increased debts. Longitudinal data shows that financial difficulties lead to increased major depression³, with housing payment problems and consumer debt leading to poorer mental health. In short, the quintessential “vicious cycle.”

But why are the implications of unemployment on mental health so vast? The importance of a job is best described by Professor Peter Warr, who proposed nine environmental features which affect occupational mental health on the basis of psychological and sociological studies. He argues

that an occupational environment allows for an individual a degree of autonomy over activities and events within their job scope. It also provides for utilisation of skills, and it is expected that workers in jobs with greater opportunity for skill use will be mentally healthier than those with restricted skill opportunities. On an interactive level, the occupation provides availability of money and subsequently a sense of physical comfort and increased autonomy. It also provides an opportunity for interpersonal contact and a valued position in society. Hence, the individual who loses his job experiences negative impacts on the mental health several fold; in material comfort, self-esteem and social niche.

In relation to the 5 components of mental health, longitudinal studies indicate significant deterioration in **affective well-being** after job loss⁴, with individuals scoring lowly on separate indices of affective well-being such as content, anxiety and depression. **Competence** is expected to decline following unemployment because of loss of skills which might be applied in future jobs⁵. The constraints of unemployment might be thought also to cause reduction in **autonomy**, with studies showing that belief in personal self-direction and locus of control decrease.

Those keeping their jobs are not immune to the effects of the crisis. The adverse effects of unemployment become apparent way before actual job loss. Anxiety about job insecurity complicates existing depression and acts as a chronic stressor with cumulative effects over time⁶. On the basis of the five components of mental health, job insecurity most likely affects the aspects of **autonomy** and **aspiration**. The autonomy of the individual to determine and control his workload is threatened by the contraction of the workforce as this usually implies that the remaining employees bear an expanded portfolio. The aspiration of the individual to pursue opportunities of employment is restricted by fewer choices and more stringent job requirements in the labour market.

Insult to these components of mental health leads the anxious working individual down a slippery slope. Catalano et al, using a labour market model, hypothesised that tolerance for behavioural and physical deviance may be reduced in times of an economic crisis following anxiety of job insecurity. The self-inflicted decrease in psychological strength has serious implications, as commercial firms are likely to lay off workers who are seen to be less productive because of behavioural or physical problems caused by their mental insecurity, leading them down the series of insults to health relating to unemployment.

The working environment is critical to good mental health and productivity. Professor Cary Cooper (Vice Chancellor and Professor of Organisational Psychology and Health at Lancaster University) has stated that "what makes people ill is the way they are managed. Management style is important and because of the economic downturn, we will see more bullying in the work place and in a more robust style".

Having analysed the effect of the economic crisis on the individual in the context of (un)employment, what necessarily follows is a series of coping mechanisms for the new stressors. This could be variable in severity and prevalence, but the most popular are alcohol and substance misuse and suicide which are pertinent areas of study in psychiatry.

A significant proportion of the unemployed will resort to alcohol and substance misuse⁷. Trend cycles show that an economic downturn is often associated with binge drinking. Within Europe, pronounced job losses (more than a 3% increase in unemployment rate) is strongly associated with an increase in alcohol-related deaths⁸. One can expect alcohol misuse to lead to increased dependence and greater pressures to their strained pockets which could rapidly lead to increased socioeconomic problems as they resort to petty and violent crimes. In an economic crisis, the impact on mortality and morbidity is exacerbated where people have easy access to unhealthy coping mechanisms. This is evident in the former USSR during the post-communist depression. In the interest of monetary gains, entrepreneurs began manufacturing creative variants of the

traditional alcoholic drinks which cost much less but have the same or more damaging effects, which increased the prevalence of substance misuse-related mortality⁹.

