Living in Health and Mental Health Despite Poverty

Linda Beeber

J Am Psychiatr Nurses Assoc 2007; 13; 27
DOI: 10.1177/1078390307302220

Guest Editorial

Living in Health and Mental Health Despite Poverty

People living in poverty have always borne a higher prevalence of mental illness. Through the years, two competing explanations existed: the "social selection" theory (people who are mentally ill drift into poverty) and the "social causation" theory (the adversity and stressors brought on by poverty are powerful enough to create mental illness), but the question remained: "Chicken or egg?"

In 2003, a remarkable natural experiment in the mountains of North Carolina produced evidence in favor of the explanation that poverty is a root cause (Costello et al., 2003). Between 1993 and 2001, a longitudinal study of the development of 1,420 low- and middle-income children was done. Each year, the children received a formal psychiatric evaluation. Roughly 25% of the children were American Indians. Halfway through the study, a casino opened on the reservation, and every Indian family was given a monetary supplement, which moved 14% of them out of poverty. The results in these children were remarkable; at the start of the study, the children whose families were living in poverty had significantly more psychiatric symptoms than the never-poor children, but after the casino opened, levels of oppositional-defiant disorders and conduct disorders among the ex-poor fell to those of the never-poor children. The levels of disorder among the children who stayed in poverty remained high. These changes occurred in merely 4 years—and the variable that changed was the movement of the families out of poverty. Explanations included more parental energy to invest once a stable income had been achieved, greater respect for parents by children, and overall greater self-esteem and self-valuing, which led to more favorable conditions for child development. What was striking was that the alleviation of one major stressor opened the door to the potential for greater mental health in a population that had endured adversity for generations.

DOI: 10.1177/1078390307302220

Mental health is now considered one of the major determinants of health and the ability to reach the full human developmental potential and productivity throughout the entire lifespan. The World Health Organization (WHO) lists mental health issues as top causes of disability for both men and women worldwide, with poverty as one of the major contributors (Murray et al., 1996). The specialty of psychiatric mental health nursing is in an ideal position to advance the science, practice, and policy in regard to poverty as a major threat to mental health.

Poverty in the United States exists alongside astonishing wealth and prosperity. The aftermath of Hurricane Katrina brought the faces of the U.S. poor to the nation and raised the discomfort of some and the righteous condemnation of others. In a short time, the faces faded away from the media, but the facts remain:

- 7.7 million U.S. families live in poverty (20.5 million citizens); it is estimated that as many as 30% of working families with one or more adults working full time still earn less than the poverty threshold (federally determined income level needed to support basic needs for a family) or have trouble meeting monthly expenses
- 35% of our children live in poverty
- 3.6 million elderly live in poverty and this number is increasing every year with the aging of our population
- Approximately 39% to 50% of our citizens living in poverty have a diagnosable mental illness (Mauksch et al., 2001)

In the United States, poverty has always carried a message of moral failure and stigma similar to that associated with mental illness. Our programs to alleviate poverty have been inconsistently implemented and subject to fluctuating availability of state resources. The challenges to us as psychiatric mental health nurses are compelling, especially as mental health care moves increasingly to the communities to manage.

Throughout our history as a discipline, psychiatric nurses have cared for the least economically resourced in public institutions across the United States. However, we have not stopped there. We have led the development of community mental health through innovative programs in storefronts, Assertive Community Treatment initiatives, domestic violence shelters, and transitional housing units that reach underserved, low-income populations. We have worked with low-income families caring for their own to build supportive services and to educate the communities in which these families live. We have researched the causes, predictors, and interventions that create disparities in mental health services for low-income populations. We have pioneered the delivery of mental health services by moving out of the office and hospital and taking interventions directly to the clients whose entrenchment in poverty makes accessing traditional services difficult. Finally, we have implemented new educational programs and used distance technologies in the United States and internationally to educate students from underrepresented groups to become psychiatric nurses. Our initiatives have been cutting-edge in part because our base is nursing, where mental health is seen as part of a larger "whole" of health and our focus is on the "living in health and mental health" of the individual, family, group, or community—not the illness.

On October 23, 2008, more than 140 scientific journals around the world will publish special issues devoted to poverty and human development. *JAPNA* will join that effort with an issue focusing on poverty and mental health. The perspective of nursing and of psychiatric mental health nursing is critical because we have been at the front of many innovative, community-based initiatives to work with people in poverty and create environments where their personal development and potential to achieve mental health are nurtured. Nursing is a needed perspective in a world where resources are finite and high-tech solutions threaten to dominate how global health resources are spent and on whom they are spent. Let us use this opportunity to struggle with the questions of what is required to create global mental health and how we can advocate for it. Let us make our contributions visible to the world by entering this global dialogue on October 22, 2007. We invite you to submit manuscripts for consideration on this important initiative. You will find information about this call for papers at http://www.sagepub.com/upm-data/13774_JAPNACFPSpecialIssuePoverty.pdf.

Linda Beeber, PhD, APRN-BC, FAAN
The University of North Carolina at Chapel Hill

REFERENCES

Costello, E. J., Compton, S. N., Keeler, G., & Angold, A. (2003). Relationships between poverty and psychopathy: A natural experiment. *Journal of the American Medical Association, 290*, 2023-2029.

Mauksch, L. B., Tucker, S. M., Katon, W. J., Russo, J., Cameron, J., Walker, E., & Spitzer, R. (2001). Mental illness, functional impairment and patient preferences for collaborative care in an uninsured, primary care population. *Family Practice, 50*(1), 41-47.

Murray, C. J., & Lopez, A. D. (1996). Evidence-based health policy—lessons from the global burden of disease study. *Science, 274* 740-743.