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The Pathogenesis of Oppression:
How Social Injustice is Making Us Sick

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Introduction

- Mental health as a social science rather than a medical science
  - psychology, cultural studies, women's studies, literature/humanities
- Cross-cultural research on mental health issues (e.g., depression)
- Working with very low-income communities in New York City
- What's missing in our analysis of mental health problems?
- An analysis of *oppression* as a precipitating factor

Current Recommendations

- We need to reduce stigma about psychiatric illness
- We need to increase access to psychiatric care among the under-privileged
- We need to decrease the cost of psychiatric drugs
- We need to recruit more women and minorities into the psychiatric profession
- We need to increase public awareness about mental health issues
- We need to implement widespread screening programs to ensure that disorders are properly diagnosed
- We need to educate the public about the rise in psychiatric disorders among adults and children
- We need to monitor psychiatric patients to ensure proper adherence to medications

Challenging the Psychiatric Paradigm

- Begins with understanding the tension between *provision of care* and *social control*:
  - Foucault: institutions as a form of surveillance
  - Metzl: "the protest psychosis"
- *Question*: who benefits from the current standard treatments?
- What if we assume that psychiatric care is driven – at least in large part – by profits?

Laura Smith

- "Oppression as Pathogen"
  - against the traditional notion of mental illness being caused by factors *internal* to the person
  - Smith argues that we can best understand causes of mental illness by looking at sources of oppression: poverty, racism, violence

Isaac Prilleltensky

- **Psychopolitical validity:**
  - **understanding the complex workings of oppression, especially the effects of oppression on marginalized groups**
  - **developing effective strategies for promoting psychological and political liberation: paying attention to the personal, relational, and collective domains**

Real World Example: “Tommy”

Tommy was adopted at age 2 and by age 3 his parents noticed he was very withdrawn, hardly speaking or looking others in the eye. He often seemed sad and kept to himself. At age 5, his parents took him to a psychiatrist who specializes in children. He said Tommy was showing signs of feeling depressed and that he would experience full-blown depression within a few years unless he was given treatment now. He prescribed medication to ease the symptoms. He said “Bring Tommy back to see me in six months and I promise he’ll be a new boy”.

What happened next?

Real World Example: “Tanika”

Tanika is a 56 year old immigrant woman from South Africa. She recently learned of the sudden death of her grandmother back home. She has been crying constantly and will not speak to anyone. Her husband brings her to the emergency room of a general hospital because he is worried she may do harm to herself. Upon arrival, she is very distressed and agitated. The psychiatrist on duty meets with her and suggests that she stay in hospital over night. At her husband’s urging, she agrees to stay. In the morning, she tells the nurse she wants to leave because she’s feeling better. She says her elders came to her shoulder at night and spoke to her, telling her that her grandmother was at peace.

What happened next?

What Works? Possible Alternatives

- **The ROAD Project (Lisa Goodman and colleagues):**
  - **uses a relational advocacy model: pairs low-income, depressed women with advocates who help them navigate the welfare system, housing restrictions, disability benefits, etc.**
- **Anti-Oppression Advocacy (AOA)**
- **Poverty Transition Programs**

Anti-Oppression Advocacy (AOA)

- aims to counteract the systemic lack of understanding of the *strengths* and *challenges* of marginalized groups
- assumes that occupying the margins provides an important vantage on power relations (bell hooks: margins as a space of resistance)
- emphasizes *advocacy* over *treatment*

Principles of AOA *(Race, Gender & Class, 2011)*

- ***Training as Un-Training:***
  - **subverting models of "expertise"**
  - **counteracting the assumption that diagnosis leads to better treatment**
- ***Social Capital Advocacy:***
  - **connecting those in poverty to material resources**
- ***Partnerships as Activism:***
  - **hospitals and universities following the lead of community activists**
  - **valuing emancipation over empowerment**

Poverty Transition Program: Study (Am. Jn. Orthopsychiatry, 2010)

- Living in poverty increases one's risk of developing depression and other conditions
- *How can we study alternative ways for enhancing mental health and well-being in low-income groups?*
- This study examined a poverty transition program in Harlem


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Project Enterprise

- Serves clients living below the poverty line (mostly clients of color)
- Peer-group, micro-lending model:
  - based on “international development” model
  - peer-group training, small micro-credit loans, shared accountability for loan payback
- Highly successful
  - loan payback rate over 92%
  - successful businesses have impacted the local community

