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Social Class, Classism, and Mental and Physical Health

As a psychodynamic psychologist, I am always interested in my countertransference. Countertransference is essentially the unconscious reactions, distortions, and biases we may have toward others. Countertransference cannot just be explored because of its unconscious nature. Instead, for many psychologists, being aware and sensitive to extreme personal reactions, and being willing to understand the root of these feelings is at the core of analyzing countertransference.

My countertransference was triggered one afternoon while I was washing the dishes and I had some cable news channel playing in the background. My focus was on the dishes and I was tangentially attending to the news when one item stopped me. Two teenagers were filing a lawsuit against McDonald's for making them obese (Santora, 2002). From the reports, the teenagers did not realize that a McMuffin in the morning and a Big Mac, Super Sized fries, Super Size Coke, and apple pie (total calories: 1,600) in the evening would make them fat. They just did not know. My countertransferential anger was intellectualized as, "How doesn't one know that all that McDonald's food would make you fat?" And I caught myself. Well, that's right, how would they know? Where would they learn that 1,600 calories for one meal is exorbitant?

How would they know what a calorie was and how it is used metabolically? Even if this information was posted in McDonald's, how does a person make sense of it? Finally, what are the alternatives for these children? It just was not sufficient to avoid these legitimate questions to blame the children alone for lack of willpower, discipline, or self-control. Instead, there are critical issues related to their behavior that help explain and contextualize how and what people do.

In February 2009 on ABC News, Diane Sawyer reported on children living in poverty in rural Appalachia in a show called "A Hidden America: Children of the Mountains." One of the segments that caught my attention was the problem of "Mountain Dew mouth." This dental problem is enamel decay due to chronic consumption of the soda Mountain Dew (Kitchens & Owens, 2008; von Fraunhofer, 2004). The resulting dental problems were lost teeth, enamel decay, discoloration, and, of course, poor health habits. Mountain Dew was not just a childhood or adolescent drink or an occasional beverage; it was sometimes used in baby bottles in place of regular milk. As a father, I knew of Mountain Dew mouth, but seeing it was astounding. Even more, considering it to be a viable drink option for a small child seemed unfathomable. But it made sense in a way—Mountain Dew was cheaper than formula or regular milk. And Mountain Dew didn't need to be refrigerated, so it could be kept anywhere.

If you were interested in understanding social class or socioeconomic status and did a literature review on most social science search engines, the likelihood is that the vast majority of literature you would review would be focused on some aspect of health. Thanks to the enormous contributions of those in health psychology, ecological psychology, and epidemiology, to name a few, we have considerable empirical and theoretical literature that has found strong relationships, if not causal links, between poor mental and physical health and being poor. The reason it is so important to review and understand this literature as helping professionals is because helping professionals need to take a biopsychosocial approach or a holistic (including spiritual) understanding of the mental health concerns of clients and patients (Suls & Rothman, 2004). Additionally, the health-related literature provides clues on how context creates conditions that may affect physical health and exacerbate mental health problems, and this literature sets the foundation for

different methodologies and theories (i.e., subjective and/or phenomenological approaches) that may be used to better understand and explore the meaning of social class and classism in people's lives.

We know that social class and classism are external, contextual, and situational. We understand social class in terms of inequality, poverty, affluence, and wealth. But how do these issues affect the ways we live, our mental health, and our relationships? That is, the larger question is how does social class “get under our skin” (Adler & Ostrove, 2006)? To start, social class and classism represent a diversity of variables that directly and indirectly influence or are strongly related to a person's, and his or her community's, mental and physical health (Isaacs & Schroeder, 2004). It is impossible to identify one cause that leads to poor physical or mental health, but instead, the array of factors should be seen as cumulative problems; each factor or cause is additive to the physical, contextual, and psychological burdens some people carry. Depending on exposure, duration, intensity, and chronicity, people may develop different thresholds for when poor health may be expressed. For some individuals, the threshold is low, so fewer of these problems may trigger a single health problem, and for others, a single health problem starts a cascade of concerns and problems. The important piece for helping professionals to remember is that often by the time clients seek help, these problems may have been occurring for some time, so there is unlikely any easy or simple remedy for some of these entrenched problems.

This chapter focuses on the effect social class and classism have on people's physical and mental health. This chapter will describe how a context of inequality impacts people's health. I will also discuss how the social class gradient is related to health and how a person's sense of control over his or her situation and environment relate to health. One specific area of focus in this chapter is the issue of malnutrition and obesity and how these problems are often exacerbated by living in poor conditions and growing up poor. I focus on these specific health problems because many helping professionals are unaware of the relationship of eating to mental health. And while much is being made in the media about the obesity crisis, helping professionals may not be aware of how they may find a role in helping people in this situation. Finally, I will discuss mental health concerns and implications for helping professionals.

The Context of Social Class and Classism

As I write this book in the latter half of 2009 and early 2010, the American economy has experienced the greatest economic decline in decades with layoffs, foreclosures, and business and bank closings. Increasing inequality

and poverty have also created conditions for “a dramatic upsurge in severe poverty” (Woolf, Johnson, & Geiger, 2006, p. 335). And while some of the super-rich have lost some of their affluence and wealth (Leonhardt & Fabrikant, 2009), those in the top 10% of the income hierarchy still earned 11.4 times as much as those living in poverty (\$138,000 versus \$12,000) (Associated Press, 2009). In fact, the 2008–2009 recession affected the middle and lowest social classes the worst and tended to spare those in the upper income brackets (Associated Press, 2009).

So, with all the economic problems, helping professionals should anticipate an increase in psychological distress, and this is exactly what was found in the American Psychological Association (2008) report on *Stress in America*. Researchers discovered that money and the economy now are the leading causes of stress for 8 out of 10 Americans. Supporting these findings, another report by the Pew Research Center (2008) found that middle-class Americans did not believe they were moving forward in their lives and felt “stuck.” Interestingly, the Pew study also found that even in this context of economic duress, these Americans in the study also reported spending and borrowing more money to live. Consequently, the “median debt-to-income ratio for middle income adults increased from .45 in 1983 to 1.19 in 2004” (p. 6) and suggests many may still be living above their economic means. Still, for some, “down-shifting”—being less materialistic and less focused on upward mobility (Schor, 2000, 2004)—may be difficult. It may be that spending has been equated with being happy, but there is virtually nothing that tells or guides individuals about what amount of money is adequate for living happily or healthfully (Morris, Donkin, Wonderling, Wilkinson, & Dowler, 2000). As a result, for some with limited healthy psychological coping skills, their distress may be compounded by the situation and their own behaviors.

