Social Inequality and Mental Health in Chile, Ecuador, and Colombia

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The results of a comparative study of social inequality and mental health show that Chile and Colombia, which have enormous social gaps despite their economic growth, are characterized by poor mental health indicators and social discontent, while the better equity indicators in Ecuador are not clearly linked to mental health. The concept of social defeat is suggested as a mediator between social inequality and individual and collective mental health, and participation and empowerment are suggested as ways of improving social well-being.

Los resultados de un estudio comparativo de desigualdad social y salud mental muestran que Chile y Colombia, que tienen enormes brechas sociales a pesar de su crecimiento económico, se caracterizan por indicadores de salud mental deficientes y descontento social, mientras que los mejores indicadores de equidad en Ecuador no están claramente vinculados a la salud mental. El concepto de derrota social se sugiere como un mediador entre la desigualdad social y la salud mental individual y colectiva, y la participación y el empoderamiento se sugieren como formas de mejorar el bienestar social.

Keywords: *Mental health, Social well-being, Social inequality, Social defeat, Public policy*

It is recognized worldwide that social variables influence people's health (WHO, 2008). In Latin America, however, an increase in macroeconomic indicators has not always translated into improved individual health and/or well-being, and this may be related to inequality. Most studies of the relationship between health and inequality focus on epidemiological variables (Kaufman and Mezones-Holguín, 2013; Muntaner et al., 2003) or on power relations and the control of capital (Domingo-Salvany et al., 2013; Rocha et al., 2013) rather than on the way people construct and represent the sociopolitical context in which they live. For this reason, the guiding question for this essay is what psychosocial processes make it possible for social inequality to affect mental health.

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Studies emphasize the social dimension, including aspects such as empathy, the ability to establish interpersonal relations (Jahoda, 1958), satisfying the need for bonds (Ryan and Deci, 2000) and establishing positive relations with others (Ryff, 1989), as a basic component of health. The WHO (2002: 2) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," incorporating the concept of social well-being originally proposed by Corey Keyes (1998) and including self-esteem, satisfaction with life, sense of well-being, social sensitivity, and positive affect (Keyes, 2005; Shapiro et al., 2008). From this we infer that the inequality and discontent that characterize Latin American countries make it highly likely that their health will be affected. This is not an assertion of social determinism but a relational view in which people cannot be separated from their physical and mental features or from the social and cultural contexts in which they are imbedded.

The effects of inequality can be explained in terms of the inability of lower-income groups to acquire the material conditions necessary for good health (Lynch, Smith, and House, 2000). Another approach suggests that physical and psychological discomfort develops when people evaluate themselves as having lower status than a reference group (Hounkpatin et al., 2015). Empirical studies such as that of Daly, Boyce, and Wood (2015) show that a low social position based on gross income compared with various reference groups (gender, age, education, and place of residence) is a better determinant of various indicators of physical health problems than gross income per se. The same occurs in predicting psychological distress (Wood et al., 2012). Low social position has been found a better predictor than gross income of symptoms of depression (Hounkpatin et al., 2015), low overall satisfaction (Boyce, Brown, and Moore, 2010), and even suicidal ideation and attempts (Wetherall et al., 2015). These studies use databases with macroeconomic and social indicators, leading some writers to point to the need for more research into the psychological mechanisms that link social context with individual malady, with social comparison being fundamental to their understanding (Hounkpatin et al., 2016; Wilkinson and Pickett, 2006).

Developmental models of social functioning show that subjects with low or subordinate social positions will display physiological and behavioral reactions that make them more vulnerable to health problems (Mendelson, Thurston, and Kubzansky, 2008). When applying this to mental health, the term "social defeat" surfaces. This concept involves negative behavioral and cognitive reactions to failure to attain status or goals in comparison with others (Gilbert, 2006). This mechanism, which assumes social comparison, has been studied empirically only in relation to individual clinical variables. Therefore, its association with social variables is still unexplored, and we suggest that it could be useful in understanding mental health in Latin America. Accordingly, this essay will analyze figures on inequality and studies that relate it to mental health and well-being in the past 20 years in Latin America and examine the concept of social defeat as a possibility for explaining the impact of inequality on mental health.

