CHAPTER 8

Socioeconomic Status and Mental Health

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In 1912, the British luxury liner, the *Titanic*, struck an iceberg off the coast of Newfoundland on its maiden voyage from Southampton, England, to New York City. This accident was one of the worst marine disasters ever, with two-thirds of the more than 2,200 persons aboard losing their lives. As the *Titanic* sank, women and children had preferential access to the lifeboats. However, the death rates for women on the *Titanic* were not random but strikingly linked to their social status. Among women passengers aboard the *Titanic*, only 3% of first-class passengers lost their lives, compared to 16% of second-class passengers, and 45% of those in third class (Carroll & Smith, 1997); that is, the quality and cost of accommodation, a marker of social ranking, clearly predicted the probability of survival. The relationship between social location and survival is not unique to the *Titanic*. A positive association between socioeconomic status (SES) and health has been found for most indicators of health status in virtually every society where it has been examined (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Antonovsky 1967; Bunker, Gomby, & Kehrer, 1989; Krieger et al., 1993; Marmot, Kogevinas, & Elston, 1987; Williams, 1990; Williams & Collins, 1995). Mental health status is no exception to this pattern. Sociologists have long noted that one of the most firmly established patterns in the social distribution of psychiatric morbidity is an inverse association between SES and mental illness (Dohrenwend & Dohrenwend, 1969).

Almost a decade ago, Dohrenwend (1990) indicated that research interest in the asso-

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ciation between SES and mental illness was waning. However, in recent years, there has been a dramatic increase in research focusing on the health consequences of SES, with a heavy emphasis on physical health outcomes (Kaplan & Lynch, 1997). This growth in research attention to the SES–health linkage is driven in part by the growing awareness, across a range of scientific disciplines, of the ubiquity and robustness of the association between SES and health and by the increasing recognition that SES differences in health in both the United States and Europe appear to be widening as economic inequalities in society widen (Krieger, Williams & Moss, 1997; Williams & Collins, 1995). This chapter provides a brief overview of early studies that assess the association between SES and mental illness. It then considers in more detail recent findings on the association between socioeconomic position and psychiatric disorders from two large, population-based studies in the United States. Finally, we consider some of the major unresolved issues in research on SES and mental illness.

EARLY STUDIES

Some of the early evidence of this association in the United States comes from studies that examine the relationship between measures of socioeconomic position and treatment for psychiatric illness. Faris and Dunham (1939), for example, studied the association between the social and economic characteristics of Chicago residential areas and the rates of first admission into mental hospitals for schizophrenia, manic–depressive disorder, drug addiction, alcohol psychosis, and old-age psychosis. They found that these mental disorders were all concentrated in and around the relatively undesirable and "socially disorganized" residential areas of the central business district. In another classic early study, Hollingshead and Redlich (1958) identified all residents of New Haven, Connecticut, who were receiving psychiatric treatment by contacting private psychiatrists and all public and private institutions in Connecticut. They found an inverse relationship between mental illness and social class.

These early studies also shed light on some of the processes by which social position affects the context of treatment. For example, the New Haven data demonstrated that high SES persons with schizophrenia entered treatment earlier than their lower SES peers. In addition, schizophrenic persons from the higher SES groups were typically referred to treatment through medical channels, whereas those from lower SES groups were referred through legal ones. The type of treatment also varied by social status. High SES persons with schizophrenia were more likely to receive psychotherapy, while their low SES peers received organic treatment or, in some cases, did not receive any treatment. High SES patients were also more likely than their low SES counterparts to be discharged to their families and communities.

These findings highlight a major problem with the early studies that used treated prevalence to study the association between SES and mental illness. These rates do not include the psychiatric problems of persons who have not entered treatment and are thus importantly affected by health care access and financing options, distance to treatment, available transportation, the client's economic status, and other structural and/or cultural barriers that affect the likelihood of seeking and receiving medical care, as well as being appropriately diagnosed. For example, recent national data of population-based rates of treated and untreated cases of mental illness indicate that only 40% of persons who have met the criteria for psychiatric illness have ever received treatment (Kessler et al., 1994). At the same