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## 15. The Politics of Tackling Inequalities: The Rise of Psychological Fundamentalism in Public Health and Welfare Reform

Lynne Friedli

Negativity enacts the dissent without which politics disappears. Negativity, in this sense, is inseparable from the struggles of subordinated persons to resist the social conditions of their devaluation.

*Berlant and Edelman 2014, p. xii*

“Preface,” in *Sex, or the Unbearable*, Lauren Berlant, Lee Edelman, Eds., pp. vii–xvii. Copyright, 2014, Duke University Press. All rights reserved. Republished by permission of the copyright holder.

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### 15.1. Introduction: The rise of psychological explanations and interventions in public health

This chapter<sup>1</sup> is concerned with the growing influence of non-material explanations for inequalities and a corresponding emphasis on psychological interventions, which aim to modify cognitive function or emotional disposition/affect (Friedli 2013, 2014). These developments intersect with and are reinforced by the parallel rise in brain science, which correlates a range of outcomes (crime, addiction, health behaviour, educational attainment) with brain structure (Katz 2013; Rose 2013). As a recent editorial in the *British Medical Journal* observes:

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1 This work now contributes to Lynne Friedli's collaboration with Hubbub, an interdisciplinary exploration of rest and its opposites funded by the Wellcome Trust (see: <http://hubbubgroup.org/>). Research for the sections of this chapter on workfare was funded by the Wellcome Trust, grant number 103817. LF is a member of Boycott Workfare, an organisation campaigning to abolish workfare.

1 Earlier versions of some of the ideas in this chapter were presented (with Robert Stearn) at the Critical Medical Humanities Symposium, 4/5 November 2013, <http://medicalhumanities.wordpress.com/2013/10/31/critical-medical-humanities-symposium-final-programme-and-invitation-to-follow-critmh-debate-on-twitter/> and appear in Friedli and Stearn (2013), Friedli and Stearn (2015), and Midlands Psychology Group and Friedli (forthcoming). The analysis of assets-based approaches previously appeared in Friedli (2013).

There is great interest in whether the structure and function of brain circuits can be changed to optimise the operation of the executive control system (Marteau and Hall 2013, p. 6750)

In public health, the psychological attributes and dispositions of individuals and communities (the ostensible presence or absence of optimism, aspiration, self-efficacy, conscientiousness, sense of coherence, etc.) are being used to explain patterns of health and health behaviour and to account for the impact of material deprivation, in a twin process of psychologizing and biologizing poverty (Edwards et al 2014). Deprivation is understood less and less in relation to issues of equity, power, and justice and more and more in terms of the impact of the 'environment' on brain function.

## 15.2. Absence of debate

Of course there is an important debate to be had about the relative contribution of psychological factors to the social gradient in health and other outcomes, but the growing authority of Whitehead's 'emerging cartel of psychocrats' (Whitehead et al 2011, p. 2830) is rarely challenged.

The absence of critical academic assessment of assets-based approaches has been discussed elsewhere (Friedli 2013), but there has also been a marked silence about the use and misuse of psychology in public policy. The Cabinet Office Behavioural Insights Unit (recently privatised) is simply the most visible manifestation of the (mis)'application of behavioural science and psychology to public policy' (Behavioural Insights Team 2013). What is less visible, and less remarked upon, are the implications of psycho-policy for the disadvantaged and excluded populations who are its primary targets, and the coercive and punitive nature of many psycho-policy interventions (Friedli and Stearn 2013; Howell and Veronka 2012).

## 15.3. Strengths-based discourse: The power of positive affect

Of particular note is the proliferation of 'strengths-based' approaches, which play an important normative role. Sometimes referred to as 'assets based', these approaches validate a very specific set of attributes that are classified as adaptive, as predictive of positive health and social outcomes (both for individuals and for communities), and are promoted via a range of psycho-interventions.

The idea that personality and outlook can be abstracted to explain health is pervasive (Morgan et al 2012; Muntaner 2004). A particular version of psychology—avowedly non-materialist, influenced by positive psychology and health behaviourism—is now so prevalent that it barely attracts comment. It has become axiomatic that self-esteem, optimism, confidence, hopefulness, sense of coherence, aspiration, coping abilities, and other markers of cheerful self-sufficiency and resilience produce health and are fundamental indicators of well-being. Their absence is routinely implicated in every health and social problem from obesity and chronic pain to inappropriate use of services and long-term unemployment. Psychology is increasingly achieving the status of 'first cause' and/or primary intervening variable.