THE SOCIOPOLITICAL CONTEXT OF INEQUALITY

Latin America has been viewed historically as founded on relations of inequality. This can be traced back to the colonizing enterprise, which set up strict power relations based on the oppression of the original peoples, imposing European cultures on the local ones. In the continent's historical development, these power relations were reproduced by the establishment of social classes that concentrated power and resources, supporting forms of government that perpetuated them. The history of the continent between the 1950s and the 1990s created dictatorial processes for Chile, Colombia, and Ecuador that perpetuated the asymmetry of power and resources among their citizens, the basis of the economic models that maintain inequality in these societies today (Katz, 2015).

CHILE

The case of Chile is emblematic. During the Pinochet dictatorship of the 1970s, under heavy repression and social control, a Milton Friedman–style neoliberal economic model consisting of the imposition of a free market, drastic tax reductions, privatization of services, cuts in social spending, and general liberalization and deregulation was implemented (Klein, 2008). As a result, a dominant elite pursuing free-market business arose, and it was allowed to concentrate economic resources and power in contrast to a working class that saw its working conditions become insecure, losing social benefits through the privatization of public services such as health care, pensions, and education (Espinoza, Barozet, and Méndez, 2013). The return to democracy in the 1990s did not improve those conditions; the postdictatorship governments maintained the economic model despite implementing social policies that allocated economic resources to the most vulnerable. This led to an improvement in poverty indicators without its translating into a more egalitarian society or an improvement of well-being.

For example, considering suicide as the extreme of psychological distress, Moyano and Barría (2006) found a direct relation ($r = 0.87$) between the growth curves of the suicide rate and the gross domestic product (GDP) during the period from 1981 to 2003. Between the 1990s and 2000 Chile had an approximate annual growth of 5 percent (Espinoza, Barozet, and Méndez, 2013), and between 2006 and 2013 it reduced poverty rates from 29.1 percent to 14.4 percent (MDS, 2015). At the same time, the Gini coefficient fluctuated between 0.50 and 0.51, above the regional average and one of the most noteworthy among the OECD countries (MDS, 2015; OECD, 2015a). The average independent income of a household in the top 10 percent was 27.6–38.8 times that of a household in the bottom 10 percent (MDS, 2015). Likewise, reviewing national stratification and mobility data for the past 10 years Espinoza, Barozet, and Méndez (2013) concluded that Chile has a relatively mobile and permeable class structure in its middle sector but a tendency toward polarization at the extremes, since social distances increase despite economic growth. Health care reform with explicit health guarantees was implemented in 2005, and in both

2000 and 2013 people at the highest social levels continued to have a greater likelihood of obtaining above-average health care than people in the lowest strata (Cabieses et al., 2015). Chile's case shows that economic growth indicators can be deceptively optimistic, concealing a highly unequal distribution of income among the population, and leads us to conclude that the mere fact of subsidizing the disadvantaged is no guarantee of social mobility or improvements in health.

ECUADOR

The past 30 years in Ecuador have been marked by abrupt political, economic, and social changes reflected in successive presidential overthrows and an economic crisis that led to a profound imbalance in the country. The 1999 banking crisis, based on economic deregulation reforms (Larrea, 2002), concentration of credit for businesses, and lack of government monitoring or evaluation (Espinosa, 2000), was a landmark event. Added to this were the drop in the price of oil, the country's principal resource, and the effects on agriculture of natural disasters (Fontaine, 2002). Government measures included a freeze on deposits and widespread bank closures or takeovers by the state, leading to the dollarization of the system as a means of adjustment and stabilization. As a result, unemployment rates increased from 8 percent to 17 percent in 1999 and underemployment to 57 percent, while the minimum wage dropped to US$53 and urban poverty rose from 36 percent to 65 percent (Espinosa, 2000; Fontaine, 2002; Larrea, 2002). Ultimately, some 700,000 Ecuadorians emigrated, mostly to the United States, Spain, and Italy.

