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"Like you failed at life": Debt, health and neoliberal subjectivity

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ABSTRACT

The need to more explicitly incorporate political economy and neoliberalism into research on social inequalities in health has been acknowledged across disciplines. This paper explores neoliberalism as it relates to consumer financial debt and internalized feelings of personal responsibility and failure for adults in Boston, Massachusetts. Using data from a mixed-methods study (n = 286), findings show that endorsing a neoliberalized view of personal debt as failure is associated with significantly worse health across a range of measures, including blood pressure, adiposity, self-reported physical and emotional symptoms, depression, anxiety, and perceived stress, even when controlling for several socio-demographic confounders. Results are discussed within the context of both neoliberal economic policies that funnel consumers into chronic debt and neoliberal sociocultural ideologies that promote self-judgments of indebtedness as personal failure. Findings highlight the importance of neoliberalism as an important contemporary social determinant of health and suggest new directions for research to explore.

1. Introduction

Scholarship on social inequalities in health has seen persistent, interdisciplinary calls for greater attention to political economy. Responding in part to what Micaela di Leonardo (di Leonardo, 1997) has called "an appalling lack of respect for intellectual labor" in the social sciences' post-1970 abandonment of political economy, a variety of scholars have advocated a need to reject the "dismissive anti-Marxism" (di Leonardo, 1997) of the contemporary academy and put issues of power and historical context back on the front burner in population health research. Biocultural anthropologists, for instance, have argued that attending to the ways in which contemporary social inequalities are structured by historical political economic processes is necessary for producing accurate models of population health (Hicks and Leonard, 2014; Leatherman and Hoke, 2016). They contend that failing to take such an approach has ethical implications, since it risks naturalizing the social conditions that shape biology and 'blaming the victim' when those conditions are embodied as poor health (Leatherman and Hoke, 2016). Sociologists and epidemiologists have echoed these contentions, especially with respect to research on population-level income inequality and health, calling out the need to incorporate political economy more explicitly into explanatory models to avoid naturalizing social inequities and stratifications (Coburn, 2000; Muntaner et al., 1999; Navarro et al., 2003; Navarro and Shi, 2001; Prins et al., 2015).

Leading theories posit that economic inequality at the population level causes poor health, at least in part, because of the psychological damage of negative social comparisons in stratified, hierarchical societies (Kawachi and Kennedy, 1999; Marmot, 2004; Wilkinson and Pickett, 2011). Critics have noted, however, that emphasizing psychological perceptions and relative social position over actual material disadvantages and class power differences problematically ignores underlying structural components that both create inequality and shape its effects (Coburn, 2000, 2004; Muntaner et al., 1999; Navarro and Shi, 2001). They suggest that psychosocial explanations may (unintentionally) participate in absolving governing bodies and policies from bearing responsibility for health inequities; even the use of the arguably neutral, descriptive term "inequality" over a more politically-charged term such as "class" can be seen as encouraging a depoliticized and naturalized view of health differences, precisely because it strips away the capitalist context within which social relations of inequality are constructed and embedded.

Drawing on these criticisms, a "neo-material" view of health inequality has argued for a more class-centered approach, recognizing that economic inequality is just one aspect of the broader systems of oppression, societal disinvestment, and political disempowerment that characterize late capitalism. Notably, this smaller body of work also includes calls for greater attention to the particular role of neoliberalism in shaping patterns of population health (Coburn, 2004; Muntaner et al., 1999; Navarro, 2007). Most simply understood as the set of economic ideals favoring free markets, privatization, and capital deregulation, neoliberalism constitutes the ideological underpinnings

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driving government and policy decisions across much of the globe since the 1970s (Harvey, 2005). The neoliberalization of healthcare, in the privatization of delivery and the shift of both treatment and prevention costs to individual consumers, is one obvious way in which population health is affected (Labonté and Stuckler, 2016). But a growing literature is also demonstrating that other measures of neoliberal impact, such as the size and universality of welfare state provisioning and targeted political attacks on the working class, also matter for health (Beckfield and Bambra, 2016; Chung and Muntaner, 2007; Collins and McCartney, 2011; Navarro and Shi, 2001). Much of this work has focused on mapping broad categories of political and welfare state organization (such as social democratic/Nordic and Liberal/Anglo-Saxon models) onto health at the national level (Bambra, 2011; Bambra and Eikemo, 2009; Navarro and Shi, 2001). This research has shown that more neoliberal political tendencies and increases in austerity and retrenched social provisioning are associated with poorer overall population health, and higher levels obesity and stress: phenomena Schrecker and Bambra call "neoliberal epidemics" (Schrecker and Bambra, 2015). These authors also note the role of cultural influence in perpetuating these epidemics, suggesting that notions of welfare dependency and other negative stereotypes that accompany neoliberal political shifts produce conditions in which "existing material disadvantage is reinforced by the continued stigmatization and marginalization of […] certain groups, (Schrecker and Bambra, 2015, pg. 116).