## 15.4. Engaging with the evidence base

These developments are of special significance in respect to health and unemployment, where psychology is contributing to the 'sidelining by stealth' of material explanations (Friedli 2014). I say 'by stealth' because psychology has not been required to defend itself in relation to an extensive body of research evidence on the social determinants of health—the conditions in which people are born, grow, live, work, and age and their political antecedents (Birn 2009; Krieger 2011; Scott et al 2013). Nor has psychology had to engage with critiques of 'supply side' economics, which call into question the effectiveness (and therefore the ethics) of addressing unemployment by attempting to modify those who are unemployed (Webster 2005).

The rise and fall of specific causes of mortality and the strong social gradient for avoidable causes of death raise challenging questions about the most effective approaches to reducing inequalities, notably approaches concerned with addressing individual attributes (McCartney et al 2013). Although interpretation of the roots of, and remedies for, inequalities is inevitably politically driven, the strength of the case for the ‘fundamental causes’ of health inequalities is striking (see Chapters 1, 8, 9, and 16). In a major revisiting of the evidence, the CSDH has demonstrated where attention should be focused: health inequalities are a symptom, an outcome, of inequalities in power, money, and resources (CSDH 2008).<sup>2</sup> These structural and material inequalities result in unequal exposure, by social position, to a range of health risks and advantages (Phelan et al 2010; Scott et al 2013; Thomas et al 2010). As causes of death and disease are socially patterned, the removal of one risk factor (e.g. smoking) will simply be replaced by another (e.g. obesity), unless material inequalities are addressed (Scott-Samuel 2011). The absence of evidence that knowledge, attitudes, and motivation have any significant impact on ‘health behaviour’ in comparison with structural factors further undermines the case for focusing on ‘reducing individual risk and increasing individual assets’ (Mackenbach 2012; Scott et al 2013):

Looking at trends over time, the KAM [knowledge, attitudes and motivation] survey consistently found a lack of association between behaviour change and levels of knowledge and motivation in all health behaviours which were explored. (Rutherford and Reid 2013)

The wealth of evidence on the health impact of the distribution of money and power, and the lack of evidence on abstracted ‘health behaviour’, raises serious questions about psychological approaches. Nevertheless, ‘resources to act on health messages’ are routinely understood as non-material: levels of mental capital or ‘psychological barriers’ to people’s ability to act on information. In public health, psychological resources have become a de facto substitute for income and security.

## 15.5. Count your assets

We believe that sustainable improvements in people’s life chances are most likely to be achieved by identifying and supporting the development of their own capabilities to manage their way out of poverty. (Scottish Government 2011, p. 9)

Assets-based approaches are essentially about recognizing and making the most of people’s strengths, to ‘redress the balance between meeting needs and nurturing the strengths and resources of people and communities’ (McLean 2011, p. 2), with a corresponding shift in focus from the determinants of illness to the determinants of health (salutogenesis). Although assets can include material resources—land, buildings, and income—in public health the primary focus is on valuing individual and collective psychosocial attributes (Friedli 2013). These include the familiar roll-call of self-esteem, aspiration, confidence, optimism, sense of coherence (SOC), meaning and purpose, the so-called intangible assets such as knowledge, skills, wisdom, and culture, and key features of social capital: social networks, reciprocity, mutual aid, and collective efficacy (Lindstrom and Eriksson 2010).

Assets-based approaches draw on positive psychology and the work of Antonovsky on SOC (Antonovsky 1987), as well as on traditions of community development (McKnight 1995) and health activism, notably in the disability rights, user/survivor, and recovery movements (Duffy 2010). Based on empirical studies of psychological resilience in the face of profound adversity, Antonovsky argues that the presence or absence of SOC is fundamental to understanding life outcomes, notwithstanding the experience of trauma. Individuals who

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<sup>2</sup> Health 2020, a new public health policy being developed by WHO Regional Office for Europe, will also focus on equity and social determinants, <http://www.euro.who.int/en/what-we-do/event/first-meeting-of-the-european-health-policy-forum/health-2020>.

experience life as structured, predictable, and explicable, who are confident that they have the resources to meet demands, and who believe that such demands are challenges worthy of investment and engagement are thus said to be consistently more likely to have positive health (Lindstrom and Eriksson 2010).