Others may slide down the depression scale so quickly that suicide becomes an easy option of relief. In the EU, there is a close correlation between national unemployment and suicide rates, with every 1% increase in national unemployment being associated with a 0.8% rise of suicide in people under 65 years of age¹⁰. Suicide appears a more popular coping mechanism in Asian cultures, who uphold the concept of 'saving face' instead of continuing life with little self-esteem, a mentality reminiscent of the hara-kiri culture. In the year following the 1997 Asian financial crisis, suicide rates among men rose 45% in South Korea, 44% in Hong Kong and 39% in Japan, on a background of Internet-organised group suicides¹¹.

Whilst the above data may be predictable, epidemiological data from history do not always concur. Despite the iconic image of businessmen jumping from their window ledges in Wall Street during the Great Depression, mortality rates from suicide in America actually fell by 10% during that entire period. On the contrary, the post-communist depression era which saw an economic decline of similar magnitude witnessed suicide rates increase by 20%. The Asian Financial Crisis, whilst producing increased suicide rates in East Asia, caused no obvious change in death rates in Malaysia and only short term rises in Indonesia and Thailand.¹² This observation has implications for public health measures for the current financial crisis – were the protective factors in these countries purely cultural and/or situational or were they attributable to a strong social support service?

*The World of the Mind*¹³, a 1987 publication by Professor Derek Davis stresses that mental health in the modern era is characterised by good interpersonal relationships and successful interaction with other environmental units. Conversely, the mentally unhealthy are likely to suffer from interactions with their surroundings and cause problems to the people around them, particularly within the family unit. The implications to the mental health of the family unit are severe.

Child neglect and abuse, a convenient outlet for the individual's sense of frustration and exasperation is a critical issue amongst the unemployed, with research consistently highlighting that job loss and inability to find work are more common among known abusers than what should happen by chance¹⁴. The causal interpretation between unemployment and abuse is difficult because of significant correlations between maltreatment and a wide range of indices of social deprivation in addition to unemployment. Nonetheless, a marked rise in abuse will lead to a future generation plagued with a significant risk of certain personality disorders and post-traumatic disorders, which place a huge burden on the suffering individual, society as well as the responsible health services

Debt usually hits the poorest and most vulnerable worst: 64% of people with annual incomes less than £9500 report debt, compared with 4% of the other UK adult population. Poverty is a major socio-economic risk factor for mental health problems, disorders and even suicide. The potential consequences of a downwards slide in the social ladder are pervasive not only on the individual, but also the family unit. Relationship problems arising from financial difficulties during unemployment have been particularly emphasised in multiple studies, and a husband's unemployment was associated with anxiety and depression amongst wives.

Researchers from Iowa State University's Institute for Social and Behavioural Research say that children from families that fall into poverty can show poor mental health by the time they become teenagers. They came to this conclusion in a study of 485 Iowa adolescents from 1991 to 2001¹⁵. The cognitive, social and emotional deficits to children growing up in extreme poverty are crucial in child psychiatry and resonate in behavioural disorders. Early socio-economic adversity experienced by children may also disrupt their successful transition into adulthood by endangering their social, academic and occupational attachment as young adults. The main finding shows the

continuity of family adversity over generations—from family of origin to a young adult's family. In other words, it is transition of poverty.

On the international stage, many developing countries will suffer from mental health problems related to physical illness. As it stands, many third world countries with substandard healthcare are plagued with diseases like malaria, tuberculosis and HIV/AIDS. These populations are reliant on meagre subsidies from their governments for cure or subsisting survival, and a huge amount of help from governments of developed countries and waiving of intellectual property rights. In the wake of the crisis, there is growing concern that funding for treatment and research of these diseases will suffer¹⁶. Resources for disease surveillance and laboratory capacity are often cut back which may seriously affect the mitigation of emerging epidemics and pandemics. Individuals in these populations will then experience increased depression and anxiety from the physical symptoms of the illness, while their family members share the burden of mental health as well as the potential psychological consequences of an imminent and actual bereavement.