Despite an economic recovery following the crisis, there were frequent changes of president until Rafael Correa came to power in 2007. His measures for achieving stability included an economic policy assumed almost completely by the state, the creation of a new constitution, and the development of social policies based on the concept of "living well" (*buen vivir*; Secretaría Nacional de Planificación y Desarrollo, 2009). These initial policies involved a distancing from the neoliberal paradigm that garnered massive citizen support for the "Citizens' Revolution" in Correa's first term. In addition, an economic bonanza achieved with the rise in oil prices to historic levels allowed for a strengthening of the state in income distribution and implementation of measures aimed at development, access to rights, and institutional consolidation (Martínez, 2015: V. Silva, 2016). A significant reduction in poverty was achieved between 2006 and 2014, from 37.6 percent to 22.5 percent (World Bank, 2016), along with a reduction in extreme poverty from 16.9 percent to 8.6 percent (INEC, 2014). The Gini coefficient, 0.55 in 2007, dropped to 0.47 in 2015 (INEC, 2014; World Bank, 2016) and was practically identical in urban and rural areas. By the same token, the inequality index dropped by 1.7 percent (UNDP, 2014). Thus inequality as measured by income level has displayed a sustained reduction over the past 10 years. A measure that provided monthly vouchers to almost 2 million people may have influenced the sustained rise in the human development index, which reached 0.732 (UNDP, 2013). Despite these advances, 23.7 percent remain at the poverty level, with significant differences between the urban (15.6 percent) and rural (39.3 percent) popula-

tions (INEC, 2014; World Bank, 2016)—figures that call the progress in the Gini coefficient into question.

In health, coverage in the more vulnerable quintiles increased from 35 percent to 80 percent between 2006 and 2013, and health insurance increased from 17 percent to 34 percent in the same period (INEC, 2014). However, a recent report from Aldeas Infantiles SOS (2015) noted the lack of psychological and mental health services for the treatment of addiction and severe mental disorders. Additionally, there are few reports on the epidemiology of specific disorders, and the data currently available on mental health tend to be presented separately from epidemiological variables. As a result, it is difficult to find an analysis that promotes a comprehensive explanation of the progress reported in these areas. For example, issues such as the 3.4 percent increase in suicides among youth from 2000 to 2012 (WHO, 2014) point to the need to know more about the social and economic factors involved in this situation.

In recent years, increasing labor flexibilization and privatization in mining projects have signaled a return to the neoliberal economic policies implemented during the 1990s (Acosta and Hurtado-Caicedo, 2016). Although the current administration has not fully recognized it, a crisis exists in the form of economic recession and deterioration of growth prospects (IMF, 2016), along with discontent among those displaced by the mining industry and an increase in unemployment from 4.2 percent to 5.4 percent (ILO, 2016).

In short, indicators in Ecuadorian society over the past decade demonstrate economic and social progress tending toward a more equitable society, but there are no data from national or international organizations that consider the relationship between social inequality and health variables. Finally, the current crisis has produced changes in the country's political and economic stability that are causing noticeable changes in the reported trend.

COLOMBIA

Colombia joined the trend toward the use of the neoliberal economic model in the 1990s, implementing significant changes in the comprehensive social security system and prioritizing investment in industry (Observatorio Nacional de Salud, 2015). These processes redefined the land and its relationships in terms of production and marketing needs (Bello, 2004), setting the stage for a widening of the gap between rich and poor. In particular, small farmers and indigenous populations cannot compete with large agricultural businesses and struggle against expulsion from their lands to make way for road building and commercial enterprises. The 2006–2010 National Development Plan was created to reduce poverty and improve health care for vulnerable groups, and when it achieved only meager results new policies with similar objectives for 2012–2021 were implemented. The social and economic policies employed by the National Planning Department to address inequality have been deemed successful in light of the decline in the Gini coefficient from 0.53 in 2014 to 0.52 in 2015 (DANE, 2015). However, UN-Habitat (2014) ranked Colombia among the 10 least equitable countries. Between 2010 and 2015, 4,574,000 people rose out of extreme poverty because of the United Network and Families in Action program, focused on support and the provision of housing. The indicators on

access to basic services such as electricity, sewage systems, and potable water improved, but those on education, health care, the environment, and the social system were judged inequitable (Observatorio Nacional de Salud, 2015).

All these changes in economic variables and inequality in Colombia proceeded in parallel to the so-called internal armed conflict that goes back at least to the 1950s, pitting the state, the guerrilla groups (the Fuerzas Armadas Revolucionarios de Colombia and the Ejército de Liberación Nacional, among others), and the "self-defense" paramilitary groups against each other. The country has the largest number of internally displaced persons in the world (IDMC, 2013) and ranks eighth in the number of refugees outside its borders (UNHCR, 2012). The farmer population is bitter about the consequences of the introduction of the neoliberal model and the market for illegal crops (Bello, 2004: 21), along with the increase in drug trafficking and the traffickers' participation in the struggle for control of territory (Castillo, 2004).

