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Political

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Stress as Personal and Political

ABSTRACT. Chronic stress has a profound, and profoundly negative, influence on health outcomes; it is one of the mechanisms by which health outcome inequities are reproduced (Thoits 2010). Work on the social determinants of health has made it clear that social and political decisions regarding the basic organization of society are the main factors determining how much stress, and what kinds of stress, different parts of the population will experience. But, in both the technical literature and in more "popular" venues, there is an emphasis on the ways in which individuals can, through individual actions ("self-care"), reduce the harms associated with the stress that they are likely to suffer. As well-meaning as those projects may be, one result is that individuals, many of whom are already socially disadvantaged in a number of ways, end up being seen (and seeing themselves) as responsible for their own failures to adequately ameliorate the stresses that they suffer. Early criticisms of the self-care movement in the US stressed the ways in which it could be, in Sidel and Sidel's memorable phrase, "diversionary from struggles for radical change in both medicine and the broader society" (1981). Today, the diversionary attention to "self-care" grows alongside the growth of strong scholarship making clear that addressing the health inequities and poor health outcomes in countries like the US will indeed require radical social change.

INTRODUCTION: THE MOVE FROM THE SOCIAL TO THE PERSONAL

Recently, an article by Toshiko Tanaka, Takao Yamamoto, and Masahiko Haruno garnered a fair bit of media attention; in "Brain response patterns to economic inequity predict present and future depression indices" (2017), they reported research that purported to show that "pro-social" individuals were more upset by unequal outcomes that didn't directly disadvantage them than were "individualists." Further, being pro-social was associated with a higher chance of developing depression

(2017). They linked this research with research showing that economic inequality is associated with poor health outcomes, including higher rates of depression. (They cite the epidemiologists Richard Wilkinson and Kate Pickett's 2006 work on income inequality and population health, and Michael Marmot et al.'s classic 1991 "Whitehall" study, which linked low job status to higher mortality risk in the British Civil Service.) The implication seemed clear—societies that were organized in ways that produced extreme income inequality were also very likely those that seemed "unfair" to pro-social individuals; thus, part of the explanation for the higher rates of depression in such societies could be attributed to the depression that resulted from pro-social individuals being upset at the unfair outcomes to which they were exposed (and everyone being upset by those unfair outcomes that disadvantaged them directly).

Tanaka, Yamamoto, and Haruno's framing of their work in terms of the research on the impacts that inequality has on population health would seem to carry some straightforward policy implications. Michael Marmot and Ruth Bell, in their "Fair Society, Healthy Lives," argue that a key to improving population health is to create societies that are "fairer"—in which there is greater fair equality of opportunity and in which overall inequalities are smaller (2012). If indeed part of what is responsible for the higher level of depression in less equal societies is that they are perceived by their members as "unfair," then improving population health by working to make societies more "fair," following the sorts of suggestions made by Marmot and Bell, would be an obvious path.

But these suggestions do not make an appearance in the original article, nor do most of the popular articles reporting on Tanaka, Yamamoto, and Haruno's work draw those conclusions. Instead, many of the articles pick up on the comments of Mauricio Delgado (a neuroscientist at Rutgers), who suggests that people with pro-social tendencies might find psychotherapy useful in order to better control their emotional responses to inequality, and thereby reduce their risk of becoming depressed (see e.g. Turban 2017 for *Scientific American*; Hong 2018 for *Reader's Digest*). This is the approach that neuroscientists Megan Speer and Mauricio Delgado took in their review of Tanaka et al.'s research; they state for example that it "is also worth considering whether engaging in strategies aimed at enhancing positive feelings, such as reminiscing about positive memories (which has been shown to reduce the HPA axis stress response), would also be effective for diminishing negative feelings associated with unfairness" (Speer and Delgado 2017, 712). While they note the existence

of "growing economic inequality across society" (2017, 711), they take this to be a raw fact, and do not draw any conclusions from it.

In Geoffrey Rose's classic paper linking epidemiology to public health, "Sick Individuals and Sick Populations," he distinguishes between research that aims to discover the etiology of individual illnesses (why did this person rather than that one contract this disease?) and research that aims to discover the etiology of the incident rates of illnesses within populations (why is the incidence of this disease higher in this society than in that one?). The answers to these questions are often very different, and Rose notes that both approaches are necessary, and are not usually in competition. However, he stresses that "nevertheless, the priority of concern should always be the discovery and control of the causes of incidence" (1985, 38). It is there, he argues, that the largest and most important gains in health outcomes can be made.

With respect to the social determinants of health, researchers have done a very good job discovering the causes of incidence; as noted above, researchers like Wilkinson, Pickett, and Marmot have done a remarkable job documenting the factors that are most strongly associated with population-level poor health outcomes. However, *controlling* those causes has proved rather more challenging; while the World Health Organization's "The Social Determinants of Health: The Solid Facts" (Wilkinson and Marmot, eds. 2003) makes many suggestions aimed at improving population-level health outcomes, they have largely not been heeded (see e.g. Marmot 2011).