Indeed, recent research suggests that neoliberalism may impact health not only through policies structuring social resources, but also through more insidious ideological processes. Peacock and colleagues (M. Peacock, P. Bissell, & J. Owen, 2014a, 2014b), in a recent qualitative exploration of social comparison among women in England, found evidence that internalization of neoliberal narratives strongly shaped women's experiences of their own and others' behaviors and uses of social services. In a discursive theme they call "no legitimate dependency," deeply held notions of individual personal responsibility around managing one's own life and health caused women to reject all non-individualistic explanations for personal hardship and to apply judgments of dependency and shirking responsibility to both themselves and others. These judgments are clear reflections of neoliberal values of individual autonomy, unconstrained personal freedom and their corollary, personal responsibility (Harvey, 2005). As such they represent what Micaela di Leonardo has called the "neoliberalization of consciousness" in which the lens through we view all aspects of our lives has become increasingly imbued with a neoliberal tinge (di Leonardo, 2008b).

In my own work among communities in Boston, I have found similar processes shaping adults' psychological experiences of financial indebtedness (Sweet et al., 2018). In qualitative research published elsewhere, my colleagues and I found that for many adults living with chronic consumer financial debt, notions of personal responsibility, shame, and failure dominate narratives about their debt experience. Expressing sentiments like "it's my fault, I should have tried to save," "[I felt] horrible, like a loser … [Like] I messed up somewhere in my life," "[You feel] like you failed at life …. You feel like less of a person," and "I feel like I'm a bad person because I can't pay this off," indebted Boston residents conveyed internalized notions of neoliberal doctrine around personal financial responsibility and the shame and guilt that comes from failing to meet expectations of budgetary management (Sweet et al., 2018).

This internalization of neoliberal ideology around personal debt may have important implications for health, especially considering the growing literature now exploring debt as a socioeconomic risk factor for disease. In the decade since the 2008 financial crisis, research exploring health impacts of debt has flourished, finding that indebtedness is associated with depression and poor mental health, low self-rated health, elevated blood pressure, poor sleep quality, and lower aggregate life expectancy (Clayton et al., 2015; Drentea and Reynolds, 2012; Kalousova and Burgard, 2013; Richardson et al., 2013; Sweet et al., 2013; Walsemann et al., 2016; Zurlo et al., 2014). As a relatively young line of inquiry, the bulk of this research has thus far focused more on demonstrating associations than on explicating pathways and mechanisms. A psychosocial stress pathway has been hypothesized (Drentea and Reynolds, 2012; Sweet et al., 2013), and factors involving feelings of social powerlessness and limited 'control over destiny' and life choices seem likely (Whitehead et al., 2016). However, explicit testing of these mechanisms is needed, and current research on debt and health still lacks critical consideration of either the political economic forces structuring consumer indebtedness or how its everyday lived experience adversely impacts health. It is likely that attention to neoliberal processes is key to both of these.

This paper offers a critical biocultural anthropological take on the role of neoliberalism in the impact of consumer debt on health. To be understood as a socioeconomic determinant of health, debt must be considered within the broader framework of neoliberal economic policy that has severely crippled the financial options of Americans while funneling them through an inequitable and predatory credit landscape. An important part of this process is the internalization of neoliberal ideological principles that prioritize personal responsibility and promote self-blame for those who have been caught in what Brett Williams calls "the credit trap" (Williams, 2005). Using data from a mixed methods study of debt and health in Boston, I explore how this internalization of neoliberal ideology around debt maps onto health and well-being. Findings show that internalized feelings of failure associated with indebtedness are strongly related to poor health across a range of psychological, metabolic, and cardiovascular measures. I suggest these aspects of internalized neoliberal ideology are not only important mechanisms in the epidemiology of debt, but that they reinforce the utility of attending more specifically to neoliberal processes in population health research.

2. Study design and methods

Data for this paper come from the "Price of Debt" study, a two-phase, mixed-methods (qualitative, quantitative, and biomarker) study of debt and health in Boston, MA. The qualitative phase of research (Phase 1) consisted of semi-structured interviews with a diverse sample of Boston adults (n = 31) exploring the variety of types of debt and experiences with debt that they had had in their lives. In addition to offering rich qualitative insights into the general experience of indebtedness for Boston adults, findings from these interviews also informed the development of a comprehensive debt questionnaire used in the later phase of the study. Details of qualitative findings from Phase 1, particularly those relating to the internalization of neoliberal ideology in the form of shame and feelings of failure, can be found elsewhere (Sweet et al., 2018). In this paper I focus on the second phase of research, in which qualitatively-informed survey questions about debt experience were explored in relation to self-reported and biomarker measures of health in a larger sample of Boston adults (n = 286). Analyses focus specifically on the subset of participants who reported currently being in debt (n = 213).

Research participants for this phase of the study were recruited from across the Boston area through publicly posted fliers, as well as via word of mouth. All interested potential participants were screened by telephone or email to ensure they met eligibility criteria - being between 18 and 64 years of age and speaking fluent English – before giving informed consent and being enrolled. After enrollment, data were collected from participants using both online and in-person formats. An online questionnaire included an extensive set of demographic questions, a comprehensive debt questionnaire (constructed with insights from Phase 1 interviews), and measures of self-reported health. Trained research personnel collected biomarker and other health measures during an in-person assessment in a private university office. Participants completed the online questionnaire either on their own time prior to the in-person health assessment, or when they came for