Colombia has improved its poverty indicators and slightly reduced inequality in recent years, but government policies are currently failing to provide services and/or quality resources. Added to this, violence and the displacement of civilians present a challenge to the state to assist various vulnerable groups by promoting agricultural development and political participation, solving the problem of illegal drugs, attending to the victims of the armed conflict, and ending the war. All of this produces socioeconomic uncertainty because of the increase in the number of beneficiaries of these policies and the challenge for coordination between the state, the private sector, and organizations to guarantee social security, education, health care, and well-being.

ASSESSING INEQUALITY IN HEALTH CARE

Ortiz-Hernández, López-Moreno, and Borges (2007) point out that a combination of criteria is employed to analyze the social determinants of health: epidemiological (mortality rates, morbidity, or life expectancy), sociological (educational level, income, and socioeconomic position), and economic (poverty, Gini coefficient). Measures that assess inequality and health tend to use social stratification, through nominal or ordinal categories, because of practical considerations or the availability of databases (Galobardes et al., 2006; Muntaner et al., 2003). They add that in general inequality is considered an expression of stratification (as in Colombia, where the ranking from 1 to 6 that is applied to housing ends up being the focal point of discrimination among people). The effects of this are significant because the social relations resulting from inequality are not questioned (Muntaner et al., 2003; 2012). Variables that focus on income level or on consumer goods do not analyze employment situations, control/authority relations on the job, or power differences between social classes. Methodological problems in evaluating social class are also evident, especially with regard to the social strata at the extremes, where people are less accessible to research efforts (Muntaner et al., 2003). For all of the above, measuring inequality could be improved if other dimensions, such as educational level in income distribution and purchasing power, were used. When the UNDP's human development index is applied to Latin America, it is clear that

purchasing power sets the conditions for health and education. If this index were analyzed from the perspective of inequality, it would drop from 0.83 to 0.67 in Chile, from 0.72 to 0.54 in Colombia, and from 0.73 to 0.57 in Ecuador. From this example and Wilkinson's (2002) inputs, it is possible to assume that the countries with better health indicators are those with the smallest gap between wealth and poverty. Another measure supplementing those currently used to measure inequality might be the International Index of Social and Health Problems, which includes, among other things, inquiries into mental disorders, social mobility, and confidence (Wilkinson and Pickett, 2010).

Instead of considering wealth and/or home furnishings, measures of income inequality tend to include the financial assets, real estate holdings, and savings instruments that are usually possessed by the higher-income sectors, reflecting a position handed down over time that directly influences health (Hounkpatin et al., 2015). When wealth is included, the description of inequality appears with a greater gap, and figures such as the global Gini soar to values close to 0.8 (UNICEF, 2012). If current poverty indicators were supplemented with measures that assessed the relationship between social determinants and health, policies could be tailored to the design of more equitable communities.

SOCIAL DEFEAT AS A MEDIATOR BETWEEN HEALTH AND SOCIAL INEQUALITY

At the individual level, it has been suggested that mental depression may explain the way inequality affects health, presenting it as a mediator of this relationship. Symptoms of depression may be a reaction to contexts such as dangerous neighborhoods and/or high levels of family conflict (Chen and Miller, 2013). Following this logic, improving people's life settings could improve their mental health. At the same time, theories of depression indicate that human beings, like other primates, are highly sensitive to social hierarchies because they provide information on the resources available to them and the likelihood of obtaining them (Price, 1972). Those who consider themselves of low social status will have little expectation of obtaining what they need; their tolerance for frustration will drop and they will avoid conflict with those more powerful by displaying submissive behavior. All these reactions will have a physical correlation involving the serotonergic system and the stress regulator, which are associated with symptoms of depression (Hounkpatin et al., 2015). In this approach, manifestations of depression are understood as defensive responses to the perception of low social status and not just reactions to an adverse condition (Taylor et al., 2011).