Indeed, even making recommendations that would address the root causes of poor health outcomes is often seen as too challenging. Peter Hotez's popular piece, "Tropical Diseases: The New Plague of Poverty" (2012), begins by explaining the tight link between poverty and disease risk. Hotez, who serves as the Dean of the National School of Tropical Medicine at Baylor College of Medicine, starts by noting that:

> In some of the poorer counties of Texas, where I live, [poverty] rates often approach 30 percent. In these places, the Gini coefficient, a measure of inequality, ranks as high as in some sub-Saharan African countries. (2012)

He then outlines some of the reasons that poverty leads to high incidents of the so-called neglected tropical diseases:

> The neglected tropical diseases thrive in the poorer South's warm climate, especially in areas where people live in dilapidated housing or can't afford air-conditioning and sleep with the windows open to disease-transmitting

> insects. They thrive wherever there is poor street drainage, plumbing, sanitation and garbage collection. . . . They are the forgotten diseases of forgotten people, and Texas is emerging as an epicenter. . . . A key impediment to eliminating neglected tropical diseases in the United States is that they frequently go unrecognized because the disenfranchised people they afflict do not or cannot seek out health care. (2012)

Hotez, in this, as in his more formal academic research (see e.g. 2018), identifies the root cause of the rise of these tropical diseases in the US as *poverty* (and inequality). But his recommendations seem to miss the mark for 'controlling the causes of incidence' almost entirely:

> We have an opportunity to stop these diseases, but we need to act. First, we need programs of active surveillance and monitoring to obtain more accurate information on the true prevalence of these diseases and how they are transmitted. We also need better diagnostic tests; worm infections like cysticercosis and toxocariasis can often be treated effectively with antiparasitics and anti-inflammatories, but they are frequently misdiagnosed. Finally, we need safer and more effective drugs and new licensed vaccines. (2012)

Hotez has identified a group of diseases caused by extreme poverty. But the recommendation for stopping them is framed entirely in individual biomedical approaches. Nowhere in the article (nor in his more recent 2018 "The rise of neglected tropical diseases in the 'new Texas'") is any policy recommendation that addresses poverty even suggested; but again, poverty is clearly identified as the cause. Hotez is of course well aware of this disconnect, and recognizes the argument that the key to addressing these poor health outcomes is economic development that alleviates poverty; but since "in this economy and politically toxic environment it would be amazing if we could get a few dollars or modest political will" to implement even the article's immediate individual recommendations, these kinds of "baby steps" still represent, in his view, the best place to begin (Hotez 2012, personal communication). But even if such change is politically impossible, if the recommendations for addressing diseases of poverty do not include addressing poverty, something important has, I think, been lost. It may be that change won't happen even with poverty reduction as a major policy suggestion. But if that suggestion is never even made, then those policy recommendations cannot even be discussed, and are likely to go unrecognized.

In short, research into the social determinants of health has made clear that improving population-level health outcomes requires the kinds of

substantial changes in policies that, for example, reduce income inequality, promote social and material security, and encourage social cohesion (see e.g. Wilkinson and Marmot 2003), but calls to make these kinds of changes are often resisted (or simply ignored) by policy makers.[1] In this paper, I argue that, far too often, problems that appear, from one perspective, to be obvious social problems requiring substantive social and political change become, through a subtle redescription, an individual's own problem to solve, through individual actions or efforts. Sometimes, this project of individualizing seems deliberately designed to shift the focus away from the possibility of meaningful social change. At other times, this redescription may instead be a matter of what particular researchers think that they have some chance of changing—they may feel that while they are not able to change the world, that perhaps they can help people change their individual behaviors. But even when such a redescription does not deliberately undermine the possibility of serious calls for social change, it can still be a part of effectively detracting attention from the social roots of the problem, and hence something that makes engaging meaningfully with political and social policy choices more difficult.

This problem is not new. In the next section, I will review some of the history of this problem, through the lens of arguments surrounding the "self-help" movements in the United States in the late 1970s. These older arguments are, I think, worth revisiting, in part because it is easy to see reflections of these same problems today, and in part because they situate the current problem in a broader context. I will then focus on one of the areas in which this problem has been especially pressing—the link between chronic stress and population-level poor health outcomes, on the one hand, and individual suggestions for "self-care" in order to address stress, on the other. My contention is that, just as the previous generation of critics of "self-care" feared, a focus on "self-care" to ameliorate the effects of chronic stress serves the purpose, intended or not, of preventing meaningful engagement with the ways in which contemporary societies are structured such that unacceptable levels of chronic stress become unavoidable for too much of the population. Finally, I will end with some reflections on the role that can be played in keeping a focus on the possibility of social and political change, even by medical and other professions who are, by the nature of their jobs, tasked with treating individuals and are not themselves well-positioned for direct political engagement. Even if, by virtue of one's particular job, one is not well-positioned to engage with social and political change, noting the ways in which such change is necessary to attack the

root causes of illness is both honest, and avoids obscuring (deliberately or not) the actual sources of the problems.

TWO VISIONS OF SELF-CARE IN HISTORY:
INDIVIDUAL VERSUS GROUP PURSUITS

In "Self-Care Is *Not* a Solipsistic Trap: A reply to critics," Alfred Katz and Lowell Levin (both of whom worked primarily in public health) defend "self-care" from the accusation that it often amounts to little more than "victim blaming" (1980, 329). They argue that far from participants being made to feel responsible for their own health failures, self-help groups are "a specific antidote to passivity, apathy, and dependency in the health care area," as these groups are often engaged in "educational and political activities" (1980, 333). In their response to this article, Victor Sidel (a physician who, among other things, help found "Physicians for Social Responsibility" in the 1960s) and Ruth Sidel (a sociologist whose work focused on the effects of poverty) distinguish between "self-care" and "mutual aid," and suggest that Katz and Levin's defense is more appropriate to the latter, and the critique more appropriate to the former:

> It has never been and is not now our view . . . that the self-help and mutual aid movement in the United States is *all* inner-directed, authoritarian, victim-blaming, manipulated by dominant forces, or diversionary from struggles for radical change in both medicine and the broader society. It *is* our view that: (a) some individuals and groups involved in the *practice* of self-care do exhibit the above characteristics, and (b) some of the *theories* of "self-care," as contrasted to a large extent with those of "mutual aid," carry within them potential obstacles to promotion of fundamental change and to effective popular control of the system after it has been changed. (1981, 656, all emphases in original)

