

Selfish capitalism and mental illness

In the last 30 years there have been hundreds of community surveys of mental illness prevalence, and over 200 of European samples (Fryers *et al.*, 2004). Unfortunately, methodological differences have made comparison of results problematic. The WHO World Mental Health Consortium study (2004) is an attempt to overcome these shortcomings (Oakley Browne *et al.*, 2006).

Nationally representative community samples (with the exception of China) have been selected, using the same selection methods. Subjects have been administered the same instruments, with care taken to employ the same interviewing techniques, including standardised training of interviewers. Thus far, results have been published for 15 of the 25 nations in the study (see table) and they are intriguing.

It might be argued that the six-fold differences between some nations (e.g. USA vs. Nigeria) reflects greater awareness of mental illness. I believe this objection is, indeed, applicable to soft measures of 'happiness' or 'life satisfaction' based on simplistic single-question five-point scales. But if



OLIVER JAMES argues that cross-cultural differences in emotional distress stem from a country's governance.

psychiatrists are good for anything it is the refining of measures of psychopathology, and considerable care was taken in constructing the WHO interview schedules to avoid cultural bias.

Whatever one's view of this problem, for the sake of argument, let us suppose that these results do truly reflect the amount of mental illness in these countries. What would explain the substantial differences? In particular, where we are comparing (developed nation) like with (developed nation) like, what explains the twofold disparity between the average for mainland western Europe and Japan combined (11.5 per cent) with the average for the USA and New Zealand combined (23.6 per cent)?

Whatever else might be involved, it is extremely unlikely to be genetics. Much more plausible is that socio-economic factors wholly or largely explain the WHO findings, and I propose the following thesis: that 'Selfish Capitalism' largely accounts for them (James, in press).

Whilst similar in some respects to Market Liberalism, Selfish Capitalism (SC) has four distinctive elements:

- evaluation of business success largely on the basis of current share price;
- a strong drive to privatise collective goods, such as water, gas and electrical utilities;
- minimal regulation of financial services and labour markets, including working practices which strongly favour employers and disfavour unions, permitting ease of hiring and firing; and
- the conviction that consumption and market choices can meet human needs of almost every kind.

On the basis of the presence or absence of these characteristics, I regard the principal English-speaking nations (the USA, Britain, Australia, Canada, New Zealand) as having SC political economies, whereas mainland Western European ones are

relatively Unselfish Capitalist (UC). In this formulation, the USA might be regarded as the apotheosis of SC governance, Denmark the nearest thing to an UC society.

Compared with UC nations, as a

Evaluating success largely on the basis of share price

consequence of being SC, the ones I so label have the following characteristics (drawing heavily for this evidence on Offer, 2006; see also International Labour Office, 2004): larger disparities in wealth between the top and bottom 20 per cent of earners, higher proportions of the population earning less than half the average wage and larger concentrations of wealth in elites of very rich citizens; mortgages compose a larger proportion of household expenditure; personal debt is larger and per capita credit card ownership is greater; personal savings are lower, often averaging nil or less than zero; average hours worked are longer; and economic security is less.

Above all, in explaining prevalence of mental illness, SC developed nations would seem to be more materialistic than UC ones (Ger & Belk, 1996). And what is the impact of this materialism? A series of studies, mostly by Tim Kasser and his colleagues (Kasser, 2002) using their criterion-validated Aspiration Index and defining materialism as the placing of a

Cross-cultural suffering

Nation	% (see below)
USA	26.4
New Zealand	20.7
Ukraine	20.5
France	18.4
Colombia	17.8
Lebanon	16.9
Netherlands	14.9
Mexico	12.2
Belgium	12.0
Spain	9.2
Germany	9.1
China (Beijing)	9.1
Japan	8.8
Italy	8.2
Nigeria	4.7
China (Shanghai)	4.3

% suffering depression, anxiety, substance abuse or impulsivity-aggression in a one-year period. All prevalences from Demyttenaere *et al.* (2004), except New Zealand (see Oakley-Brown *et al.*, 2006).

high value on money, appearances (social and physical) and fame, demonstrate that materialism consistently correlates with mental illness. Kasser reports studies with samples from 14 different nations, which show that highly materialistic people are significantly more likely to suffer depression, anxiety, substance abuse and personality disorder. Focusing on materialist motives and goals – but especially motives – has been shown to prevent people from meeting four fundamental human needs: for security, community participation, feelings of competence and autonomy (Kasser, 2002). People who do not meet these needs are at greater risk of mental illness (James, 2007a; Kasser, 2002; Ryan, 1995).

Selfish capitalism theory's most important prediction is that citizens of such societies are more likely to suffer than those in UC ones: since SC societies are more materialistic, higher proportions of their populace are not meeting fundamental needs, creating higher prevalence of mental illness. This has been tested in two ways (James, in press).

