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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Economic stress in childhood and adulthood, and poor psychological health: Three life course hypotheses



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ARTICLE INFO

Article history:

Received 16 April 2013

Received in revised form

8 November 2013

Accepted 19 November 2013

Available online 26 November 2013

Keywords:

Economic stress

Mental health

GHQ12

Life course perspective

Social capital

Sweden

ABSTRACT

Investigations of mental health in a life course perspective are scarce. The aim is to investigate associations between economic stress in childhood and adulthood, and poor psychological health in adulthood with reference to the accumulation, critical period and social mobility hypotheses in life course epidemiology. The 2008 public health survey in Skåne is a cross-sectional postal questionnaire study. A random sample was invited which yielded 28,198 respondents aged 18–80 (55% participation). Psychological health was assessed with the GHQ12 instrument. Logistic regression models were used to investigate the associations adjusting for age, country of birth, socioeconomic status, emotional support, instrumental support and trust, and stratifying by sex. The accumulation hypothesis was confirmed because combined childhood and adulthood exposures to economic stress were associated with poor psychological health in a graded manner. The social mobility hypothesis was also confirmed. The critical period hypothesis was not confirmed because both childhood and adulthood economic stress remained significantly associated with poor psychological health in adulthood. Economic stress in childhood is associated with mental health in adulthood.

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1. Introduction

Poor psychological health is one of the chronic health problems with highest prevalence globally. In Sweden, 39.8% of all newly granted sickness benefits among men and 41.5% among women in 2006 were due to psychiatric disorders and syndromes, including “burnout” syndrome (Danielsson, 2009). A 10–15% proportion of all adults in Sweden are estimated to have mental health problems which would motivate seeking help within the health care system (Persson, 2005). Poor psychological health is not only a highly prevalent cause of chronic disease in the general population. It is also an important explanation behind socioeconomic differences in health in the general population. Socioeconomic differences in psychiatric disorders have been observed internationally for decades (Stanfield and Marmot, 1992). A recent study in southern Sweden has indicated that the non-manual employees in higher positions category have a similar prevalence of poor psychological health as non-manual employees in middle positions, non-manual employees in lower positions, skilled manual workers, unskilled manual workers and self-employed (no significant differences when analyzed with non-manuals in higher positions as references

group) among both men and women. In contrast, the early retired, the unemployed, students and persons on long term sick leave have significantly higher odds ratios of poor psychological health among both men and women (Lindström et al., 2012a). Poor psychological health in adulthood is also associated with other current conditions in adulthood such as age, sex, country of birth (Lindström, 2004), emotional support, instrumental support and generalized trust in other people (Lindström et al., 2012b). Trust in others may be regarded alternatively as a psychological trait or as an aspect of social capital (Putnam, 2000).

Psychological health and socioeconomic differences in psychological health in adulthood may, however, also be causally affected not only by current social and economic conditions in adulthood but also by a wide variety of comparatively prevalent childhood conditions. Childhood seems to be a particularly sensitive period with regard to environmental disturbances which increase risk of depression (Heim et al., 2010). Experiences of childhood adversity with psychological consequences reaching into adulthood in the form of depression and anxiety are prevalent in western countries. In the USA, the rate of child abuse and neglect reached 10.6% in 2007 (US Department of Health and Human Services, 2009). It has been estimated that approximately 30–40% of the risk of depression across the life course is genetically determined, while the rest of the risk can be attributed to environmental factors (Merkangas and Swendsen, 1997; Heim and Binder, 2012). The role of early life environmental stress factors in developing major depression, apart from genetic factors, has been

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demonstrated in twin studies (Kendler et al., 2000). Such childhood stressors include physical, sexual, emotional and verbal abuse, neglect, social deprivation, household dysfunctions including violence and witnessing violence, poverty, parental separation, parental death or illness, disaster, substance abuse and criminal activity (Brown et al., 2009). Recent studies suggest a substantially increased risk of internalizing depressive and anxiety disorders into adulthood following early life stress in childhood (Kendler et al., 2003; Nugent et al., 2011). Childhood sexual or physical abuse was shown to be associated with increased risk of symptoms of depression and anxiety, addiction, psychiatric admissions and suicide attempts (McCauley et al., 1997). Poor paternal relationship or maternal overprotection is also associated with increased risk of depression (Lizardi et al., 1995). In fact, there seems to be a dose–response relationship between the severity of the experience of childhood adversities and the severity of depressive episodes and overall lifetime experience of chronic depression (Chapman et al., 2004) as well as between childhood adversities and adult experience of mental health problems in general (Edwards et al., 2003).