Despite the evangelical zeal that assets-based approaches have generated, notably in Scotland, where they have enjoyed strong support from Professor Sir Harry Burns (Chief Medical Officer in Scotland 2005–14), there is no evidence that SOC can explain health inequalities, or that assets approaches can reverse the main avoidable causes of morbidity and mortality. A recent analysis of data from a cross-sectional survey of the populations of Glasgow, Liverpool, and Manchester did not support either a lower SOC or psychological outlook (optimism, aspirations, hedonism, individualism) as plausible factors in explaining Glasgow's excess mortality and poor health (Walsh et al 2013).

In the absence of evidence and critical debate, the function of assets-based approaches is purely ideological. They are being used:

- ♦ to reinforce the view that the way in which poor people make use of welfare benefits (income and services) is morally flawed and unaffordable;
- ♦ to perpetuate the idea that 'a culture of poverty' produces psychological traits that trap people (and their children) in 'lives of destitution' and dependency; and
- ♦ to suggest that 'cycles of dependency and need' are characteristic not of the rich, currently enjoying unprecedented levels of fiscal privilege and state benefits, but of the poor.

As Mark Steel has observed, 'it takes a trained mind to understand that the people who are robbing us are the poor' (Steel 2013).

## 15.6. Limitations of materialist analysis

Assets-based approaches are strongly associated with a non-materialist position—money does not matter as much as relationships, sense of meaning and belonging, opportunities to contribute, and autonomy. Like the wider wellbeing debates (Friedli 2009; ONS 2011), they address some limitations of materialist accounts:

They speak to the resistance of deprived communities to being pathologised, criminalised, ostracised; to being described in public health reports in terms of multiple deficits and disorders: chaotic, unengaged, and disaffected. (Friedli 2011, p. 29)

Strengths-based discourse has been an important element in resistance to the imposition of psychiatric labels and diagnostic categories and to public health attempts to pathologize those who are poor. The capabilities approach in the work of Sen, Nussbaum, and others is part of wider international efforts to recognize and address the non-material dimensions of poverty and deprivation, which feature so strongly in narrative testimonies of citizens living in poverty and other excluded groups (Nussbaum 2011). What is at stake is the social, emotional, and spiritual impact of poverty and inequality, as well as the view that well-being does not depend solely upon economic assets (Sen 1992).

The problem with the assets-based literature is that respect for people's capacity for resistance (generally described as 'resilience') is abstracted from any analysis of social injustice or the causes of inequalities: 'naming who and what are the forces and institutions creating and perpetuating inequitable conditions in the first place' (Birn 2009, p. 168).

## 15.7. Public health and the Glasgow pSoBid study

Strengths-based discourse also dominates public health as part of an ostensibly scientific psychological model that validates the health-giving properties of certain attributes: ‘the right kind of affect’ and ‘unimpaired cognitive function.’<sup>3</sup> A cheerful disposition, in combination with a thankful heart and highly developed ‘executive control’, are so widely celebrated in public health literature that the politics (and epidemiology) of this reification is rarely questioned. In this brave new world, people who are poor constitute clusters of impaired brains, targets for novel and exciting new interventions:

Although the number of children born into poverty in the UK and elsewhere is high and may be rising, a broadening array of findings from brain and behavioural sciences suggest novel targets for intervention to reduce the strength of association between ‘demography and destiny . . .’ Together with interventions that target brains, those that target environments could reduce the double hit faced by those born into poverty: living in environments that contain more cues for unhealthier behaviours, **coupled with a reduced capacity to inhibit responses to those cues** (emphasis added).

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In other words, notwithstanding rising levels of poverty, brain and behavioural science can solve the problem of poor people’s inability to resist unhealthy behaviour. The objectification of ‘those born into poverty’ in this paper (and many other papers) and the casual fatalism regarding poverty, are a reminder of the growing social, emotional, and moral distance between people who design public health interventions and those who experience them (see Chapters 6, 16, and 17). A reminder too, of public health’s contribution to social abjection: stigmatizing the behaviour and existence of the poorest citizens (Tyler 2013).