This debate points toward the existence of two distinct visions of self-care. The first, what Sidel and Sidel dub "mutual aid," was about people caring for each other outside of the traditional medical profession. It had its roots, in part, in the Women's Health Movement of the 1960s and 1970s, where women were "fighting to gain control of their own reproductive rights" (Nichols 2000, 56). As used in this context, "self-help health groups" were about, for example, women helping *themselves* (as other women), "reclaiming power from the paternalistic and condescending medical community" (Nichols 2000, 56). The "self" here was directly opposed to an "other"—a paternalistic, inattentive, condescending medical establishment—and the "self-help" was in fact "mutual aid"—people

with similar concerns helping each other rather than being reliant on that "other."

The second usage focuses instead on the supposed "power" that individuals have over their own health; this approach, as Levin and Idler put it, is situated "within the traditional health education literature as focused on risk reduction and disease prevention at the level of personal action" (1983, 181). The focus is on "the association of life-style factors with both morbidity and mortality," and so "on personal initiatives to prevent disease and promote health" (Levin and Idler 1983, 190). Individuals are supposed, on this view, to inform *themselves* about the best way to achieve and maintain health, and to act, as individuals, in ways that will promote their individual health. In its strongest form, researchers like John Knowles (known as critic of the American medical system and medical administrator) wrote that the "next major advances in the health of the American people will be determined by what the individual is willing to do for himself. . . . If he is willing to follow Breslow's seven rules for healthy living, he can extend his life and enhance his own and the nation's productivity" (Knowles 1977, 78). The individual becomes responsible not just for their own health, but, again, as an individual making personal decisions about how to live, the individual becomes responsible for the health of the nation.

The first interpretation of "self-care"[2] was pointedly political. Levin and Idler, for example, argue that self-care can be seen "as a political concept involving individual skills in collective action on structural issues," which "had its early expression in the consumer health movement," in the 1960s and 1970s (1983, 181). They write that "the collective action perspective on self-care is found largely within the broader frame of lay initiatives in health, particularly through neighborhood voluntary organizations and mutual aid groups" (1983, 181). According to Nichols, while "individuals within the [Women's Health Movement] had widely divergent goals," there was "one common goal that united them all: 'a demand for improved health care for all women and an end to sexism in the health system'" (Nichols 2000, 56; quoting Marieskind 1975). This was essentially a political struggle, and not something that individuals could expect to achieve on their own. The fight to change childbirth practices was about changing hospital policies and practices, and not primarily about individual decisions (see e.g. Nichols 2000, 57). Helen Marieskind notes forcefully that the National Women's Health Network was, from the beginning, "strongly political in interest" with a focus on "collective

health activities" (1975, 217). "Women," Marieskind writes, "have had the opportunity to discuss their dissatisfaction and recognize its collective nature," and, through the Women's Health Movement, "have social vehicles through which to express this dissatisfaction" (1975, 219). Even health-related activities, which might seem, on the face of it, to be focused on individuals, were, in practice, essentially social in nature as realized in the Women's Health Movement. For example, as historian of science Michelle Murphy makes clear in *Seizing the Means of Reproduction*, the practice of vaginal self-examination (popularized by groups part of and aligned with the Women's Health Movement) was both taught and acquired its meaning in groups; "vaginal self-exam" became "a collective act" through the "small group format" in which it was practiced (Murphy 2012, 57). Murphy notes that this "immodest witnessing" was part of the project of politicized knowledge production—"feminist self-help fostered an affective economy that sought to align women in a collective project of bonding and pleasure through the epistemic value of collectivized observation" (2012, 80).

In the second interpretation, however, self-care is interpreted to mean individuals taking care of themselves, as individuals; self-care refers to "those activities individuals undertake in promoting their own health, preventing their own disease, limiting their own illness, and restoring their own health" (Levin and Idler 1983, 181) or a "process whereby a layperson can function effectively on his own behalf in health promotion and prevention and in disease detection and treatment at the level of the primary health resource in the health care system" (Levin 1976, 206). It is this interpretation that leads to claims about there being an "individual moral obligation to preserve one's own health" (Knowles 1977, 59), a theme that is repeated in a number of places. It was particularly common in the "wellness" movement where "holistic" approaches (including meditation) were promoted. So for example, Elliott Goldwag suggests that "stress," far from being an "outside pathogen," is our own responsibility:

> We talk about the stress produced by our jobs, our home, our family, our business, the weather, the government, world conditions, and so on. Once again, we are led to believe that we are victims of some outside force that is imposing its will on us and causing us distress. . . . We choose our own psychological pathogens of stress by the way we choose to perceive and interpret events in our lives. (1979, 25)

Donald Ardell, similarly, suggests that individuals should be "aided in understanding how they are responsible for the pressures and tensions in

their lives" (1977, 15). Both because of the ways in which we organize our lives, and the ways in which we perceive the world, we ourselves are responsible, on this view, for the stresses that we suffer.