We have established that Chile is a highly unequal country, and, consistent with this, epidemiological studies there show a prevalence of major depressive disorders of 9.2 percent, very similar to that found in the United States (9.6 percent) and among the highest in the world (D. A. Silva and Valdivia, 2013; Vicente et al., 2006). Similarly, we have pointed to the country's sustained economic growth and the GES plan for subsidizing health care, both of which should have had a positive impact on mental health in recent decades. Instead, while in 2003 (before the GES) 17.5 percent of the population showed

symptoms of depression, in 2009 (after the GES) the figure had changed only changed slightly, to 17.2 percent (Errázuriz et al., 2015). These figures show that provision of resources without a transformation of the social structure does not produce the desired effect. In fact, while the GES plan improved access for the disadvantaged sectors, inequality in health care associated with educational level, income, and type of retirement system increased between 2000 and 2013 (Cabieses et al., 2015), which could explain the sustained figures on depression and other indicators of poor health. In Colombia, a country with a socioeconomic model and inequality indicators similar to Chile's, indicators of well-being for the 18–44-year-old population were between 32.5 percent and 42.2 percent depending on the question and gender. In this regard, Hounkpatin et al. (2016) suggest that in inequitable settings comparisons can result in physical and psychological distress.

Not all those who consider themselves of low social status will develop a depressive disorder; it has been suggested that this will require psychological characteristics that interact with the setting and the individual's biological makeup. The concept of social defeat, defined as a sense of failure associated with the loss of a valued status or important personal goal (Gilbert and Allan, 1998), has social comparison at its core but adds an individual component in proposing that human beings develop their own psychological hierarchies of goals and are conscious of their social positions in relation to those goals. In nonpathological conditions unfavorable social comparison implies accepting the defeat—feeling its consequences (submission, low motivation, hormonal reaction) only temporarily before redirecting motivation and behavior toward new goals (Sloman, Gilbert, and Hasey, 2003). Nevertheless, when one is incapable of overcoming the defeat, a psychopathological condition—feeling trapped and chronically suffering its consequences (Taylor et al., 2011)—will appear. This mechanism has received broad empirical support for explaining depression, anxiety, and suicide (Siddaway et al., 2015; Taylor et al., 2011).

People in the disadvantaged classes in Chile can be assumed to live with a chronic sense of defeat and distress over the inability to attain valued goals because of the lack of the resources to reach them. This constant sense of defeat may help us to understand why the prevalence of depressive symptomatology increases as the socioeconomic level declines (Jiménez and Orchard, 2013) independent of mental health subsidies and of the relation between low social status and the prevalence of mental disorder or symptoms of comorbidity and anxiety in general (Vicente et al., 2006). In terms of working conditions, social class, and mental health the data also support our suggestion, showing that upper-class people are less likely to display mental health problems than supervisors and formal and informal workers (Rocha et al., 2014).

With regard to the perception of their social position, qualitative studies show that Chileans view their society as highly classist and provide many examples of the advantages of having economic resources or belonging to a high social class. Worse, they maintain that this situation is inherited by certain individuals or groups (Garretón and Cumsille, 2002). The inability to overcome defeat has been put forward as the variable most highly associated with suicide (Siddaway et al., 2015). The idea of the heritability of class may be related to the increase in the suicide rate by 54.9 percent between 1995 and 2009, especially

among youth (OECD, 2015b). In Colombia a measure of socioeconomic stratification in which 1 is extreme poverty and 6 is economic solvency (Alzate, 2006) has led to a demarcation of classes, conditioning the perception of social position and identifying the opportunities of each stratum in terms of certain social criteria, which makes social mobility difficult for the less favored social classes. Consequently the 2015 national mental health survey indicates that the adolescents of the lower strata have a higher frequency of depressive, anxious, and psychotic symptoms and that disorders are more prevalent at the lower levels of the social scale. In particular, anxiety disorder is more frequent in persons living in poverty. If we focus on a specific population of "the defeated" in Colombia such as those displaced by the internal conflict, studies show a greater frequency of mental disorders than in the nondisplaced population: 47 percent for anxiety disorder, 37 percent for major depression, and 37 percent for risk of suicide (Londoño et al., 2005). It is striking that, following the Chilean trend, we have begun to see a rise in adolescent suicide rates from 1.57 per 100,000 in 2008 to 1.75 in 2012 (Instituto Nacional de Medicina Legal y Ciencias Forenses, 2013).