The increase in psychological disorders during an economic crisis is manifold. The subjective features of mental health problems translate into an increased use of GP consultations¹⁷ as well as the use of mental health and support services. The financial downturn also makes private healthcare much less viable for an increasing number of people¹⁸ particularly in developed countries like the UK where a substantial proportion of the population tend towards private healthcare. This might reflect the situation in Asia in 1998, when there was a significant shift of patients from private hospitals to public health facilities¹⁹, and if this happens in the UK, the ability of the NHS to deal with this increasing burden will be put into question.

The current situation is likely to worsen, with recent World Bank data estimates that an additional 100 million are expected to fall into poverty at the current rate of economic decline. The mental health situation is exacerbated by expected reductions in public sector expenditure on health services. The NHS was tasked to reduce expenditure in 2010 by £2.3 billion – and if the past is anything to go by, mental health is most likely to experience the most severe cut in budget allocation.

While the NHS does not feature highly on the newest emergency budget cuts, the mental health profession has learnt from history that it is not a priority even within the NHS. Rethink²⁰ highlighted significant cuts in mental health services in places ranging from Cambridgeshire to London, causing closures of acute mental health service wards, occupational therapy clinics and loss of rehabilitation beds. This is a trend which is likely to continue into the next few years, and one wonders how the mental health establishments will cope with a decreased financial allocation and an increased demand for mental health services.

The silver lining to this economic downturn is its positive outcome of placing understated mental health issues into the spotlight. While it would be ideal to solve the underlying problem of the economy, this is best left to government policy-makers, and the health service is best left to deal with what it does best. The next course of action for mental health services is to make sense of the behavioural models relating to economic crises and devise actions to alleviate the impact of the economic crisis.

One of the most contentious points from available studies is the presence of causality between economic insecurity and suicide rates. Malaysia detached itself from the common-sense association of unemployment and suicide rates when it ignored the advice of the international financial community to reduce spending on social protection²¹. Closer to home, suicide rates in Sweden and Finland decreased despite substantial increases in unemployment rates²². This may be attributed to the Nordic social welfare model which produces high social protection and labour market programmes²³, as well as national suicide prevention activities. It is now up to the UK to

decide on whether to emulate its Nordic neighbours at implementing labour market programmes, as studies have shown that efforts towards job maintenance and re-integration of workers into the workforce helps reduce suicide rates. These support services boost the majority of the 5 components of mental health described earlier, especially in the more objective behavioural aspects of competence, autonomy and aspirations of the individual.

Expanding beyond active labour re-integration, countries which have shown alternative sources of social support have also shown a reduction in adverse health effects like depression, anxiety and suicide. Research in the former USSR showed how these mental health problems were substantially reduced when many people were members of trade unions or sports clubs²⁴. This is hardly surprising, as the presence of a support system as an alternative to the family unit can be comforting to the depressed or anxious individual.

Controlling the popularisation of unhealthy coping mechanisms is also a key public health measure. High profile reports of suicides such as recent coverage by France Telecom may provoke imitation and suicidal ideations in an otherwise stable though psychologically vulnerable individual²⁵. As alcohol problems and mental health are also closely related, it would be wise to restrict any rise in alcohol or drug accessibility during these times, and perhaps even consider a more stringent alcohol taxation protocol²⁶.

On a larger scale, the 2004 WHO declaration on mental health in Europe calls for work on social inclusion of stigmatised groups, amongst them the impoverished and unemployed. It is committed towards providing education, information and support programmes targeting these high risk groups, as well as the implementation of community development programmes.²⁷ We hope that national health authorities worldwide embody the commitments of the declaration, which are predicted to have a positive impact on the social interaction, niche and status of the financially strained individual in society.

The ultimate impact of the current crisis on mental health and its associated services will not be known immediately, but from history we can predict that the outcomes are not likely to be positive. A careful evaluation of any proposed short term budget cuts is urgently needed. It would be sensible to avoid cuts that would eventually cost the health service more; and even more crucially we have to recognise and embrace the key steps that may ameliorate the detrimental effects of this economic crisis.

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