It is in this mode that self-care is, as above, criticized as "inner-directed, authoritarian, victim-blaming, manipulated by dominant forces, or diversionary from struggles for radical change in both medicine and the broader society" (Sidel and Sidel 1981, 656). Robert Crawford, approaching the topic from the perspective of cultural studies and political science, notes the ways in which this perspective shifts responsibility away from structural factors and towards individual decision making; while "health problems may originate outside the individual, e.g. in the American diet . . . since these problems are also behavioral, solutions are seen to lie within the realm of individual" (1980, 368). Because one *can* change one's diet, the ways in which the society in which one lives makes particular food choices easier or more difficult can get ignored. Even if such an individual approach "may prove beneficial for those who adopt a more health-promoting life style, . . ." Crawford notes, "it may in the process also serve the illusion that we can as individuals control our own existence, and that taking personal action to improve health will somehow satisfy the longing for a much more varied complex of needs" (1980, 368–69). Crawford's criticism of the turn towards "self-care" and the focus on individuals making healthy decisions is explicitly that it, under the guise of empowering individuals, in fact creates a narrative in which meaningful social or political change becomes impossible:

> However, as political language, individual responsibility is highly problematic. Most obviously, it risks all the myopia of classical individualism which I have been discussing. It risks fostering the illusion that individual responsibility is sufficient. It leaves unexamined the "voluntary" assumption about human behavior, through which it is taken for granted that because individuals can and do choose to act differently, it simply remains for them to make such choices. In other words, it promotes a conception which overlooks the social constraints against "choosing." (1980, 377)

A model that promotes individual responsibility is deeply problematic when individual choices are constrained by powerful social forces; it is unfair to tell someone to 'choose wisely,' when their poverty, the racism that is directed at them, or their social position more generally makes particular choices difficult, or even all-but impossible. Crawford notes further that a focus on individual choice "may also exacerbate an already prevalent sense of powerlessness about controlling the forces which impinge on

individuals by promoting a concept of control which may be viewed as an alternative to political efficacy: 'I can't change the world, but at least I can change myself'" (1980, 377). Telling someone that their poor health is their own fault, and that they alone are responsible for fixing it, is one way to make radical social and political change seem both unnecessary, and impossible.

Contrast this, Crawford says, with "working class struggles to shorten the work week, abolish child labor, and change working conditions" (1980, 365), or with "political activists in the occupational and environmental health movements" who "focus on factors external to the individual—objective factors, like the corporate production of carcinogens that pose concrete health threats" (1980, 384). Here, the focus remains firmly on the level of social policy. Individuals are not asked to make sure that they are safe at work, nor are they expected to themselves make decisions to avoid the toxins in the environment. Instead, the fight is for policies that are meant to ensure that no one is forced to work under unsafe conditions, or to live in a place contaminated with carcinogens.[3]

The pendulum has swung well away from thinking of self-help and self-care in the first mode. The idea of groups helping themselves, and embracing the collective nature of political struggle, is no longer associated with self-help terminology (indeed, the very project seems rather alien to today's debates surrounding health and healthcare in the US). The second mode—self-care as the individual taking responsibility for their own health—now dominates. As the next section makes clear, this approach reaches an absurd apotheosis when attention is turned to the dangers of chronic stress; Crawford's prescient criticisms seem ever-more relevant.

STRESSFUL SOCIETIES AND STRESSED INDIVIDUALS: INDIVIDUAL RESPONSES TO STRESS AND POPULATION-LEVEL HEALTH OUTCOMES

In "Stress and Health: Major Findings and Policy Implications," sociologist Peggy Thoits argues that the evidence increasingly supports the view that cumulative stress has a profound impact on health outcomes (Thoits 2010). At the individual level, it is well established that chronic stress is associated with higher rates of cardiovascular disease (see Steptoe and Kivimäki 2012), and with higher rates of obesity, diabetes, and metabolic syndrome (Kyrou and Tsigos 2007). It is a risk factor for asthma (Kozyrskyj et al. 2010), for cancer (Moreno-Smith, Lutgendorf, and Sood 2010), and for arthritis (Cutolo and Straub 2006). Chronic stress is implicated in dementia and mild cognitive impairment (Marin et al. 2011), as well as

memory problems (Kirschbaum et al. 1996), and it can lead to depression (van Praag 2004).

But Thoits does not limit her analysis to the ways in which chronic stress can harm individuals. Rather, she argues "that differential exposure to stressful experiences is one of the central ways that gender, racial-ethnic, marital status, and social class inequalities in health are produced" (2000, S44). Thoits notes further that, since in many contexts, "problems can beget more problems," stressors tend to accumulate, and get transmitted across generations; this accounts, in part, for "the reproduction of social disadvantage from one generation to the next" (2000, S45). The chronic stress of growing up in poverty, for example, damages children's cognitive development, and so is one of ways in which children growing up in poverty are further disadvantaged (see e.g. Evans and Schamberg 2009; Kim et al. 2013). The harms of chronic stress may be transmitted between generations via epigenetic pathways (and maternal imprinting more generally); stressful environments in one generation might predispose the next generation to relatively worse health (and, of course, to the additional stresses that go along with having poor health) (see e.g. Thayer and Kuzawa 2011).

Indeed, the concept of 'allostatic load'—"a measure of the cumulative physiological burden exacted on the body through attempts to adapt to life's demands" (Seeman et al. 2001, 4770)—helps link the literature on the effects of chronic stress on individuals to the literature on the health disparities between racialized populations, and those between social/economic classes. High allostatic load is caused by "repeated or chronic stressors in daily life," and is generally measured by biomarkers associated with stress responses (Duru et al. 2012). Black Americans, who have on average much worse health outcomes than do white Americans, also score more highly on "allostatic load" measures (see e.g. Geronimus et al. 2006). Geronimus et al. argue that in the United States "Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" (2006, 826). It is in part for these kinds of reasons that medical anthropologist Clarence Gravlee (2009) argues that it is racism, and the stresses associated with both the direct and indirect effects of living in a racist society, that create the enormous health disparities between Black and White Americans observed in the US. Even so-called "preventable" risk factors for poor health outcomes—such as tobacco and alcohol use—are associated with the stress, and especially with the chronic stresses, associated with racism; this provides another avenue

through which stress can come to be associated with population-level health outcomes (see e.g. Kaplan 2010 and citations therein).