I mention this because when we examine economic distress in the context of a recession, understanding psychological distress means that the helping professional needs to also consider the positive and negative behaviors in which people engage. It is not a simple direct relationship between a context of recession and psychological distress. Instead, helping professionals need to consider the mediating and moderating behaviors and attitudes that people sometimes engage in that work against the person’s best self-interest.

Moreover, by the *context of social class and classism*, I refer to the societal systems (e.g., Bronfenbrenner, 1986; Robert, 1999) and the social structures (legal-educational, historical, and social) (Liu & Ali, 2005) that create inequality. This inequality materializes in people’s lives through unequal distribution of resources, wealth, and access to power. Even though poverty (near poverty and extreme poverty) has significant and negative effects on mental and physical health, it is important to understand that

beyond individual-level attributions, societal-level inequality has a greater and more profound impact on people's health. As Babones (2008) concludes in his study of income inequality, "It can be concluded that there is a strong, consistent, statistically significant, non-artifactual correlation between national income inequality and population health" (p. 1614).

Therefore, the greater the inequality in a society (where the rich are extraordinarily rich and poor are unimaginably poor), the more health-related problems one should find. Adler (2009) also suggests that inequality is specific to a context (or country); that relative income and not absolute income is a stronger factor in a person's health. That is, across countries, the absolute value of a person's income may differ (an American dollar is still worth more than many currencies, so an income of \$10,000 in the United States is likely different than \$10,000 in a developing nation) but even though "individuals in the United States have higher incomes than do middle-income individuals in less affluent countries, . . . they do not necessarily have better health" (p. 667). For example, in the United States, one indicator of health in a community is life expectancies. In one area of Montgomery County, Maryland, for instance, poor Black men have a life expectancy of 57 years versus rich White men, who have a life expectancy of 76.7 years (Marmot, 2006). And while research shows that life expectancies have increased for all groups regardless of social class, those in the top tier of society have seen their gains grow more and faster than those in the bottom tiers (Singh & Siahpush, 2006). Thus, it is possible to point to improvements among those who are poor, but as the Matthew Effect demonstrates (the rich and wealthy, because of their position and privilege, will always get more from societal gains than those who are poor), the gains by the rich still outpace those of the poor and the chasm continues to grow (Bakersman-Dranenburg, van IJzendoorn, & Bradley, 2005).

Life expectancy disparities may result from living in inequality and poverty, which increases rates of disease and consequently decreases life expectancy. From the national to the state to the neighborhood level, these inequalities affect the individual. Neighborhoods are divided into safe and unsafe spaces, and for those living in the unsafe spaces, their health suffers from exposure to violence, toxins, and environmental stress. For instance, in one study, Chen and Paterson (2006) found that adolescent self-rated health, body mass index (BMI), blood pressure, and cortisol levels were related to neighborhood level and family socioeconomic conditions. Poor family and neighborhood socioeconomic conditions were related to psychological stressors such as experiences with hostility and discrimination (Chen & Paterson, 2006). Thus, the feedback circuitry for poor health is external and environmental, but it is also related to our perceptions and capacity to cope with these stressors and how our bodies respond in kind.

Thus, being poor and living in poor neighborhoods that are perceived to be unsafe is part of the process by which ecological inequality permeates into the individual.

There are also interpersonal consequences for inequality that affect our physical health. In our relationships, inequality creates conditions for perpetuating discrimination and prejudice, and these marginalizing experiences are likely related to disrespect of others (Miller, 2001). In a situation where there is high income inequality, there are significantly decreased positive social interactions because these inequalities (Sapolsky, 2005b). In these environments, people are likely to feel poor and are made to feel poor by others, and thus there is an increase in psychological distress (Sapolsky, 2005b). Individuals who perceive inequality and unfairness are likely to also experience “increased coronary events and impaired health” (De Vogli, Ferrie, Chandola, Kivimaki, & Marmot, 2007, p. 513). Therefore, just living in and seeing unfairness creates conditions of psychological distress and problems with health. Furthermore, these forms of disrespect and injustice foment anger and frustration, which eventually impact the person’s self-esteem and relationships with others (Miller, 2001). As Pascoe and Richman (2009) discuss in their review of literature on health and perceived discrimination, individuals have increased stress responses in the face of perceived discrimination and are less likely to participate in healthy behaviors. In fact the chronic physiological response by the body when confronted with stress is likely to have deteriorative effects on the body. As McEwen (1998) has pointed out, people’s stress response is adaptive at first and allows the person to be vigilant against possible threats, but over time, the physiological response to chronic stress is deleterious to the individual’s body. That is, the elevated and “sustained levels of the stress response hormones, glucocorticoid and catecholamine, adaptive in normal levels, may also accelerate the disease process” (p. 544). Additionally, chronic stress increases hypertension; inhibits digestion, tissue repair, and ovulation; and impairs cognition (Sapolsky, 2005b).

So there is a pattern such that environmental inequality affects neighborhoods, families, and individuals, and these marginalizations and hostile interactions create interpersonal conflict. Sustained conflict implies increased and chronic distress and stress, and consequently there are physiological as well as psychological effects (Sapolsky, 2005a). Thus, improving physical and psychological health may be a matter of both decreasing inequality and increasing economic growth (Pickett & Wilkinson, 2007; Ram, 2005). That is, it is important to lift people out of desperate situations and provide more resources but also to close the gap between rich and poor.