From a more collective standpoint, the low motivation and submission that social defeat produces limit individuals' ability to take advantage of opportunities to improve their situation (Gilbert, 2006). More specifically, remaining in defeat is a link to fatalism, defined by Martín-Baró (1973: 486) as "an attitude of passive acceptance of a present and a future in which everything is already predetermined." This is a maladaptive strategy characterized by inaction despite constant discomfort. In this regard, Vidal et al. (2014) point out that Chileans with higher incomes demonstrate better social strategies for dealing with distress. Similarly, members of the disadvantaged classes display less participation and less confidence in public institutions (INJUV, 2012; Latinobarómetro, 2015; OECD, 2015a; UNDP, 2012). In Ecuador, a country with better equality indicators than Chile or Colombia, political participation in the elections of 2013 and 2014 showed a rate of 83.2 percent, an increase of 22.6 percent (Consejo Nacional Electoral, 2015). In contrast, abstention in Chile reached 58 percent, the highest in Latin America among nations with nonobligatory voting, followed by Colombia, with 52.1 percent (International IDEA, 2016).

The consequences of social defeat can be softened by social support (Williams, 1997, cited in Taylor et al., 2011). Rocha et al. (2014) found that Chileans with less perceived social support had worse self-perceived physical and mental health. If support is sought through social media, collective action may result (Sullivan et al., 1980), and action over time may amount to a social movement (Turner and Killian, 1987). The formation of social movements has intensified over the past 10 years and come to cover a variety of issues (Garcés, 2012). In Chile, the defeated have organized themselves to demand rights that, under the socioeconomic model, have become acquirable goods according to one's purchasing power, leaving aside a large portion of society without the possibility of attaining education, quality health care, or a dignified retirement. From another point of view, we could conclude that any country's measure against the collective demand serves to maintain the defeated in their state of inaction. For example, in Ecuador, with the latest government move toward neoliberalism

communities have been stripped of their territories to the benefit of large-scale mining (Acosta and Hurtado, 2016; Colectivo de Investigación y Acción Psicosocial, 2015; 2017) and subjected to the detention of their leaders, militarization, and violence (CONAIE, 2017). These actions seek to break up collective action, fostering the submission and inaction that stem from the state of defeat.

DISCUSSION AND CONCLUSIONS

Latin America is a region of extreme socioeconomic inequality (UNICEF, 2012). This is apparent, for example, in the concentration of wealth in small portions of the population as a result of the capitalist and neoliberal model operating in countries such as Chile and Colombia, where limited and subsidiary states have left supplying goods and services to the population to the private sector (García-Castro, 2010; Harvey, 2007; Katz, 2015). Although the model of the state in Ecuador is different, its progress in the area of health care, as in Chile and Colombia, has been slow because not everyone can afford this subsidized service (OECD, 2015a; UNDP, 2013). This has led to persistent discontent and mistrust of institutions and governments (Baletti, 2016; Latinobarómetro, 2015). The region has historically been characterized by social movements, and during the past decade they have become widespread and their demands wide-ranging. Critiques of the neoliberal model, which, in the guise of free development, fuels individual growth through capital accumulation and the reproduction of profit, touching aspects of life that in welfare states are considered rights, are thereby highlighted (Garcés, 2012; Katz, 2015). Discontent also appears when a state is unable to reduce poverty indicators or offer a range of basic and varied services to the population. Ecuador is in this situation, and, although there is less inequality among its citizens, discomfort and discontent persist.

In the case of Chile, strategies for assessing and taking action on social inequality since 1990 have had a positive effect on poverty reduction, but indicators of mental disorder, levels of participation, and confidence in institutions have not improved. Health care continues to vary in quality with the type of coverage, and there has been little investment in mental health treatment (Errázuriz et al., 2015). High levels of inequality persist, with extensive segregation of social classes and little social mobility. Currently, this structure is being strongly questioned by social movements advocating for equality in education, health care, and pensions and opposing the assignment of the status of "commodity" to these basic rights.

Ecuador has seen significant economic and social progress in the past 10 years, but there is a crisis caused by the decline in the price of petroleum and excessive state control of the country's figures on health care. This, along with punitive actions against those who question the administration, has provoked changes in political and economic stability. The prearranged agreements for the expected sale of oil and the impact of the 2016 earthquake forced government budget cuts that created uncertainty about how the advances of recent years might affect the health and well-being of Ecuadorians subjected to them.