Work on the social determinants of health point towards a relationship between recognized risk factors for poor population-level health outcomes (high levels of income inequality, high levels of job and financial insecurity, poor social services, poor investment in human resources, etc.) and stress—it is (likely) through chronic stress that the major risk factors for poor population health are translated into the expected poor health outcomes (see e.g. Braveman and Gottlieb 2014; Wilkinson and Pickett 2007; Wilkinson and Pickett 2006; Wilkinson and Marmot 2003). Both absolute and relative deprivation are sources of psychosocial stress, and this likely explains, at least in part, why greater income inequality within societies is associated with worse health outcomes (see Wilkinson and Pickett 2007). At the extreme, social stress is thought to be part of the explanation for the sudden dramatic drop in life-expectancy in Eastern Europe—a drop of over 10 years between 1990 and 1994 in Russia, for example (see Notzon et al. 1998)—after the end of the Cold War (see e.g. Weidner and Cain 2003; Stone 2000). And it is thought to play a role in the so-called "diseases of despair" (e.g. drug overdoses, alcohol-related liver failures, suicides; see e.g. Case and Deaton 2017) that have resulted in U.S. life expectancy dropping in both 2016 and 2017 (see e.g. Woolf and Aron 2017; Woolf et al. 2017).

STRESS AND SELF-CARE IN THE TWENTY-FIRST CENTURY: THE INDIVIDUAL VERSUS THE SOCIAL

To some researchers, chronic stress is seen as part of the social determinants of health, and the solution too is seen to lie firmly in the realm of social policy. Epidemiologist Steven Woolf and policy analyst Laudan Aron, for example, write that the increased mortality in the US is associated with a time period when "educational performance weakened, social divides (including income inequality) widened, middle class incomes stagnated, and poverty rates exceeded those of most rich countries" (2017, 2). They note that the US's "social contract is weaker than in other countries—those in need have less access to social services, healthcare, or the prevention and treatment of mental illness and addiction" and that the "'American dream' is increasingly out of reach, as social mobility declines and fewer children face a better future than their parents" (2017, 2). "In theory," they write:

policy makers jolted by the shortening lifespan of Americans would hasten to correct these conditions. They would promote education, boost support for children and families, increase wages and economic opportunity for the working class, invest in distressed communities, and strengthen healthcare and behavioral health systems. (2017, 2)

These solutions are about social change—the authors are recommending a fairly radically restructuring of our society, a restructuring that would result in fewer people suffering the kinds of chronic stress that lead to premature death. However, they note that this is not what current policy makers are doing. Instead, the obvious solutions to these problems, "which involve investment to support struggling families and communities and thereby improve public health . . . are often rejected, usually by leaders with competing self interests or ideological objections" (2017, 2). They note that far from addressing these serious needs, "recent legislation and regulations may prolong or intensify the economic burden on the middle class and weaken access to healthcare and safety net programs" (2017, 2). Policies that widen income inequalities and make living a minimally decent life more precarious are likely to exacerbate chronic stress and the poor health outcomes that go along with it, and yet these are precisely the kinds of policies being pushed in the US (as well as in many other countries pursuing 'austerity'-based economic policies, for example).

Similarly, researchers like Marmot and Wilkinson explicitly reject explanations and recommendations focused on individual decision making, and recommend instead that the problems that they identify be addressed through policy changes. In his *The Impact of Inequality: How to Make Sick Societies Healthier*, Wilkinson notes that it is "not a guide to the dos and don'ts of healthy behavior" but is instead focused on "the roots of the social malaise affecting many of the richest societies," (2005, 1–2)—that is, on the "psychological factors" that impact health, mostly via "frequent or recurrent stress" (2005, 12). Marmot and Bell suggest that given contemporary understandings of the ways in which social inequality (and related problems) produce poor health outcomes, there is a "need for action across the whole of society, focusing on those social factors that determine health outcomes" (2012, S10). Writing together for the World Health Organization, Wilkinson and Marmot argue that the link between chronic stress and poor health implies that improving health outcomes will require "reducing insecurity and unemployment" and enabling "all citizens to play a full and useful role in the social, economic and cultural life of their society" (2003, 11) via policies that provide for

example "minimum income guarantees," and that deliberately "aim to reduce social stratification" (2003, 17) explicitly via "reducing social and economic inequalities" (2003, 23). It is worth noting well that these are, in the contemporary political context in the US (and many other countries), radical suggestions for changes in social policy.

But along with this literature, there is the more prominent discourse of individual responsibility; in order to address chronic stress, "self-care" is recommended, the same kind of "self-care" that, again, Sidel and Sidel criticized as "inner-directed, authoritarian, victim-blaming, manipulated by dominant forces, or diversionary from struggles for radical change in both medicine and the broader society" (1981, 656). This holds at both the level of popular discourse and that of academic research. Suggestions for dealing with chronic stress that focus on individual behavior, whether promoted directly to individual "consumers" or to health professionals, have the effect (and perhaps, in some cases, the purpose) of shifting responsibility for dealing with chronic stress back onto the stressed individuals themselves.