The Social Class Health Gradient

Research suggests that being in poverty, living in inequality, and being in low-income situations are related to a wide range of health-related problems. For instance, these individuals tend to less frequently use health care services and receive poorer-quality care (Asch et al., 2006; Hopps & Liu, 2006); have higher infant mortality (Singh & Kogan, 2007); have poorer actual and self-rated physical health (Mackenbach et al., 2008); have increased rates of cardiovascular disease (Winkleby, Kraemer, Ahn, & Varady, 1998); have increased risk of heart problems (Kareholt, 2001); have increased rates of cancer risk, treatment, and survival (Brown et al., 2001; Robbins, Whittemore, & Thom, 2000); infrequently use mental health services (Garland, Lau, Yeh, McCabe, Hough, & Landsverk, 2005); and have increased levels of functional physical limitations (Minkler, Fuller-Thompson, & Guralnik, 2006). Inequality is also related to poor physical health (Kunst et al., 2005; Smith & Brunner, 1997), and those who perceive themselves to live in poor neighborhoods tend to also have negative health indicators such as high body mass index (BMI) and higher prevalence of depression (Schaefer-McDaniel, 2009), as well as experiences with hostility and discrimination (Chen & Paterson, 2006). Along with objective inequality (i.e., income), even perceived and subjective evaluations of inequality or disadvantage are related to poorer self-rated health (Haines, Godley, Hawe, & Shiell, 2009). Thus, perceiving oneself as low status may be related to poorer health (Schnittker & McLeod, 2005). For instance, cardiovascular risk among women with lower subjective social status was related to having “less healthy dietary and exercise behaviors” (Ghaed & Gallo, 2007, p. 668).

Being poor and working class also increases the likelihood that one will be employed in hazardous and dangerous work that leads to increased risk of fatalities, serious injuries, and debilitation (Young, Meryn, & Treadwell, 2008). For many employed in these occupations, the health insurance safety net is either absent or very thin, so injuries on the job can quickly lead to bankruptcies and homelessness. Living in poverty and existing in conditions of inequality also mean problems with stable employment, which affects not only income but also health insurance and coverage. Furthermore, psychological stressors parents experience also permeate the home. Research suggests that parents who find themselves out of work for long periods are also likely to have adolescents who rate themselves poor on self-rated health questions (Sleskova et al., 2006). So parental economic distress and duress is felt by everyone in the familial system.

The research mentioned here gives a glimpse into the many factors contributing to people’s poor health. Most people may understand intuitively that higher income and ranking in social class tend to be related

to better health. Reasons people are likely to cite for this gradient may be access to health care, preventative care, better schools, less violent environments, and better nutrition. These suppositions would be partially correct. There is a health gradient such that the higher one is on the social class hierarchy, the more likely one is to have better actual and self-reported health (Adler, Boyce, Chesney, Cohen, Folkman, Kahn, & Syme, 1994; Adler & Snibbe, 2003). In part, those higher in the economic hierarchy are likely to have better preventative treatment, interventions, access to health care, and use of available resources (Hopps & Liu, 2006). Furthermore, it is not just being wealthy that is related to better health; research generally suggests that the longer one is wealthy, the more likely one will have better health (Benzeval & Judge, 2001). Given that wealth and health are related, there are potentially racial differences. Racially, the group that typically is seen at the higher end of the health gradient is still overwhelmingly White, married, high in education, and employed in professional work (Lee & Marlay, 2007). And it is the affluent Whites who are likely to receive more and better overall health care (Daniels, Noe, & Mayberry, 2006; Fiscella, Franks, Gold, & Clancy, 2000). Thus, the research suggests that being wealthy and White potentially is related to better health, in part because of access to health care and avoidance of toxic and violent situations, but also because being affluent and White confers privilege and power and possibly a sense of control over one's situation.

Sense of Control

Those people growing up and living in wealth and affluence are likely to have a better sense of control and higher expectations of control in their lives (Sapolsky, 2005b). Conversely, those in lower social classes are less likely to perceive their illnesses as controllable (Maher & Kroska, 2002). Being able to predict or have a sense of control over the cause of psychological distress may have an incredible impact on one's body. As Marmot (2006) suggested, along with all the other potential causes of disease and mortality, there is a psychosocial variable related to one's health. Psychosocial stress and the perception of control may also be related to the onset and course of any particular illness (Sapolsky, 2005b). Marmot (2006) posits that a "status syndrome" (p. 1304) exists such that the higher the perceived social position of the individual, the better the individual's self-rated health. To support this idea, Marmot examined data from the Whitehall study of British Civil Servants in the 1970s and the rates of coronary heart disease (CHD) among these workers.

Originally, British health officials believed CHD was related to affluence because CHD was supposed to be caused by stress and an affluent lifestyle.

Yet in examining the data from the workers, the researchers found that while the top third had high rates of CHD, the second third had higher rates than the top third, and the lowest third had even higher rates than the top two groups. Even when access to health care and unhealthy lifestyles were controlled and accounted for, these results persisted. The researchers posited that the individual who is lowest in social status is least likely to feel that his/her “fundamental human needs for autonomy and to be integrated into society will be met. [And] failure to meet these needs leads to metabolic and endocrine changes that in turn lead to increased risk of disease” (p. 1304). What Marmot is alluding to is the sense of control an individual perceives and its potential relationship to health. It is the feeling of not being valued and not having much agency over one’s environment that may be related to poorer health.

In another study on self-control among workers, Christie and Barling (2009) examined national data on Canadian employees. They found that the less perceived personal control an individual has over his or her work environment, the more likely that individual will experience deleterious effects of work stress. This particular variable of perceived personal control is one factor that is related to the cumulative effects of low income and low occupational prestige over a lifetime. So even though higher-status workers and occupations may report work demands and stress, perceived control in their work environment may be higher and thus the demands are not as deleterious or perceived to be noxious by the individual. In essence, higher-status workers “are afforded greater substantive and social luxuries, such as money, power, and opportunity, the benefits of which are far reaching” (Christie & Barling, 2009, p. 1467).