A potent example of these trends is a series of papers linking personality characteristics to health behaviour that forms part of the Glasgow Centre for Population Health pSoBid study (GCPH 2013), which aims to ‘examine the pathways between people’s social circumstances, mental wellbeing, and biological markers of disease’ (Millar et al 2013; Packard et al 2012; Velupillai et al 2008). The pSoBid research is concerned with an important question: can a deeper understanding of psychological factors (the domain of the psychosocial) deepen our understanding of health inequalities, notably Glasgow’s ‘excess mortality’? (Walsh et al 2013). In practice, however, the pSoBid protocol for examining questions such as ‘do deprived groups differ from affluent ones in psychological profile (affective state and cognition)?’ (Velupillai et al 2008, p. 3) reinforces certain messages about people living in deprived areas (with their ‘impaired cognitive function’ and ‘altered (negative) mental outlook’). This framing both justifies and promotes (psychological) interventions that target the health behaviour of people who are poor:

From a public health perspective it is important to establish if those who need to take on board messages advocating lifestyle change (weight loss, physical activity) are in a position affectively and intellectually to receive them. Equally, certain personality and other individual difference factors modify responses to stress and challenge, conferring both vulnerability and protection, and must be accounted for as moderating variables.

<sup>3</sup> My thanks to Robert Stearn (personal communication) for the apt description ‘the right affect’.

Reprinted from Yoga N Velupillai, Chris J Packard, G David Batty, Vladimir Bezlyak, Harry Burns, Jonathan Cavanagh, Kevin Deans, Ian Ford, Agnes McGinty, Keith Millar, Naveed Sattar, Paul Shiels, and Carol Tannahill, Psychological, social and biological determinants of ill health (pSoBid): Study Protocol of a population-based study, *BMC Public Health* 8, p.126 doi:10.1186/1471-2458-8-126 © 2008 Velupillai et al; licensee BioMed Central Ltd. This quote is licensed under the terms of the Creative Commons Attribution License

Just as in assets-based discourse, the underlying message here is that resilience to ‘stress and challenge’ flows from psychological rather than material resources.

Papers by Packard and colleagues (2012) and Millar and colleagues (2013) show that the pSoBid study’s actual concern is ‘the identification of individuals whose personality styles render them vulnerable to particular health risks’ (Millar et al 2013, p. 8) on the basis that ‘individuals who display certain personality characteristics are more likely to indulge in harmful health behaviours and to have increased risk of morbidity and mortality’ (Millar et al 2013, p. 1). The use of the term ‘indulge’ in reference to harmful health behaviours signals a familiar normative message; concepts like ‘pessimistic worry’ and ‘low conscientiousness’ encode a moral framework that locates poor health in attributes defined as psychological deficits. The caveat that certain personality characteristics are ‘associated with low SES’ does nothing to prompt questions about the usefulness of the constructs or to subvert notions of ‘harmful health behaviour’ as a determinant of health. On the contrary, it confirms the original hypothesis—that deprived groups differ from affluent ones in ‘psychological profile’—and invites and authorizes ever-more intrusive psycho-interventions targeted at disadvantaged populations:

A strategy of adapting interventions to the behaviours and beliefs that characterise particular personality types may improve the implementation of intervention programmes. (Millar et al 2013, p. 8; see also Packard et al 2012, p. 8)

Although there is robust evidence that interventions focusing on health behaviour are likely to increase health inequalities (see McCartney et al 2013; and Chapters 1, 2, 8, and 9), in the pSoBid studies, psychology functions to distract attention from the established and primary relationship between material deprivation and poor health. In a curious sleight of hand, psychology assumes a special importance for those who are most deprived:

Personality traits and mental wellbeing are more important determinants of health behaviours within areas of high socioeconomic deprivation . . . no personality trait or aspect of mental wellbeing appeared to predict this health behaviour in the more affluent group. (Packard et al 2012, p. 9)

Other research in the pSoBid series examines the ‘association between neighbourhood level deprivation and brain network structure’. This apparently demonstrates ‘a structural organization that is consistent with a [brain] system that is less robust and less efficient in information processing. These findings provide some evidence of the relationship between socioeconomic deprivation and brain network topology’ (Krishnadas et al 2013). So there we have it. Deprived Glaswegians may defy claims that they lack a ‘sense of coherence’ (Walsh et al 2013), but there is a marked deficit in their ‘brain power’.

Although ostensibly concerned with the impact of deprivation, these papers serve to obscure the fundamental drivers of health inequalities: inequalities in power, privilege, and resources. In Packard et al’s conclusion, in what amounts to a specification for social marketing (NSMC 2013), the social determinants of health are entirely absent:

Persistence of a social divide in health may be related to interactions between personality, mental wellbeing and the adoption of good health behaviours in deprived areas. Effectiveness of health messages may be enhanced by accommodating the variation in the levels of extraversion, neuroticism, hopelessness and sense of coherence. (Packard et al 2012, p. 1)

As has been noted, what is also absent is any reference to the contested nature of constructs such as personality and mental well-being, their ideological underpinnings, and the processes through which specific characteristics acquire both social value and economic reward. In other words, the political nature of these issues is evaded.