On the popular side, Google searches for "self-care" reveal a plethora of websites devoted to suggestions for "taking care of yourself." Noting that "constant stress and anxiety can have an adverse effect on your mental and physical health," websites suggest that "self-care habits like eating healthy, connecting with a loved one or, practicing meditation cuts [sic] down the toxic effects of stress by improving your mood and boosting your energy and confidence levels" (Nazish 2017). They ask if "your close relationships and daily activities [are] adding to your sense of overall stress?" and suggest that if they are, then one needs to "take small, realistic steps toward change to help make a significant difference in your quality of life" (Student Counseling Center, UT Dallas n.d.). They provide recommendations for "clinicians," noting that "when you're stressed and exhausted, you have less energy to give to others" (Tartakovsky 2016) and that self-care therefore can protect one from "burnout," and ensure that "you are content, focused, motivated, and 'on your game'" (John Duffy, quoted in Tartakovsky 2016). The recommended "self-care" practices that the popular discourse promotes tend to center around a few major tropes.[4] These include mindfulness-based meditation practices (as noted below, these are also front-and-center for research-oriented self-care practices), light exercise, healthy eating, purchasing gifts for yourself, taking naps, etc. (see e.g. Nazish 2017, Tartakovsky 2016, etc.). Indeed, these have become so

standard that criticisms focused on the overuse of these elements are now common. Sometimes, writers on these websites focus on one kind of self-care and denigrate other elements; Wiest for example stresses the importance of healthy eating and working out, while denigrating such activities as taking salt baths and eating cake (Wiest 2017). Other internet writers focus on the ways in which the "self-care" movement itself has become just another test for individuals to fail (e.g. Tumlinson 2017 "The Burden of 'Self-Care'").

Even at the level of popular culture, some writers *have* made the connection to the use of self-care to detract from movements designed to encourage (or force) radical social change. Jordan Kisner's *New Yorker* piece, "The Politics of Conspicuous Displays of Self-Care," for example, ends with a warning that "the risk of promoting individual self-care as a solution to existential anxiety or oppression is that victims will become isolated in a futile struggle to solve their own problems rather than to collectively change the systems causing them harm" (2017). As columnist Laurie Penny puts it in "Life-Hacks of the Poor and Aimless"

> The isolating ideology of wellness works against this sort of social change in two important ways. First, it persuades all us that if we are sick, sad, and exhausted, the problem isn't one of economics. There is no structural imbalance, according to this view—there is only individual maladaption, requiring an individual response. (2016)

These responses, however, are both relatively few in number (and are limited in impact) when compared to the enormous number of popular sources that continue to recommend "self-care" in the sense of individuals engaging in the sorts of mildly relaxing activities noted above.

Academic research pushing the "self-care" has tended to focus on mindfulness-based stress-reduction (MBSR) practices.[5] Beth Roth and Diane Robbins, for example, taught an 8-week mindfulness-based stress-reduction (MBSR) program to patients at an "inner city health center" (2004). Patients met for 2 hours each week, and "were asked to devote 30-45 minutes per day, 6 days per week" to meditation practice (2004, 114). The point of the training was, of course, stress reduction; and stress, Roth and Robbins make clear in their literature review, was clearly a problem in that population (poor, mostly Hispanic). They note that:

> The stress burden associated with low socioeconomic status consists of a variety of environmental, institutional, and psychological factors, which frequently are found in inner city neighborhoods. These factors include

high population density, poor sanitation and living conditions, higher costs for basic goods and services, inadequate nutrition and physical exercise, inferior quality of elementary and high school education, poor employment opportunities, high unemployment and underemployment, high levels of noise, crime and violence, high levels of incarceration and homicide, increased tobacco and alcohol use, lack of health insurance and decreased access to health care with the attendant delay in the detection and diagnosis of disease and the differential management and treatment of illness. The subjective experience of racism and discrimination may be an additional important stress that adversely affects physical and mental health. (2004, 113)

After running through this list of serious problems facing the poor, Roth and Robbins turn to note that the "way a person perceives a difficult event, and the skill with which the individual handles the experience, help determine the degree to which the experience is stressful" (2004,113). This is a slightly less extreme version of Goldwig's claim, noted above, that "[w]e choose our own psychological pathogens of stress by the way we choose to perceive and interpret events in our lives" (1975). It is from this observation that they conclude that "successful stress reduction strategies for racial and ethnic minorities could potentially improve their health status" (Roth and Robbins 2004, 113)—if the individuals in racial and ethnic minority populations could be taught to *perceive* stressful events differently, and to *handle* those events with more skill, their health might not suffer so much from the stressful events. But of course, this way of approaching the problem places the causal force of chronic stress back on the person suffering from it; one might read this as implying that the *real* issue is not any of the factors associated with poverty and racial discrimination noted above, but rather how the individuals suffering from those forces *perceive* their difficulties.

It is difficult not to read Roth and Robbins' paper as the apotheosis of the threat identified by Sidel and Sidel, that, again, self-care would become "diversionary from struggles for radical change in both medicine and the broader society" (1981). Faced with a population suffering from a litany of social ills, Roth and Robbins instruct the already over-burdened participants in their study to add a half-hour to 45-minute meditation routine to their day. Of the 115 patients initially enrolled in the MBSR program, 39 dropped out "for various reasons, including lack of interest, lack of transportation, lack of childcare, and assorted family needs" (Roth and Robbins 2004, 114); the control group consisted of people who were

unable to participate, in some cases because of conflicts "with new state welfare-mandated work schedules" (2004, 115). While Roth and Robbins found that there were statistically significant positive differences in the mindfulness group versus the control group, the hope that such practices could be used to ameliorate any substantial part of the stress-related health disparities in the populations considered seems profoundly misguided. Asking people struggling to deal with a wide variety of serious problems to engage in, and stick with, a time-consuming practice, is a recipe for failure.[6]