Lachman and Weaver (1998) also examined the relationship among sense of control, social class, and well-being and found that among those in the lowest social classes, those who had a sense of control, believed they had some efficacy in their environment, and believed other people did not limit or constrain them had self-rated health and well-being at similar levels to those in the highest social class groups. These same individuals were likely to report better health, more life satisfaction, and fewer depressive symptoms (Lachman & Weaver, 1998).

Other research further suggests that people who report a “higher” subjective social class standing may have positive health outcomes. One study found that endorsing a higher subjective social class had a role in protecting against adiposity (i.e., fat tissue) in adolescent girls (Lemeshow, Fisher, Goodman, Kawachi, Berkey, & Colditz, 2008). In other words, the girls in this study who rated themselves low on subjective social class had 69% higher odds of having a higher BMI than girls who rated themselves higher in subjective social class (Lemeshow et al., 2008). Thus, seeing oneself

in a lower social class position seems to be related to increased odds of having body fat. Another study by Cohen, Alper, Doyle, Adler, Treanor, and Turner (2008) even found evidence that higher subjective social class, independent of objective indices of social class (absolute income, education level, or occupation), was related to decreased chances of getting the common cold. Thus, there is some evidence to suggest that individuals who have some sense of control and capacity to predict what will happen in their environment may have better self-rated health. This is not to disregard or diminish the severe impact of being poor, because those who are poor already start with certain health burdens in comparison to those in wealthier statuses.

Along with understanding the health gradient, it is important for helping professionals to integrate other factors that may impact the client's health. While there may be many factors that impact a client's overall health, I identify two facets that I believe helping professionals do not often consider. The first facet I discuss is the impact of a toxic environment and how it may be related to a person's health. Related to the environment is the problem of obesity and nutrition, the second facet. Focusing on obesity and nutrition may seem obtuse as a helping professional consideration, but as an aspect of a person's overall physical and mental health, obesity and nutrition are important contributing variables.

Environmental Toxicity, Health, and Social Class

Most people are able to determine social class differences within their neighborhoods. Driving around a particular city or town, one may even come across the "over the train tracks" changes in neighborhoods. On one side of the tracks is a nicely manicured, clean, and quiet community. Crossing the tracks, though, brings people to a whole new dilapidated community that may be only a short distance from the manicured side. Some call this change in context and ecology a form of environmental racism (Bullard, 1993) because those who live on the "wrong side of the tracks" tend to be overwhelmingly people of color and low income. I would strongly agree with this sentiment. These divisions between neighborhoods are likely formed through racism and discrimination (i.e., red-lining), and often result in individuals living in these situations with poor housing, poor neighborhoods (lack of maintained roads, sidewalks), and toxic environments (power lines, sewage, pest infestations). This form of environmental racism might also be considered environmental classism because most people in these situations are poor and people of color. These poor environments only exacerbate and add to the vulnerabilities for many of these community members who are trying to become and remain successful and healthy.

As I mentioned, one manifest way inequality impacts people's lives is through exposure to toxins and environmental assaults that are not likely to be present or are less frequently found in more affluent neighborhoods. Odds are that poor, impoverished, low-income individuals tend to live in environments where their exposure to environmental toxins is higher than that of the affluent (Allen, 2001). These toxins are both material (e.g., lead, toxic chemicals, pesticides; Dilworth-Bart & Moore, 2006) and ambient (e.g., high noise level, crowding; Evans, 2004; Evans, Gonnella, Marcynyszyn, Gentile, & Salpekar, 2005), and the combination is toxic and corrosive to both body and mind. For example, low-income individuals, especially children who live in situations of chaos (e.g., lacking structure and routine, high ambient noise, crowding) may have high levels of psychological distress, learned helplessness, and problematic behaviors (Boyle & Lipman, 2002; Evans, 2004, 2006; Evans & English, 2002; Evans, Gonnella, Marcynyszyn, Gentile, & Salpekar, 2005). Additionally, exposure to chronic poverty and other risk factors (e.g., poor housing and family chaos) appears to have a deleterious effect on children's physiology—for example, increased cortisol levels and dysregulated cardiovascular response to stress (Evans & Kim, 2007). Finally, exposure to these toxins dramatically impacts these poor communities because people in disadvantaged communities have fewer doctor visits, have fewer chances of diseases being detected, and have less access to treatments and interventions.

Exposure to toxins such as lead, especially among children, can have long-term neurological and cognitive consequences such as developmental delays (Bellinger, 2008). In one study on air pollution in New York City, nonsmoking Black and Dominican American women whose children were exposed prenatally to air pollution (i.e., airborne polycyclic aromatic hydrocarbons [PAH] that are released during incomplete combustion of fossil fuel, tobacco, and other organics; this is the dark-black sooty exhaust coming from buses and trucks) were found to have lower full-scale IQ and verbal scores than those less exposed to PAHs (Perera et al., 2009). Exposure to air pollutants seems to interact with being in low economic situations to create a situation that is related to children performing lower on standardized intelligence tests. It is unclear how PAHs impact the IQ directly, but there is evidence now to suggest that early and long-term exposure has consequences. What this means is that having children who start early with poor health tends to suggest that they may have higher probabilities of becoming unhealthy adults (Evans & Kim, 2007).

Finally, another form of environmental classism is poor or substandard housing as well as living in segregated housing (Evans et al., 2005). Those who are poor tend to live in housing that is more crowded, and this reduced living space is related to elevated psychological stress (Evans, 2006). Poor

housing (apartment or house, rental or owned) also may mean poorer or older construction, and this may expose children to materials that leak toxicity into the home (e.g., toxic fumes), are toxic or dangerous if ingested (e.g., lead-based paint or water pipes), as well as problems with pest infestations (e.g., flies, cockroaches, mice, and rats). Additionally, these homes may be poorly kept and maintained, and because of the lack of money, owners and renters may have problems repairing or replacing damaged parts of the home.

All these aspects of environmental classism are important for the helping professional to consider because these problems set the baseline from which individuals may regard their health. Some of the prenatal aspects as well as the general environmental toxicity (e.g., airborne PAH) are clearly out of the individual's ability to control, but all of them may have had some impact on the individual's development. For helping professionals, it may be important and necessary to assess for exposure to environmental classism to develop a full bio-psycho-social conceptualization of the client.