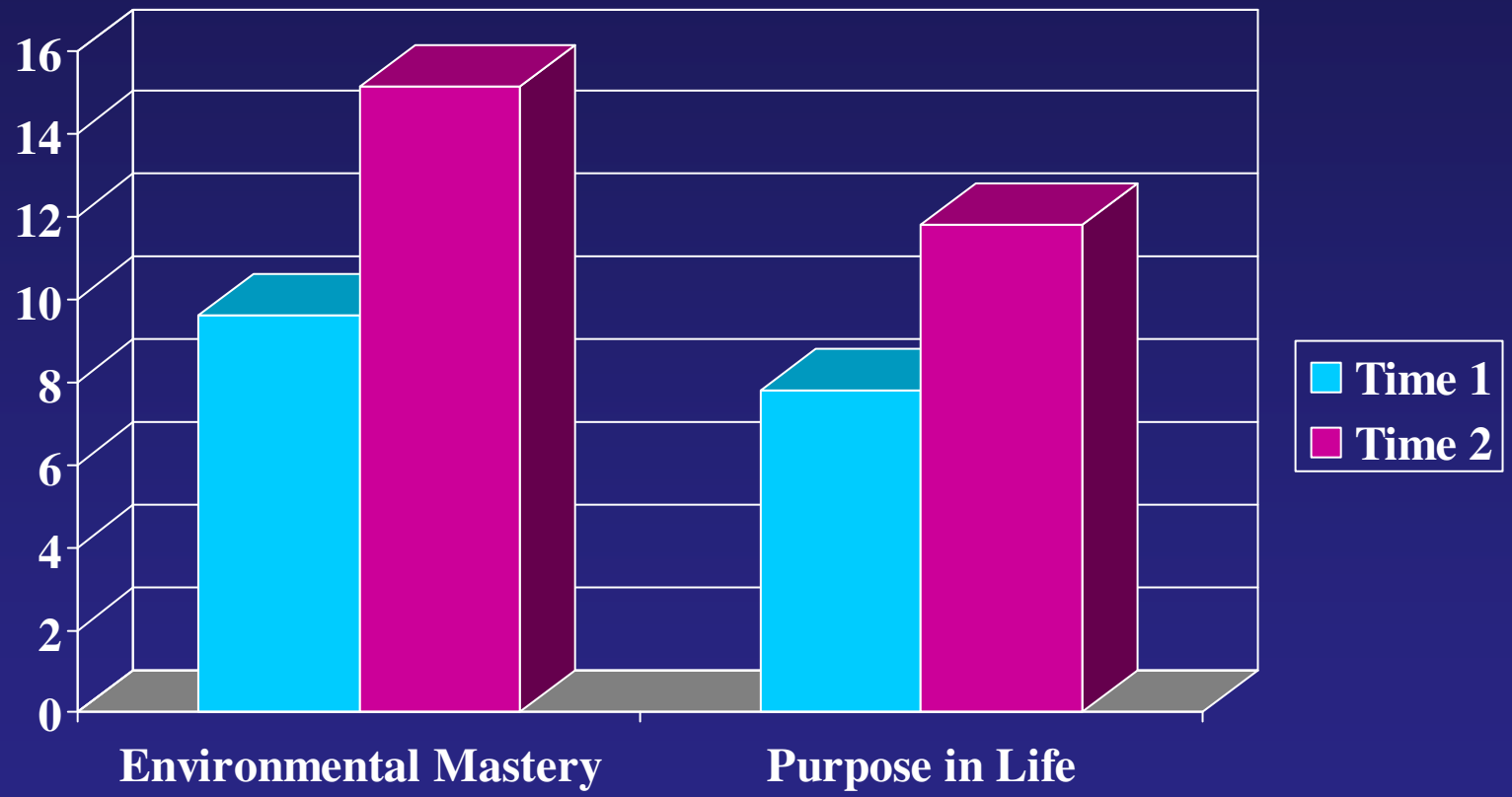
The Study

- Can this peer-support poverty transition program significantly impact the mental health of low-income clients?
- What aspects of the program are most helpful to clients in enhancing well-being?
- Participants: 59 current clients
- Collected data on depression and psychological well-being before participant began training (Time 1) and again after six months in the program (Time 2)

Results: Depression

- At Time 1: 28 participants met *SCID* criteria for depression
- At Time 2: 17 of those participants met *SCID* criteria for depression (39.3% recovered)
- This recovery rate is comparable to rates of treatment using medication and psychotherapy

Results: Psychological Well-Being



Why does it work?

- Thematic analyses were conducted on interviews to derive a set of themes
- Participants who showed the most significant recovery reported that *sense of connection* to other clients was the strongest factor in their experience in the program

Looking Ahead: The Biggest Challenges

- Educating the public about the risks of psychiatric medication
- Counteracting assumptions about drug therapy and psychotherapy as superior to community-based care
- Supporting a system that is fundamentally predicated on conflict of interest