In Colombia the state has committed itself to responding with public policies to improve the quality of life for the most vulnerable, and analysis of social determinants has served to measure mental health in the population. Because of the country's history, this includes identifying the conditions for peace, whose link to health is a challenge requiring public policies that include all groups.

In all three countries, better health and greater satisfaction require reducing the gap between rich and poor. Guaranteeing access to quality services and promoting citizen participation and empowerment are, however, still pending items in Latin America because of the tension that exists between civil society and the state (Astete and Vaccari, 2017). On the one hand, the state needs to provide guarantees of access to services; on the other, it limits participation in decision making in the political realm, preventing people from controlling wage inequalities and the reduction of poverty in a given sector (Katz, 2015).

The Gini coefficients in 2015 were 0.45 in Ecuador, 0.52 in Colombia, and 0.49 in Chile, and no measures have been aimed directly at improving them. The increase in funding for various programs does not guarantee better health for the population or any reduction in these coefficients. In Chile and Colombia, suicide rates, for example, remain largely unchanged (11 per 100,000 inhabitants in Chile and 3.8 in Colombia) (Errázuriz et al., 2015; Instituto Nacional de Medicina Legal y Ciencias Forenses, 2013). In Ecuador, the increase in social investment, including the human development voucher paid monthly to a large portion of the population, has not reduced the poverty rate (currently 23.7 percent). Ecuador has no public figures on the effects of the holistic "living well" plan, and studies that link the Gini, the human development index, poverty measured by income, and percentage of informal labor with mental health epidemiology do not exist. However, there are many inconsistencies between its high human development index (0.732), its 0.45 Gini coefficient, and its poverty level (INEC, 2014; World Bank, 2016). The efforts made in health care do not specify the issue of social determinants as the point of departure. Therefore, a more comprehensive analysis will be required to demonstrate the impact of these changes.

For these reasons, evaluating psychological factors in relation to inequality and health seems an appropriate way of guiding possible individual or collective action. People are conscious of their positions in society, and this makes the social composition of their country a fact that helps define their position in life. In Chile, where purchasing power conditions the "purchase" of important personal goals, the feeling of defeat is generalized, explaining the elevated indicators of mental health problems. Despite this, a culture that promotes social support persists, demanding equality through collective action. In Colombian society disadvantaged groups are marked by the subsidy policy and by a history of displacement and seizure of their lands. While in the former the perception of defeat predominates, the second has objectively been "defeated" and will require focused attention on mental health given that the social divide leaves them with few tools for dealing with the consequences. Both groups display poor mental health indicators. Reporting on Ecuador's social composition has left aside groups such as indigenous populations in economically coveted areas whose attempts to overcome defeat have been

heavily repressed. Added to this is the quarter of the population that is steeped in poverty and job insecurity, an issue that cuts across the three countries because of the effects of the prevailing economic model. Our analysis suggests that part of the Ecuadorian population may be at risk of developing psychopathological processes.

Becoming conscious of one's social position intersects with elements of identity that shape beliefs about oneself and one's goals and expectations of their achievement. Adolescence may be a phase particularly susceptible to the effects of defeat, since identification of reference groups and future goals and, because of progress toward more abstract thought, the incorporation of macrosocial aspects into one's understanding of society are under way. In this regard, the idea of the heritability of class and the conditioning factor of money in the personal goals of Chileans and the identification of class in terms of numbers in Colombian society could exacerbate the perception of defeat, a mechanism associated with suicide. Here we may find an explanation of the increase in the suicide rate in this age-group in these two countries. Reactions to social defeat may involve passivity and apathy, which may lead to resistance and opposition. However, we found no studies of the transformation of social defeat into social movements. The transcultural validation under way in Chile, Colombia, and Ecuador of the main scale of evaluation of social defeat will allow us to corroborate our concept of mental health at the individual and collective levels.

Social defeat should be included in the explanation of the effect of inequality on mental health, and mechanisms for dealing with social defeat should be promoted. From a clinical standpoint, action can be taken to reinforce the social support of surrounding networks. Experiments on this exist in the area of social-communal psychology, where actions are focused on strengthening participation and empowerment. Solidifying strategies for collective coping and community organization, along with the development of leadership and negotiation skills, could provide true alternatives for coping with social defeat, improving subjective well-being, and contributing to the changes advocated by social movements.

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