Social Class, Malnutrition, Obesity, and Health

Another sometimes overlooked cause and consequence of inequality and mental health is nutrition. Intuitively, helping professionals may assume that if one is poor or low income, the person is less likely to eat, eat well, and eat healthfully. In part this is true, but exploring the literature on this simple subject exposes the complex relationship among being poor and malnutrition, obesity, and health. For health professionals interested in taking a holistic approach to working with clients and patients, it is important to understand how context shapes physiology and mental illness. Quite simply, there is a relationship between an individual's social class, health, diet, and weight. In particular, a socioeconomic gradient exists between diet and education and income, such that the higher one's income and education, the more likely the individual will have a healthy diet (Darmon & Drewnowski, 2008; Drewnowski & Specter, 2004) and even value thinness (Sobal & Stunkard, 1989). On the other end of the economic spectrum are those who are poor and near poor. For these individuals, access to adequate and healthy food is constantly a problem. For example, in a recent study, researchers were alarmed about finding that almost half of all children between 1 and 20 years old will experience some period on food stamps (Rank & Hirschl, 2009). For some children, this will be a chronic and long-term problem, and for others, they will only have a transitory period on food stamps. But being on food stamps is only reflecting a larger problem of Americans not having adequate food (U.S. Department of Agriculture, 2009). Surprisingly, in 2008, one in five children will have been

in a household without adequate food, and nearly 15% of all Americans will not have had adequate food (U.S. Department of Agriculture, 2009).

Before delving too far into this topic, some points of clarification must be made and some limitations must be addressed. First, I purposely differentiate between hunger and malnutrition in this discussion. Certainly there are sectors in the United States where children, adults, and families are pervasively hungry and in want of food (Drewnowski & Specter, 2004). This food deprivation has its own biological and physical consequences such as poor neurological development in children, adults who are underweight (which is especially pernicious for pregnant mothers), and a psychological fear of not having food or access to food (i.e., food insecurity). Second, there is ample evidence that investigates the racial and ethnic differences in obesity. For instance, obesity seems to be more prevalent and persistent in certain low-income racial minority groups such as American Indian/Native American children, where it is twice as common when compared to White and Asian American children (Anderson & Whitaker, 2009; Delva, O'Malley, & Johnston, 2006), and because of the scope of this chapter, much of this literature is not addressed directly. Therefore, the reader should keep in mind that racial and ethnic differences may be an issue in some of the literature reviewed. And third, in relation to racial and ethnic differences, helping professionals would need to be sensitive to different cultural values, parenting styles, and values around eating, diet, and obesity (Chamberlin, Sherman, Jain, Powers, & Whitaker, 2002; McLaren & Kuh, 2004). Furthermore, some aesthetic norms for body shapes may not be representative of how other cultural groups value size and proportions, and there are cultural and geographic differences with respect to preferences for type and amount of food, and consumption patterns (communal, familial, and individual).

For Americans, one of the most pressing health problems today is obesity and other health sequelae (e.g., diabetes, cardiovascular problems) related to malnutrition or poor nutrition. To begin, obesity is typically defined in relation to body mass index, which is an individual's weight in relation to his/her height (kg/m^2). Being overweight is classified as having a BMI > 25 , and being obese is > 30 (U.S. Department of Health and Human Services, 2000). Please note that there are problems with using only BMI as an index of obesity because this index does not consider differences in muscle mass, which weighs more than body fat. Thus, people with higher muscle mass in relation to height may be considered obese by this index. But given the wide use of the BMI criteria at this moment, we can use this as a general framework to understand obesity.

What may contribute to obesity? Some suggest that the obesity epidemic is related to an individual's lack of self-control (Offer, 2006). That is, in a

consumerist society, why not expect people to indulge their material and gastric preferences? Others would argue that health inequalities and poor health are related to the individual intelligence (Gottfredson & Deary, 2004). In other words, individuals who have low intelligence may have problems with self-care, problem solving, and evaluating risky behaviors (Gottfredson & Deary, 2004); it may be that having a low IQ may be related to poor health behaviors such as not reading nutrition labels, considering the relationship of exercise to health, or having access to adequate health care. Of course, one of the risky and unhealthy behaviors may be eating calorie-dense and rich foods without much concern for long-term physical consequences. And some research does suggest that there is a relationship between high obesity rates and populations who are the most impoverished and least educated (Drewnowski & Specter, 2004).

Assuming that IQ is directly related to health behaviors may be an oversimplification of complex interactions and dynamics among a number of variables. Also, it may not be IQ that is related to obesity but the person's level of education. In a recent report by the Robert Wood Johnson Foundation's Commission to Build a Healthier America (2009), the researchers found that level of education was related to health. Specifically, an increase in the number of years of schooling and education was positively related to better health outcomes (longer life, more exercise, avoiding tobacco, and regular health care). More education by the parents also positively affected children as well (e.g., decrease in infant mortality). It seems that higher education may be related to more knowledge about health and healthy behaviors, higher levels of employment and income, and a better sense of control over one's environment, higher social standing, and better social support. Overall, the findings also suggest that higher educational level and better health can be transmitted intergenerationally so that educational, economic, and health benefits become advantages.

Therefore, focusing only on these internal dispositions and intelligence belies not only the significant impact of education and income but also of poverty on health behaviors and the individual's propensity toward obesity and other problems of poor nutrition. Focusing on self-control or intelligence does not address objective problems such as the price of food and healthy eating (Drewnowski & Specter, 2004). Additionally, self-control and intellect do not address the legacy of poverty and inequality for some individuals and the impact of hunger and food insecurity (Drewnowski & Specter, 2004) with respect to overconsumption, malnutrition, and eventually obesity.