## 15.8. Workfare

While notions of psychological failure are implied in public health discourse, they are explicit in welfare reform interventions targeting social security claimants (Friedli and Stearn 2013; Friedli and Stearn 2015). Eligibility for both out-of-work and in-work benefits is contingent not only on certain behaviours, but also on possession of positive affect. ‘Employability’ is now less a set of skills than a mindset. Psycho-compulsions familiar from the ‘recovery agenda’ (Howell and Voronka 2012) are key features in ‘workfare’—the central plank in the management and governance of a wide range of ‘unproductive’ or failing citizens, i.e. those who are out of work, not working enough, not earning enough, and/or failing to seek work with sufficient application (see Box 15.1).

The use of positive affect in the delivery of workfare has far-ranging consequences for people who are unemployed, sick, disabled, or in ‘in-work’ poverty. These include mandatory participation in ‘positive psychology’ courses and the use of psychological referral as punishment for non-compliance with the new regimes of welfare conditionality to which people claiming out-of-work benefits (or, in future, universal credit) are subject (Citizens Advice Bureau 2013). This means that those currently claiming benefits, and those who could be at risk of doing so, are regularly subjected to the blandishments of positive thinking. As we have seen, this includes positive affect as a substitute for income and security.

These developments mean that—in the lives of those who are poor—positive psychology is now as significant a feature of conditionality as going to church once was, and they share a common evangelical language: ‘something within the spirit of individuals living within deprived communities that needs healed’ (SCDC 2011, p. 3).

Unfortunately, the compulsions of positive affect are not confined to Sundays.

I am shy and have difficulty speaking to people and I will not do play acting in front of a group of people I am very uncomfortable with. . . . I was told I would be sanctioned if I didn’t take part, so I said I would get up, but I am not speaking. . . . After that, we had to fill out yet another ‘benefits of being assertive’ sheet.

Reproduced from K. Day, *How Work Programme Makes me Feel*, Sunday 18th August 2013, <http://soisthismylifenow.blogspot.co.uk/2013/08/how-work-programme-makes-me-feel.html>. Accessed 12th February 2015 © 2013 K. Day, with permission

Compulsory positive affect and psychological authority are being applied in workfare for three reasons:

- ◆ to identify ostensible psychological barriers to gaining employment;
- ◆ to punish people for non-compliance (through conditionality and benefit sanctions); and
- ◆ to inculcate attributes and attitudes said to increase employability.

The consistent failure of Work Programme interventions to improve work outcomes has resulted in a much greater focus on psychological or ‘soft outcomes’, said to ‘move people closer to work’:

Evidence from this evaluation suggests that while there was **no significant difference in job outcomes** at the end of the programme, [it was] **successful in achieving soft outcomes such as increases in motivation, confidence, job-seeking behaviour and a positive change in attitudes to work**. These softer impacts may yet translate into job outcomes and sign off from JSA.

Reprinted from Nilufer Rahim, Mehul Kotecha, Jenny Chanfreau, Sue Arthur, Martin Mitchell, Colin Payne and Sarah Haywood, *Evaluation of Support for the Very Long-Term Unemployed Trailblazer*, p.4 © 2012 Department of Work and Pensions. This quote is licensed under the terms of the Open Government License, v.3. Emphasis added

Efforts to achieve these ‘soft outcomes’ are evident in the course content of mandatory training programmes run by major workfare contractors like A4e and Ingeus. The A4e Engage Module states that ‘students will learn how to develop the right mindset which will appeal to employers’ (other elements of this module are assertiveness, confidence, benefits of work, motivation, and enhance your mood). One of the criteria for being sent on Community Work Placements (DWP 2013) is ‘lack of motivation’, regarded in the policy literature as a significant impediment to gaining employment, although never precisely defined.

### Box 15.1. Workfare.

Workfare is any activity that a person in receipt of social security payments is obliged to do in order to continue to receive those payments, and which they carry out under the threat of sanctions. Often, workfare is forced, unpaid work for a business, charity, or social enterprise, or mandatory participation in training.

Sanctions are the cessation of payment of one or more benefit, in whole or in part, for a period of time. They are the threat which ensures people engage in workfare. Typically, sanctions involve a 100% decrease in the amount paid; for Jobseeker’s Allowance, they can last from 4 weeks to 3 years.