Far from being an outlier in the field, however, Roth and Robbins' paper is simply one of many attempting to use mindfulness-based stress reduction practices as a kind of self-care to address problems that, seen through the lens of the research on the social determinants of health, would seem clearly to be problems best addressed by changes in social policy (perhaps radical ones). A 2013 meta-analysis found some 32 studies focused on mindfulness-based treatments for "clients from nondominant cultural and/ or marginalized backgrounds" (Fuchs et al. 2013). Burnett-Zeigler et al.'s "Mindfulness based stress reduction adapted for depressed disadvantaged women in an urban Federally Qualified Health Center," despite focusing on low-income Black women, never mentions the social determinants of health, causes of race- and income-related health disparities more generally, or racism (2016). Dutton et al.'s "Mindfulness-Based Stress Reduction for Low-Income, Predominantly African-American Women With PTSD and a History of Intimate Partner Violence," does at least mention the social elements, but uses these to defend the individual approach; the authors suggest that the "cumulative and enduring life stressors such as poverty, racial discrimination, and family instability" make "accessing standard exposure-based cognitive therapy PTSD treatments . . . difficult" and suggest mindfulness practices as a way to "help overcome some of these barriers to care" (2013). But again, the very difficulties that make accessing standard therapeutic practices problematic are also likely to make any time-consuming practice problematic, at least in the long run.

Some papers, for example "Mind-Body Interventions to Reduce Risk for Health Disparities Related to Stress and Strength Among African-American Women: The Potential of Mindfulness-Based Stress Reduction, Loving-Kindness, and the NTU Therapeutic Framework," do acknowledge the argument that "system-wide health policy changes are needed to solve the social determinants of health and that focusing on person-centered interventions places unfair burden on individuals to change despite obvious structural odds" but nevertheless recommend individual mindfulness-based

approaches (Woods-Giscombé and Black 2010, 122). They argue that "without person-centered approaches, individuals could be left floundering and without adequate support or resources to manage multiple sources of stress while waiting for system-wide social and structural changes to be executed" (Woods-Giscombé and Black 2010, 122). Similarly, Andreas Schmidt acknowledges the worry that MBSR practices are being used as a "coping mechanism for issues whose real (or morally relevant) aetiology lies elsewhere" but argues that while presenting MBSR practices as "a panacea might risk either undermining its credibility or crowd out a discourse about necessary social change," it is nevertheless "a plausible part of a mix of policies" that can provide "individuals with psychological all-purpose benefits" (2016, 453).

These approaches raise an important question for those who believe that the only truly effective solution to the health disparities that result from the social determinants of health (including the associated chronic stress) will be substantial structural changes: should one nevertheless continue to push individualistic "self-care" approaches, on the grounds that it is very unlikely that meaningful structural changes will be made in time to help individuals who are suffering now, and, given the contemporary political context in the US for example, that it seems increasingly unlikely that meaningful positive structural changes will be made at all (at least in the foreseeable future)? It is of course possible, even likely, that some people in objectively terrible situations would nevertheless benefit from mindfulness-based stress-reduction practices, but it seems unlikely that these practices could be a long-term solution, nor does it seem like a solution that is likely to benefit more than a very small fraction of the people requiring help. Note for example that the MBSR practices recommended are time-consuming, and it is likely that many people whose lives regularly subject them to unreasonable levels of chronic stress, even those who initially benefit from MBSR, will discontinue their practice. Indeed, research suggests that over 70% of individuals in MBSR studies discontinue the practice, and subsequently lose many of the gains initially found in those studies (see Garcia-Campayo et al. 2015 and cites therein).

That patients will be blamed by many in the medical community, and/or will blame themselves, for failing to maintain practices (even practices that are, objectively, time consuming and difficult to maintain), is at least suggested by the literature surrounding diabetes care in the US. For example, Claudia Chaufan, Sophia Constantino, and Meagan Davis write that in their sociological research:

> We find that despite the well-documented structural causes of poor health (e.g., precarious employment, inadequate housing, unaffordable healthy foods) that we documented in an earlier article, and that were acknowledged by all participants, staff tend to identify the ultimate source of poor health and health inequalities *within* clients, that is, in their lifestyle choices, psychological inclinations, parenting practices, or cultural preferences. Put another way, they believe that individual characteristics of clients *make the difference* in their health, such that if these changed, clients' health would substantially improve and likely be no different from that of higher income groups. Notably, we also identify this discourse among clients themselves, even if in a qualified manner. Challenges to this fundamental belief are rare. (2013, 145; emphases in original)

Staff members, asked to consider the causes of poor health outcomes in their clients, cited "ignorance" as a major cause; Chaufan, Constantino, and Davis note that "repeatedly, staff members explained that many clients simply 'don't know how to prepare healthy foods,' 'can't identify common vegetables' (like artichokes or bok choy[7]), or 'aren't getting the nutrition education they need'" (2013, 147). Although staff members did acknowledge that "their clients came to the United States to escape joblessness and poverty in their countries of origin, that upon arrival in the United States they were stranded in low-paying and precarious jobs, and that all too often they could not make ends meet," they did not seem to take these seriously as causes of poor health outcomes (2013, 147). Instead, "these structural constraints were quickly dismissed as not the 'real' cause of poor health, giving way to the notion that the fundamental *difference maker* was some personal quality, such as ignorance or laziness" (2013, 147; emphasis in original). Indeed, the authors note that "even when prompted to think 'outside the box' by imagining how they would deal with health inequalities among their clients if they had a 'magic wand' that made any and every change possible, staff resorted to solutions that focused on changing something about individuals" (2013, 156). And these attitudes were reflected in the clients' understanding of themselves, as well. When they were asked the "magic wand" question, their responses were similar—that they should "educate ourselves" or "take control of our lives" (2013, 157). People struggling to get by under appalling conditions nevertheless blame themselves for their perceived failures to make the "right" sort of decisions.