Malnutrition is directly linked to hunger because an individual who does not have the necessary caloric or nutrient intake per day is at risk of a whole array

of acute and chronic physical problems. But for those in poverty, malnutrition is not necessarily related to caloric intake. Instead, an interesting paradox results among those in poor and impoverished settings. Among those who are poor, the access to and preference for energy-dense (high-calorie) foods is not only easy but also frequently ideal (Darmon & Drewnowski, 2008; Drewnowski & Specter, 2004). That is, the cost per serving for these energy-dense foods is so low that these foods are often the most attractive in comparison to foods with more nutrients (e.g., whole grains) and fresh fruits and vegetables (Darmon & Drewnowski, 2008; Drewnowski & Specter, 2004; Reed, Fazao & Itskowitz, 2004). The energy-dense foods tend to be composed of “refined grains, added sugars, or fats . . . [and] the high energy density and palatability of sweets and fats are associated with higher energy intakes” (Drewnowski & Specter, 2004, p. 6). Consuming these high calorie foods makes sense from the perspective of food insecurity because these foods are more affordable and more prudent purchases than “diets based on lean meats, fish, fresh vegetables, and fruit” (p. 6). Consequently, as income decreases, individuals tend to eat less expensive foods while attempting to maintain the same energy level (Darmon & Drewnowski, 2008; Drewnowski & Specter, 2004).

Related to food insecurity and mental health are recent research findings that suggest those families living in poverty and who experience food insecurity may also have mothers who have mental health concerns (Melchoir et al., 2009). The research suggests that not only are low-income mothers living in unstable and unpredictable environments that may trigger maternal mental health problems such as depression or psychosis, but maternal depression, for instance, is also related to creating conditions for children’s feelings of food insecurity. Mothers who are depressed, for example, are less likely to make meals or shop for food. These low-income mothers may also find themselves in abusive relationships and lack access to money and transportation, all of which contribute to the problems of food insecurity and potentially malnutrition. Therefore, there are extra-familial causes to food insecurity as well as within-family factors of which helping professionals need to be aware.

Living in these situations of stress also may produce weight gain. Research on rats under stress (i.e., exposure to cold and aggression) has shown that the sympathetic nerves release a neuropeptide Y (NPY) and its receptors such that there is a positive feedback mechanism to increase abdominal fat as a survival mechanism (Kuo et al., 2007). While rats are not human, of course, the research does suggest a potential link between psychological stress and the induction of the body to create fat, in particular abdominal fat. Evidence supporting this position comes from a review of the empirical literature that found some limited evidence that “depression, hostility, and

anger [may] predict increased risk for the metabolic syndrome” (i.e., central adiposity or fat and insulin resistance; Goldbacher & Matthews, 2007, p. 240). Thus, it is not just individual choices and dispositions that are related to poor health and being overweight; existing in situations of chronic stress (i.e., poverty) may also contribute to a high BMI.

What we also know is that those who live in lower-income, poor, and impoverished neighborhoods face a number of environmental factors that contribute to their poor health (Larson, Story, & Nelson, 2009). These communities, both rural and urban, tend to have fewer supermarkets available to them and yet have higher rates of liquor, convenience stores, and tobacco outlets (Asumda & Jordan, 2009; Chuang, Cubbin, Ahn, & Winkleby, 2005; Cubbin & Winkleby, 2007; Darmon & Drewnowski, 2008; Inagami, Cohen, Finch, & Asch, 2006; Moore & Diez Roux, 2006; Theall, Scribner, Cohen, Bluthenthal, Schonlau, & Farley, 2009). The problem of the increasing number of liquor stores is the effect it has on relationships in the neighborhood. Research suggests that increases in the number of liquor stores are related to decreases in social capital or social networks (Theall et al., 2009). Reduced social networks likely mean poorer neighborly relationships and thus, for the individual, fewer social support resources to use and access when the person is in duress. On the contrary, research also suggests that people who experience greater and diverse social interactions throughout a day may be more likely to consume alcohol less and smoke tobacco less (Cohen & Lemay, 2007). Thus, strong social support networks may make the business of alcohol and liquor stores less profitable in some neighborhoods.

Along with the increases in liquor stores, poor neighborhoods often have many fast-food restaurants (Block, Scribner, & DeSalvo, 2004; Kwate, Yau, Loh, & Williams, 2009; Lewis et al., 2005; Odoms-Young, Zenk, & Mason, 2009; Pearce, Hiscock, Blakely, & Witten, 2009; Sharkey, 2009; Smoyer-Tomic et al., 2008). Fast-food outlets often replace supermarkets and other retailers who may offer healthier alternatives to fast food. This unequal access or barriers to supermarkets, for instance, is mostly a problem related to poor African and Latino communities. Compounding the problem of scarcity of supermarkets is the fact that some lower-income individuals tend to have more transportation problems. Thus, lack of easy and frequent access to a conveniently located supermarket is a barrier to healthy eating.

The problem with fewer supermarkets is that people have limited access to a wide variety of fresh foods, which some convenience stores carry but at a much higher cost per serving than supermarkets. For example, in one study of Baltimore neighborhoods, milk, cereal, and bread were 20% more expensive in the convenience stores than in a supermarket a little more than

a mile away (Franco, Brancati, & Diez-Roux, 2007). Moreover, these communities, most often African American and Latino, tend to have fewer or no “community-level psychical activity-related settings (such as sports areas, parks and green space, public pools and beaches, and bike paths/lanes)” (Powell, Slater, & Chaloupka, 2004, p. 135). The lack of these physical activity-related settings and the presence of dilapidated and poorly kept environments (Cohen, Farley, & Mason, 2003) all contribute to restricted or limited options for physical activity, which in turn contributes to sedentary lifestyles and behaviors (Craig, Brownson, Cragg, & Dunn, 2002; Dowda, Ainsworth, Addy, Saunders, & Riner, 2001; Gordon-Larsen, Nelson, Page, & Popkin, 2006; Powell et al., 2004; Roemmich, Epstein, Raja, Yin, Robinson, & Winiewicz, 2006).

Those who are poor not only face limitations with respect to economic resources such as income but also must grapple with their physical health. Assaulting their physical health are nutrient-poor foods, high-calorie foods, and the lack of exercise and play space. These physical health problems are pertinent to helping professionals because it makes little sense to work with a client who is struggling with depression or anxiety, for instance, and not consider the outlets for exercise that may help ameliorate the mood. Helping professionals would also need to understand the relationship between the client’s focus, attention, and energy if that client’s food consumption patterns revolved around calorie-dense and sugar-rich foods. Finally, helping professionals who conceptualize clients integrating these perspectives may also develop more diverse perceptions of people of color who are likely to live in these situations.