The first is by comparison of SC and UC nations. As noted, the WHO study finds twice the prevalence of mental illness in the English-speaking nations compared with mainland Europe and Japan. Much more contentiously – since it entails comparison of results using differing methods – further analysis comparing SC English-speaking with UC nations (mainland Western European and Japan), also finds large disparities in prevalence (James, in press). When results for Britain (23 per cent), Australia (23 per cent) and Canada (19.1 per cent) are added to the USA (26.4 per cent) and New Zealand (20.7 per cent), these SC nations have twice the prevalence of the UC ones.

The second test of the theory examines time-trends in mental illness prevalence in societies which have moved from relatively UC to SC political economy. From the late 1970s onwards, driven by Thatcherism, Reaganomics and more recently, 'Blatcherism', the English-speaking nations became substantially more SC, albeit with differing rapidity (Hamilton & Denniss, 2005; Offer, 2006). Whilst prevalence of mental illness may have been already increasing compared with 1945 in these nations (James, 1998), did this accelerate the rate of increase?

Nationally representative samples of Americans were questioned about their

emotional well-being in surveys originated by Joseph Veroff in 1957, 1976 and 1996. The same basic instruments were employed in each study, making it an almost unique project in its temporal sweep. A key question was 'Have you ever felt that you were going to have a nervous breakdown?'. 15 per cent more replied 'yes' in 1976, compared with 1957. Between 1976 and 1996, the proportion who gave this answer was two thirds higher than that (Swindle *et al.*, 2000). Of course this finding is open to the objection that, just as cultures may vary in their awareness of mental illness, so may generations. But this is at least a possible indication that American rates were increasing faster after 1976, a period in which SC governance was increasing (Offer, 2006).

In Britain, three large, nationally representative samples born in the same weeks in 1946, 1958 and 1970 have been questioned when in their thirties or early forties (Ferri *et al.*, 2003). For most measures, rates of illness had almost doubled between people born in 1946

(aged 36 in 1982) and 1970 (aged 30 in 2000). Substantial rises were also identified by Glyn Lewis (Lewis & Wilkinson, 1993) between 1977 and 1985 in large, nationally representative British samples. A particularly poignant case in point is that of girls from the 'upper' social classes I and II. A British study surveyed large samples of 15-year-olds in 1987 and again in 1999, finding a startling leap in illness among the class I and II girls, from 24 per cent to 38 per cent, and little increase among class IV and V girls (West & Sweeting, 2003).

But perhaps the most striking example is what happened in Australia just between 1997 and 2001, a period of particularly accelerated SC governance there (Hamilton & Denniss, 2005). It so happened that prevalence of mental illness and psychological distress were measured in two nationally representative samples of Australians in 1997 and again in 2001 (Australian Bureau of Statistics, 2003a).

Although measures of mental illness based on ICD-10 (Australian Bureau of Statistics, 2003a) did not find an increase,

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those using the Kessler K10 instrument (Australian Bureau of Statistics, 2003b) for measuring psychological distress did. Overall, the proportion who were psychologically distressed in 2001 – such that they would urgently require treatment – had increased by two thirds compared with 1997. For women, it had nearly doubled, with the most dramatic increases

among the under-forties. Levels had also risen substantially among those with high or moderate levels of distress (Australian Bureau of Statistics, 2003b).

Of course, SC theory is by no means the only possible one for explaining the WHO results and the trends detailed here. For example, with colleagues, I have demonstrated a strong, linear, statistically significant relationship between levels of inequality in the developed nations in the WHO study and prevalence of mental illness (Pickett *et al.*, 2006). To what extent inequality is regarded as an independent variable rather than as dependent on SC governance is debatable.

In explaining cross-national prevalence of mental illness it would be of interest to explore the independent causal roles of such factors as individualism as opposed to collectivism (Oyserman *et al.*, 2002), anomie (Durkheim, 1952), alienation (Mirowsky & Ross, 1989), culture (Goodwin, 1999) and self-enhancement (Mezhulis *et al.*, 2004), to name but some. Many of these may also be correlated with

SC and with each other; disentangling causes and effects will prove complex.

Selfish capitalism theory offers a real alternative to the genetic and evolutionary hypotheses which have become so popular in recent years as the theoretical context for far too much research. It provides a falsifiable explanation of cross-national prevalence of mental illness, proposing close scrutiny of contemporary psychosocial and economic trends, and their relationship with structures of governance.

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DISCUSS AND DEBATE

Do large cross-national differences in mental illness prevalence cast doubt on the degree to which genes are a major determinant of mental illness?

Apart from Selfish Capitalism, what might explain a twofold difference in mental illness prevalence between English-speaking and Western European nations?

Should psychological evidence be the main foundation of political governance?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.psychforum.org.uk.

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Richard Ryan's self determination theory:

www.psych.rochester.edu/SDT

Avner Offer:

www.history.ox.ac.uk/staff/postholder/offer_a.htm