In the latter two decades there has been a surge in life course research, i.e. research concerning the influence of risk factors in early life on health later in life. The notion that exposure to risk factors in early life in utero or in childhood may causally affect health later in life was first empirically investigated by Barker in relation to the metabolic syndrome, type II diabetes and cardiovascular diseases. Barker (1995,1998) suggested that the last trimester of life in utero was a “critical period” which if exposed to growth retardation would eventually result in a number of increased risk factors and diseases related to the metabolic syndrome. The critical period hypothesis has later been empirically investigated with regard to a variety of diseases other than the metabolic syndrome and its clinical consequences (Sahade et al., 2011). The literature concerning childhood experiences of psychological and psychosocial adversities and their effects on depression, anxiety and other mental disorders in adulthood suggest that childhood may be regarded as a “critical period” also for these conditions. Since Barker's original work, an entire theoretical framework, several models, a range of concepts connected with this theoretical framework, and other complementary as well as competing life hypotheses have emerged. Such hypotheses include the accumulation of risk hypothesis in several forms including accumulation of risk over time and accumulation of risk over time by clustering of risk factors over time, birth cohort effects, chains of risk models and several variants of the critical period hypothesis (Ben-Schlomo and Kuh, 2002; Kuh et al., 2003). Two main life course hypotheses other than the critical period hypothesis are the accumulation of risk and social mobility hypotheses. The accumulation of risk hypothesis suggests that exposures accumulate during the life course in order to cumulatively increase the risk of chronic disease in adulthood (Hallqvist et al., 2004). The social mobility hypothesis is more directly focused on life course social epidemiology. The idea behind the social mobility hypothesis is that intra- and inter-generational social mobility, mostly defined in terms of socioeconomic status (SES) by occupational status, education, income or economic stress, will have an effect on health in adulthood. This hypothesis also implies that social mobility per se should be considered a potentially important social cause of disease (Lynch et al., 1994).

In this study the aim is to empirically test the critical period, accumulation and social mobility hypotheses in the 2008 public health survey distributed to a random sample of 18–80 years old adults in Skåne, southern Sweden, in relation to poor psychological health in adulthood. A public health survey item concerning recalled economic stress in childhood will be combined with an item concerning the current experience of economic stress in adulthood. Previous studies have suggested the importance of

childhood poverty, social deprivation and various household dysfunctions as early life stressors for mental health in childhood and adulthood (e.g. Brown et al., 2009), but no study has empirically tested the association between both childhood and adulthood economic stress and poor psychological health in relation to the accumulation, critical period and social mobility hypotheses. The item concerning economic stress in adulthood has been analyzed in relation to health and health related behaviors in earlier studies based on earlier public health surveys in Sweden (Fritzell and Burström, 2006). A previous study based on the 2008 Skåne survey has investigated the associations between economic stress in childhood, economic stress in adulthood and self-rated global health (Lindström et al., 2012b). A second study has analyzed associations between economic stress in childhood and adulthood and tobacco smoking (Lindström et al., 2013). We investigate whether economic stress in childhood or economic stress in adulthood is critically associated with poor psychological health in adulthood when investigated in the same model (critical period), whether economic stress in childhood and economic stress in adulthood have a graded association with poor psychological health in adulthood (accumulation), and if social mobility is associated with poor psychological health in adulthood (social mobility).

The aim is to investigate the associations between economic stress during childhood and adulthood, and poor psychological health with reference to the accumulation, critical period and social mobility hypotheses, including demographic, socioeconomic, psychosocial factors and trust in the multiple adjusted models.

2. Methods and materials

2.1. Study population

The 2008 public health survey in Skåne in the southernmost part of Sweden is cross-sectional. A total of 28,198 persons randomly selected from the official population registers of people living in Skåne born between 1928 and 1990 answered a postal questionnaire in August–September 2008, and the participation rate was 55%. Two reminder letters were sent. The study has been approved by the Ethical Committee at Lund University, Sweden (No. 2010/343).

2.2. Definitions

2.2.1. Dependent variable

Self-reported psychological health (GHQ12) includes 12 items reflecting different aspects of psychological health. The items included in the GHQ12 are “Have You been able to concentrate on what You have been doing during the past weeks?”, “Have You had problems with Your sleep during the past weeks?”, “Do You feel that You have been useful during the past weeks?”, “Have You been able to make decisions in different areas during the past weeks?”, “Have You felt tense during the past weeks?”, “Have You during the past weeks been able to appreciate what You have been doing during the days?”, “Have You been able to deal with Your problems during the past weeks?”, and “Generally speaking, have You felt happy during the past weeks?”. These eight items had four alternative answers: “More/better than usually”, “As usual”, “Less than usual” and “Much less than usual”. The items were dichotomised with two alternatives denoting “good” psychological health and two alternatives denoting “bad” psychological health. Four other items had somewhat different alternative answers: “Have You felt unable to deal with Your own personal problems during the past weeks?”, “Have You felt unhappy and depressed during the past weeks?”, “Have You lost faith in Yourself during the past weeks?” and “Have You felt worthless during the past weeks?”. The four alternative answers to these four items were “Not at all”, “No more than usually”, “More than usually” and “Much more than usually”. The answers to these items were also dichotomised to denote “bad” psychological health or “good” psychological health. If three or more of all the 12 items denoted “bad” psychological health, general psychological health (GHQ12) was denoted as “bad”. This instrument for the measurement of psychological health is the shortest (other GHQ measures contain for instance 28 or 60 items) but has still been shown to be a very robust measure of psychological health (Goldberg et al., 1997).

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