Social Class and Mental Health

As helping professionals, we understand that there is some relationship between social class and a person’s mental health and perceptions about economics, and the research generally supports this notion (Gift, Strauss, Ritzler, Kokes, & Harder, 1986). Tangentially, there is even brain research (mostly imaging studies) that has suggested that different regions of the brain are related to how individuals process arousal, uncertainty, risk taking, money motivation, and anticipation of purchases (Critchley, Mathias, & Dolan, 2001; Dagher, 2007; Knutson, Rick, Wimmer, Prelec, & Loewenstein, 2007; Knutson, Wimmer, Kuhnen, & Winkielman, 2008; Kuhnen & Knutson, 2005; Pessiglione et al., 2007; Tobler, Fletcher, Bullmore, & Schultz, 2007). Additionally, research suggests that individuals with neurological problems in the prefrontal lobes of the brain (the logical reasoning

regions) tend to show problems in finances and credit card use (Spinella, Yang, & Lester, 2007). These studies are interesting because they suggest different aspects of our neurological makeup contribute to how we respond to material (e.g., money) and how these may then be related to our relationships and our self-perception. But at this point, the brain imaging studies can only allude to how these different neurological patterns may be related to mental health.

Even when it comes to major mental health issues, the research on the impact of social class is not completely clear. We know that the social class context of poverty and inequality are likely to be related to increased risks of major depression in adults, but the specific pathways for this relationship are not clear (Gilman, Kawachi, Fitzmaurice, & Buka, 2002; Goodman & Huang, 2001). There are various explanations for these relationships such as social selection, social causation, and the neomaterialist hypotheses. In social selection, a person's downward mobility is related to his/her mental illness. That is, someone who has depression is not likely to be upwardly mobile, so it is likely that mental illness is related to one's poor economic condition, setting, context, and history (Costello, Compton, Keeler, & Angold, 2003; Wadsworth & Achenbach, 2005). Simultaneously, social causation would suggest that downwardly mobile individuals were also prone to alcoholism (Hemmingsson, Lundberg, & Diderichsen, 1999). That is not to say that for some individuals, mental illness is related to decreased earnings and therefore diminished social mobility and social status (Kessler et al., 2008). Instead, it is more likely that there are social factors and sociostructural features that have impacted the lives of the poor and have contributed to (not directly caused) mental illness and continued downward mobility. However, some research suggests that there are reciprocal relationships between social class and mental illness such that one's social class is both cause and consequence of mental illness (Hudson, 2005; Johnson, Cohen, Dohrenwend, Link, & Brook, 1999; Miech, Caspi, Moffitt, Wright, & Silva, 1999).

However, the point at which mental illness is a cause or consequence of social mobility may be related to the question being asked by the researcher. For instance, social selection may potentially be an adequate explanation if one were to explore the relationship of alcoholism to downward social mobility (Hemmingsson, Lundberg, & Diderichsen, 1999). Someone who is an alcoholic may have problems holding a job and may not be promoted or given a salary raise. In effect, social selection would show that the mental illness of alcoholism is related to economic problems and possibly to downward mobility. But in general, most researchers embrace an interactionist perspective, which is an integration of social selection and causation (Conger & Donnellan, 2007). The integration perspective acknowledges that something does occur in relation to social class, but it is still largely unclear how the specific mechanisms operate. For instance, in one study of

Blacks and Latinos who moved from high-poverty to low-poverty neighborhoods, those students who moved tended to show significant improvement in achievement scores when compared to those who stayed in high-poverty neighborhoods (Leventhal & Brooks-Gunn, 2004). The improvement is a wonderful outcome of the change in environments, but the specific components and their interaction with social class and academic improvements are still unclear. In another quasi-experimental longitudinal study of rural children, one quarter of whom were American Indian children, Costello, Compton, Keeler, and Angold (2003) found that the persistently poor and ex-poor children had more psychiatric problems than those children who were never poor. Halfway through their observations, an Indian casino opened, which increased the American Indian annual income. The authors found that psychiatric symptoms such as conduct and oppositional disorders decreased while anxiety and depressive symptoms remained the same. Therefore, there was some evidence to suggest that income had an impact on some psychiatric problems but not on others. Why this occurred to some group members and not others and why only on certain symptoms but not others is an area that needs to be explored in future studies.

Similarly, the neomaterialist approach is an attempt to integrate competing theories of poor mental health among those who are poor. Before the neomaterialist approach, the strict materialist approach suggests that it is a lack of money and resources that is directly linked to poor physical and mental health (Lynch, Smith, Kaplan, & House, 2000). The other possible explanation was a purely psychosocial interpretation, which suggests that “income inequality affects health through perceptions of place in the social hierarchy based on relative position according to income” (Lynch et al., 2000, p. 1201). The individual’s perceived place creates negative feelings, and these feelings in turn are related to psychological stress. The individual also has poor interpersonal interactions and withdraws from social interaction and thus, pathology is triggered as a result of these negative biological (physiological reactions to stress) and negative social consequences (Lynch et al., 2000). Integrating the two, the neomaterialist approach

says that health inequalities result from the differential accumulation of exposures and experiences that have their sources in the material world . . . [for instance] the effect of income inequality on health reflects a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health, and social infrastructure. (Lynch et al., 2000, p. 1202).

Another important facet in understanding social class and mental health comes from Singh-Manoux and Marmot (2005). They argue that along

with all the structural problems and reasons related to physical and mental health, one should also consider the role of socialization. These authors suggest that individuals are socialized into attitudes, beliefs, and behaviors that are then tied to the individual's health. For instance, the individual's views on health-damaging behaviors (e.g., tobacco or alcohol use), the individual's ability to cope with psychological distress, and how the individual interacts and seeks out social networks are all conditions of socialization that are related to the individual's health. An illustration of socialization and help seeking comes from the men and masculinity literature. This literature suggests that men's unwillingness to seek help for physical or mental health concerns is related to maintaining a sense of strong invulnerable masculinity (Addis & Mahalik, 2003). Men are socialized and reinforced for certain health-related behaviors—or in this case, nonaction—even though in some circumstances this inaction is deleterious to their health.

