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Childhood and adulthood risk factors for socio-economic differentials in psychological distress: evidence from the 1958 British birth cohort

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Abstract

Social inequalities in psychological status have been attributed to health selection and to social causation. We used data from the 1958 British birth cohort, followed over three decades, to identify causes of inequality in adulthood. Psychological status prior to labour market entry influenced inter-generational mobility, but selection effects were weaker for intra-generational mobility, between age 23 and 33. However, selection failed to account for social differences in risk of distress of approximately threefold in classes IV&V compared with I&II. Both childhood and adult life factors appeared to contribute to the development of inequalities. The principal childhood factors were ability at age 7 for both sexes and adverse environment (institutional care for men and low class for women). Adult life factors varied, with stronger effects for work factors (job strain and insecurity) for men and qualifications on leaving school, early child-bearing and financial hardship for women. Gradients in psychological distress reflect the cumulative effect of multiple adversities experienced from childhood. © 2002 Elsevier Science Ltd. All rights reserved.

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Introduction

Socio-economic differences have been observed across a range of mental disorders, including, schizophrenia, anti-social personality disorder and affective disorders, specifically depression and anxiety (Dohrenwend & Dohrenwend, 1974; Leaf, Weissman, Myers, Tischler, & Holzer, 1984; Dohrenwend, 1990; Bruce, Takeuchi, & Leaf, 1991; Dohrenwend et al., 1992; Kessler et al., 1994; Lewis et al., 1998), most studies showing higher rates of disorder among lower socio-economic groups. For more common mental disorder and distress the findings are less consistent (Dohrenwend & Dohrenwend, 1974; Weich & Lewis, 1998; Stansfeld, Head, & Marmot, 1998a), especially during early adulthood (Macintyre & West, 1991; Glendinning, Love, Hendry, & Shucksmith, 1992; Miech, Caspi, Moffitt, Wright, & Silva, 1999).

In general, socio-economic status differences in health have been attributed to either health selection or to social causation. According to the selection hypothesis, men and women with pre-existing illness drift down the social scale and, conversely, those with better health tend to move up the scale. (Thus, health selection is also referred to as health-related social mobility.) Selection effects may be stronger for some conditions, such as schizophrenia and conduct disorder, than for other conditions, notably affective disorders (Dohrenwend et al., 1992; Miech et al., 1999). Likewise, the strength of selection effects may vary with life stage, with more pronounced effects at the time of labour market entry when the individual's adult social position is established. It has been shown that the influence of psychological

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disorders on educational achievement commences from early in childhood (Offord et al., 1992) and continues in relation to adolescent conduct disorders (Jayakody, Danziger, & Kessler, 1998; Miech et al., 1999). In turn, education strongly influences adult social position (Caspi, Elder, & Herbener, 1990; Kuh, Head, Hardy, & Wadsworth, 1997). Psychological status may have an impact on adult social position not solely through education, but also through its effect on social functioning, skills and relationships. Thus, selection effects related to psychological status may be stronger at the transition from class of origin to own destination class (inter-generational mobility) than with any changes in social position during adult life (intra-generational mobility). This expectation of greater health selection during inter-generational mobility is not specific to psychological status, but is thought to apply to other health measures (West, 1991).

Alternatively, social causation could explain health differences through the experience of adversity and stressors in low social status, and conversely, with more favourable conditions experienced in higher social groups. Social differences in factors relevant to mental health are evident at each life stage onwards from birth (Power & Matthews, 1997). First during early life, social causation may begin with conditions in the home environment that are regarded as central to the development of emotional well-being (Offord et al., 1992). A broad range of influences may be relevant, some of which are denoted by family structures, such as one-parent families, parental divorce and institutional care (Quinton & Rutter, 1988; Rutter, Quinton, & Hill, 1990); while other dimensions relate to the quality of family functioning, encompassing emotional support and stimulation, parental aspirations and involvement (Brooks-Gunn, Klebanov, Liaw, & Spiker, 1993). Early educational experiences may also contribute to the development of emotional well-being (Hertzman & Wiens, 1996), particularly through the development of self-esteem and mastery, and these will continue to play a role through to adolescence.

Second, social causation may be linked to material disadvantage in childhood or in adult life (Lundberg, 1991; Offord et al., 1992; Weich & Lewis, 1998). Material circumstances could affect psychological status through social comparison, whereby deprived individuals are adversely affected because of perceived inequity (Wilkinson, 1997). Perceived inequity may be greater in societies with larger income inequalities, which in turn, may increase ill-health (Wilkinson, 1997), although this has been questioned (Muntaner & Lynch, 1999). Alternatively, material circumstances may affect other relevant factors, such as educational achievement, family structure and relationships, which in turn may increase the risk of poor mental health, although financial disadvantage may exacerbate or even underlie these risks, for example, as experienced by lone mothers (Brown & Moran, 1997; Hope, Power, & Rodgers, 1999a). Thus, there may be either direct or indirect mechanisms linking material circumstances and psychological status.

Third, social causation includes adult social relationships that impact on adult mental health and that vary by socio-economic status (Turner & Marino, 1994; Stansfeld et al., 1998a). These factors to some extent are a continuation of family functioning and structure (marital status, lone parenthood) in the early home environment, but in adulthood they also include social support and networks. It is well established that divorce and separation are associated with higher rates of psychiatric distress (Bloom, Asher, & White, 1978; Kitson & Morgan, 1990) as demonstrated in the life events literature (Paykel et al., 1969). For women, there may be an additional influence of the burden of childcare, as indexed in many studies by number of children, single motherhood and teenage pregnancy, all of which have been associated with adverse psychological distress (Brown & Harris, 1978; Weissman, Leaf, & Bruce, 1987; McLanahan & Adams, 1989; Maughan & Lindelow, 1997; Lipman, Offord, & Boyle, 1997; Weich, Slogett & Lewis, 1998). Beyond structural factors, quality of social relationships is predictive of mental health. In particular, lack of emotional support and negative aspects of close relationships are associated with higher rates of psychological distress (Oxman, Berkman, Kasl, Freeman, & Barrett, 1992; Stansfeld, Fuhrer, & Shipley, 1998b). Lack of emotional support may also be a vulnerability factor increasing the risk of depression in the face of life events (Brown & Harris, 1978).

Fourth, factors related to labour force participation are part of social causation. There is evidence that unemployment and job insecurity adversely affect a range of mental health outcomes from minor distress to suicide (Banks & Jackson, 1982; Rodgers, 1991a; Burchell, 1994; Ferrie, Shipley, Marmot, Stansfeld, & Davey Smith, 1998; Gunnell et al., 1999). Other conditions at work, including high levels of job demands, low work social support and low decision latitude may influence psychological distress (LaRocco, House, & French, 1980; Wall et al., 1997; Stansfeld, Fuhrer, Shipley, & Marmot, 1999) and decline in psychological functioning (Martikainen, Stansfeld, Hemingway, & Marmot, 1999). Most aspects of labour force participation are strongly patterned by socio-economic position, and in some instances appear to have a strong effect on the social gradient in depressive symptoms (Stansfeld et al., 1998a).

Other factors may be involved in social causation, including, several health related behaviours, although the direction of association with adult mental health is not always well established. Co-morbidity has

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