The story of the relationship between stress and health is all-too similar to the tale of tropical diseases and poverty with which this piece started. Decades of research into the social determinants of health point clearly towards ways in which social policies influence population-level health outcomes. One mechanism—perhaps the main one—through which the social determinants affect health is chronic stress. People whose social positions result in their suffering more chronic stress live, on average, shorter, less healthy lives. Societies in which there is more stress are less healthy societies. It seems clear that too many contemporary societies are unhealthy for too many people, and becoming more so. But, in both the popular discourse and among researchers, these facts—facts about, as Geoffrey Rose put it, "sick populations"—get lost. Instead, there is a turn towards the individual as the causal locus. Individuals, the story goes, even those in "sick populations," are sick at least in part because of the way that they themselves perceive and react to the stressors in their lives. Controlling the health problems associated with living in stressful situations therefore becomes the responsibility of the individuals—all too often, the responsibility of individuals who are already disadvantaged by their economic status, their race, or their social position more generally.

It may be that, given current political trends in the US (and e.g. much of western Europe), there is no real hope for creating societies that are more fair, less stressful, and in which more (rather than ever fewer) people can lead flourishing lives. Certainly in the US context, the hope of creating such a society seems naïve. Indeed, it would appear that creating a less racist society, and working to address the legacies of our history with racism in the US, is a task from which we are, as a culture, fleeing rather than embracing. But solving our health disparities, and our very poor population-level health outcomes overall, requires nothing less. That we lack the political will to do so is a poor reason to shift the burden back onto those already suffering.

NOTES

1. This is perhaps most obvious in the context of the United States (the primary focus of this paper), but similar moves can be seen in most countries in which "neoliberalism" is or is becoming the dominant social/political ideology. See for example Vicente Navarro's "What we mean by social determinants of health" (2009) and Alec Irwin and Elena Scali's "Action on the social determinants of health: A historical perspective" (2010) for more on the conflict between "neoliberal policies" and a true public health approach to reducing health inequities and improving quality of life.

2. Some authors, e.g. Kronenfeld (1979), distinguish between "self-help" groups, which tend to be "focused on organizing consumers to battle for their rights or focused upon community organization" and which "involves concerted effort by some organizations of people to participate together towards the solution of a mutual problem (Kronenfeld 1979, 263), on the one hand, and "self-care," which can be "very individual in nature," and is associated with "a greater emphasis on personal responsibility, prevention of disease," and self-care understood narrowly to mean "self-treatment" (Kronenfeld 1979, 263–64). But as the exchange recounted above between Katz and Levin, and Sidel and Sidel, made clear, these distinctions were by no means universally recognized.

3. In practice, of course, these protections were not and are not extended to everyone; the literature on environmental justice points towards one area of failures (see e.g. Brulle and Pellow 2006), and the weak labor laws in industries dominated by e.g. immigrant labor and the poor point towards another (see e.g. Bernhardt et al. 2009).

4. These particular kinds of practices and ways of talking about self-care became much more common relatively recently. "Self-Care," Jordan Kisner wrote in 2017, "rose as collective social practice in 2016 alongside national stress levels." This particular manifestation of the movement, she claimed, was "powered by straight, affluent white women." It is interesting to note that Kisner stresses that this focus was distinctly different from the way that, in her view, the term was initially repopularized in the 1970s and 1980s, when it was a "gesture of defiance" used by "people of color and queer communities" as "a way to insist to a violent and oppressive culture that you mattered, that you were worthy of care" (Kisner 2017). See also above for the different uses of "self-care" in the women's health movements.

5. In this piece, I focus on what I view as one obvious shortcoming of MBSR practices—that their focus on individual change hides (sometimes inadvertently) the social and political forces conspiring to make contemporary life

in many countries (including especially the US) more stressful than it needs to be. Other (though related) objections to MBSR practices focus instead on the way in which such practices have become divorced from the Buddhist traditions in which they arose, and in particular, from the transformative goals of mindfulness practices within those traditions (see e.g. Purser and Loy 2013; Purser and Mililko 2015; Hyland 2016). Purser and Loy refer to the kind of MBSR practiced with an eye towards individuals managing their own stress rather than transformative change as "McMindfulness" (2013) (but see e.g. Schmidt 2016, who argues that health professionals committed to 'liberal neutrality' should embrace this departure of mindfulness from its Buddhist origins). The criticism that this kind of MBSR is divorced from the ethical considerations and social responsibility that "right mindfulness" demands makes a similar point to the individualization of what are really social problems, albeit from a different direction.

6. It seems clear that researchers like Roth and Robbins are not consciously aiming to recommend strategies unlikely to work and likely to result in the very people they are working with being blamed for their stress-related illnesses—rather, as 'on the ground' medical practitioners engaged with disadvantaged populations, they are working within the clinical, individual frameworks that they have actual control over. My complaint is not that they are engaged in such individual interventions rather than attempting to intervene at the level of social change or political change, but rather that their approach seems to ignore the social and political reality of the individuals that they hope to help, and that they way that they write makes even *perceiving* that social and political reality more, rather than less, difficult.

7. How artichokes and bok choy became the standards by which to judge people's ability to identify "common" vegetables is left vague in this piece.

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