Helping professionals should also consider the individual's health literacy. Health literacy is conceptualized as “a constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment” (Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs [CHL], American Medical Association, 1999, p. 553). In their report, the CHL found that individuals who had poor health literacy also tended to report worse health status, and these problems may also be related to increased risk of hospitalization (CHL, 1999). Health literacy is not only about the individual's ability to interpret and comprehend complex legal and medical language presented on many forms and notifications (Breese, 2005), but also about the ability to orally engage medical professionals and ask important and pertinent questions about one's health care (CHL, 1999). For helping professionals, it would be important to assess for the level of the client's understanding of the health materials (e.g., consent forms) and also to normalize the difficulty many people may have in understanding and interpreting the materials. Helping clients to ask appropriate questions, normalizing the anxiety around health-related information, and having resources available may be actions that engender future healthy behaviors and help seeking.

Finally, understanding the relationship between one's family of origin's social class, current social class, and health behaviors and attitudes is important. As Liu (in press) has suggested, it is necessary to consider the lifespan of the individual and how social class has impacted and shaped the individual's current worldview rather than focusing only on the individual's current social class position. More specifically, it is necessary to explore the individual's experiences with past and present economic difficulties and how these problems may be related to current mental health problems or crises (Hemmingsson, Lundberg, & Diderichsen, 1999; Lahelma, Laaksonen,

Martikainen, Rahkonen, & Sarlio-Lahteenkorva, 2006). Helping professionals should try and understand that a client's experiences with family financial distress and community economic problems may create psychological distress among parents who in turn may have less-positive interactions with their children (Gutman, McLoyd, & Tokoyawa, 2005). These familial or historical experiences with financial distress may manifest in the individual through dysfunctional coping styles such as materialism or a focus on money. Understanding the full history of the client may be a necessary step in understanding the causes for current attitudes and behaviors.

Implications for Practice

One approach or framework helping professionals may use is to integrate the biological, psychological, and social aspects and mechanisms that are related to our clients' health (Suls & Rothman, 2004). This tripartite model provides three points of access for the helping professional. The bio-psycho-social model provides a framework to assess clientele across relevant areas of life and experiences and attempts to provide a more whole profile of the client. With social class, the bio-psycho-social model approach allows the helping professional to ask, for instance, about where the client grew up, the health of the mother and healthiness of the pregnancy, any traumas or violence experienced, possible exposure to toxins, experiences with poverty or homelessness, and current diet. Along with integrating the biological mechanisms, the helping professional is encouraged to understand the psychological aspects related to disease and dysfunction and how the person's perceptions, attitudes, experiences, and history are related to his or her current state. Finally, the social aspect compels helping professionals to consider the context within which the individual lives and how situations and the macro functions of society may impinge on the individual. For those helping professionals who are social justice oriented, understanding the context of racism and classism and how it impacts the physical and mental health of clients allows for other ways to be advocates and change agents for clients (Liu & Hernandez, 2010). I would also suggest the possibility of spirituality as part of the assessment and considerations for clients. Often, solace and meaning may be found through various spiritual and religious avenues, and the helping professional should consider the meaning making of spirituality as well as the potential for spirituality to be associated with the person's well-being (Rose, Westefeld, & Ansley, 2001).

Another consideration for helping professionals is to explore more specifically the health behaviors of clients. Helping professionals should

train and educate themselves on basic metabolic issues and perhaps take a course or workshop on nutrition, kinesiology, or health behaviors. Helping professionals should ask clients about what are they eating, how much, and when. Are the clients exercising? Do the clients have opportunities for healthier behaviors? This last concern is pertinent because devising a plan of action with a client without appropriate resources will only frustrate the client and damage the helping professional's credibility and trustworthiness (Sue & Zane, 1987). This expectation would require helping professionals to explore the environment of the client and be familiar with resources and outlets that will support the client's and helping professional's goals.

Finally, in working with clients, the helping professional will need to collaboratively develop a means to communicate basic health-related information. The helping professional should not assume that the client understands the materials. Instead, the helping professional should rely on their working alliance and relationship to make sure the client understands via some Socratic questioning (e.g., helping them learn to ask the appropriate questions necessary for them). Many times, clients are presented with complex forms that are difficult to interpret even for the educated reader, so the helping professional should seek a partnership with the client to help him or her better understand the health information presented.

Conclusions and Summary

The purpose of this chapter was to provide helping professionals with some foundation on the health consequences related to inequality, poverty, and being poor. Overwhelming research evidence suggests that being at the bottom rungs of the economic hierarchy has deleterious consequences for one's physical and mental health. Even if one were to successfully break the cycle of poverty and live in wealth and affluence, exposure to the toxicity of poverty at an early age can have long-term consequences.

The two specific forms of environmental classism discussed were the toxicity related to living in poverty and the problems of malnutrition. For infants and children, these two problems may start a life-long battle of poor physical and mental health. And for helping professionals, it is imperative that the client's concerns and issues be contextualized by understanding how the context of poverty and inequality may be related to the client presenting concerns. Taking this bio-psycho-social approach may allow the helping professional a broader perspective on the causes of the problems and also on possible solutions.

Finally, for helping professionals with a social justice orientation, understanding environmental classism allows for other avenues of client advocacy. For instance, it may be important that helping professionals be involved in local government as a way to help communities get more supermarkets, playgrounds, and recreational options. Limiting the expansion of liquor stores, fast-food restaurants, and convenience stores, for instance, may allow those in poverty to have more access to better-quality food. These forms of social justice advocacy are not within the standard nomenclature such as antiracism, but the effect of these efforts is in fact antiracist and anticlassist. Working for the community in these capacities allows one to develop relationships across communities and become a visible advocate.