Source: Data from L. Friedli and R. Stearn *Whistle while you work (for nothing): positive affect as coercive strategy—the case of workfare*, 2013. Retrieved from <http://medicalhumanities.wordpress.com/2013/12/10/whistle-while-you-work-for-nothing-positive-affect-as-coercive-strategy-the-case-of-workfare/> and D. Webster, *Independent review of Jobseeker’s Allowance (JSA) sanctions for claimants failing to take part in back to work schemes*, 2014. Retrieved from [http://www.cpag.org.uk/sites/default/files/uploads/CPAG-David-Webster-submission-Oakley-review-Jan-14\\_0.pdf](http://www.cpag.org.uk/sites/default/files/uploads/CPAG-David-Webster-submission-Oakley-review-Jan-14_0.pdf).

## 15.9. Increasing positive affect

In addition to mandatory training informed by positive psychology, claimants may be subjected to strengths-based interventions, including online psychometric testing, and ‘failure to comply may result in loss of benefits’ (SKwawkbox 2013). As Cromby and Willis have noted, every aspect of the Values in Action (VIA) ‘Inventory of Signature Strengths’ test recently imposed on claimants contravened the British Psychological Society’s ethical code (Cromby and Willis 2013).

Positive affect as it is now deployed constitutes a more and more arduous and demeaning array of tasks whose insufficient performance is a sanctionable offence. Working on these deficits becomes the full-time, unpaid labour of millions of people, which, together with mandatory job search activities, ensures that these days, people who are poor have no money, no time, and no place:

Basically what I'm saying in short is that I feel there is no place in society for a quiet, shy, creative person like me. And now I feel I don't even deserve to call myself creative, because I don't even do that anymore, because I am too depressed.

Reproduced from K. Day, *How Work Programme Makes me Feel*, Sunday 18th August 2013, <http://soisthismylifenow.blogspot.co.uk/2013/08/how-work-programme-makes-me-feel.html>. Accessed 12th February 2015 © 2013 K. Day, with permission

## 15.10. Conclusions

[T]he voices of resistance against the abjectifying logic of neo-liberal governmentality are growing louder. (Tyler 2013, p. 2)

The participation of psychology (and by implication, psychologists) in the delivery of coercive goals in health and in welfare reform clearly raises ethical questions. The discourse of assets, the psychological determinism of the Glasgow pSoBid study, and the psycho-compulsions of workfare all demonstrate, to varying degrees, the coercive use of positive affect. Public health's preoccupation with a 'tiny proportion of variables' (Lewis 2014) involves increasing levels of abstraction: the brain is abstracted from the person; personality, disposition, and behaviour are abstracted from context, history, and political struggle. Whether in health or in employment, psychology is implicated in what amounts to a 'substitution of outcomes', where the modification of psychological attributes stands in for delivering actual improvements in health or increasing the availability of real paid work. Choosing *psycho*-analysis over *economic* analysis has serious consequences for how public health explains and responds to issues of social justice. The discourse of 'assets' and 'resilience' is entirely consistent with the erosion of universal services, the dismantling of social security, and new configurations of the deserving and undeserving poor.

Psychology now plays a central and formative role in stigmatizing the 'existence and behaviour of various categories of poor citizens' (Slater 2013). Mandatory work activity and 'supported job searches' involve tasks experienced as humiliating and pointless by job seekers (Day 2013a): the 'grotesque daily practices of condemnation and disenfranchisement' that contribute to the social abjection of the most socially and economically disadvantaged citizens (Tyler 2013, pp. 170–171). There is no evidence that work programme psycho-interventions increase the likelihood of gaining decent paid work. In perpetuating notions of psychological failure, they shift attention away from the social patterning of poor health and unemployment and from wider trends: market failure, the rise of in-work poverty, the cost-of-living crisis, and the scale of income inequalities (Shildrick et al 2012; Whittaker and Hurrell 2013).

Psychology is the origin of the term psychosocial and the linking of the social patterning of psychological stressors to disease distribution (Krieger 2011, p. 193). If inequalities in health are a matter of social justice—a consequence of inequalities in power, wealth, and income—then psychology and those engaged in psychosocial research have a shared responsibility to ask and to address the political question: who and what is responsible for the generation and patterning of psychosocial stressors? As things stand, such questions are largely absent from public health, which is becoming more and more enmeshed in the cult of the 'ideal' personality. Even so, these questions are being asked elsewhere, in the bubbling-up of multiple forms of resistance to neoliberal definitions of value and worth and to the erosion of the hard-won rights of social citizenship.

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