01 - 1. Social Classification

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In Britain occupational classification forms the principal mode of social classification: The social class of a household is determined on the basis of the head of a family. Dominance and dependence are two essential underlying themes behind the categorical divisions of social classes. Most psychiatric disorders are more common in lower social classes; with controversial exceptions noted for anorexia, alcohol use and bipolar disorders. Anorexia: It is debatable whether social class affects the true prevalence of anorexia or whether the differential rates noted in various studies reflect variations in helpseeking/referral pattern. At present the growing consensus is that the social classes 1 and 2 are more prevalent in clinical (as opposed to community-based) samples but there are no differences in distribution of various clinical features across the social groups. The quality of family relationships and types of family constellations are also broadly consistent across the social classes in affected families. A prodrome of excessive diet consciousness and the actual onset of the disease itself are noted at somewhat younger ages in social classes 1/2. Community studies have shown that the degree of urbanization has a significant impact on the prevalence of anorexia, bulimia and binge eating disorder (Favaro et al., 2003). Social class, professional status, and education are not associated with an increased risk of reporting an eating disorder in such community samples. Bipolar disorder: An overrepresentation is found in the higher occupational class in bipolar probands' brothers and children. It is consistently noted that the family of origin in bipolar probands belong to a higher social class though the patients themselves might be at a lower social class. Tsuchiya et al., (2004) showed that higher social class of parents together with longer paternal education history and larger possession of wealth increased the risk of bipolar disorder in the offspring. It is speculated that ‘bipolar genes’ may offer some survival benefits such as superior creativity or productivity, which uplifts the families to higher social status. Suicide: The relationship between suicide and social class has not been conclusively established as of yet. While some authors have reported that higher social class is related to higher rates of suicide, most other studies indicate that lower social class is associated with Classes Categories Class 1: Professional, managerial and Class 2: Intermediate Class 3: Skilled, manual, clerical Class 4: semi-skilled Class 5: unskilled Class 6: unemployed

 higher rates of suicide. It is shown that among mentally ill, the higher the social class, the more the risk of suicide (Silverton et al. 2008). Alcoholism seems to defy social class boundaries. A Swedish conscript study (Hemmingson et al., 1999) reported that intergenerational

social mobility that is associated with healthrelated factors, but not alcoholism itself, makes a significant contribution to explaining variation in the rates of alcoholism among the different social classes. The class-related differences in alcoholism among young adults seem to be influenced heavily by factors that are established by adolescent years. But such adverse conditions did not seem to be well reflected by social class of origin. By far, a significant influence on the prevalence of alcoholrelated harm seems to be the public health policy regarding pricing and the sales of alcohol. In all aspects of health including life expectancy, infant and maternal mortality, there is a discrepancy between social classes, despite the existence of the NHS, which was developed to combat this. There is a question of whether the low social class has lead to poor health or if poor health leads to deterioration in social status (as suggested in the Danish bipolar study above). There is a consideration for cultural differences among social classes in terms of diet, exercise, alcohol intake and awareness of mental health problems and the treatments available.

JARMAN INDEX

A scoring system developed by the British general practitioner Brian Jarman for the level of social deprivation in a community, using census data on percentages of old people living alone, single-parent families, children younger than 5 years of age, unskilled and unemployed persons, ethnic minorities, overcrowded dwellings, changes of address in previous year, etc. Although a valid indicator, it is not generally accepted outside the United Kingdom.

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